Board of Directors Part One

Agenda and papers
of a meeting to be held in public

2.00pm–4.40pm
Tuesday 26th January 2016

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

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

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 26th January 2016, 14.00 – 16.30
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

	PRELIMINARIES			
1.	**Chair's Opening Remarks** Mr Paul Burstow, Trust Chair		Verbal	-
2.	**Apologies for absence and declarations of interest** Mr Paul Burstow, Trust Chair	To note	Verbal	-
3.	**Minutes of the previous meeting** Mr Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	**Outstanding Actions** Mr Paul Burstow, Trust Chair	To note	Enc.	p.11
4.	**Matters arising** Mr Paul Burstow, Trust Chair	To note	Verbal	-
	REPORTS & FINANCE			
5.	**Service User Story** Video Presentation, Primary Care Service Lead	To note	Verbal	-
6.	**Service Line Report – Adult Primary Care Services, TAP, PCPCS** Mr Tim Kent, Primary Care Service Lead	To discuss	Enc.	p.12
7.	**Trust Chair's and NEDs' Reports** Mr Paul Burstow, Trust Chair	To note	Verbal	-
8.	**Chief Executive's Report** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.53
9.	**National Planning Guidance Update** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.57
10.	**Draft Quality Strategy** Ms Louise Lyon, Director of Quality & Patient Experience	To discuss	Enc.	p.92
11.	**Quarter 3 Quality Report** Ms Marion Shipman, Associate Director for Quality & Governance	To note	Enc.	p.113
12.	**Finance and Performance Report** Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.139
13.	**Training and Education Report** Mr Brian Rock, Director of Education & Training/Dean	To note	Enc.	p.149
14.	**Training & Education ICT Full Business Case** Mr Brian Rock, Director of Education & Training/Dean	To approve	Enc.	p.153

15.	**Quarter 3 Governance Statements** Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.199
16.	**Emergency Planning Preparedness Assurance** Dr Rob Senior, Medical Director	To approve	Enc.	p.204
CLOSE				
17.	**Notice of Future Meetings** • Tuesday 9th February 2016: Directors' Conference, 10.00am-2.00pm, Lecture Theatre • Tuesday 23rd February 2016: Board of Directors' Meeting, 2.00pm – 5.00pm, Lecture Theatre • Thursday 3rd March 2016, Council of Governors' Meeting, 2.00pm – 5.00pm, Board Room • Tuesday 8th March 2016: Leadership Conference, 9.00am – 1.00pm, Lecture Theatre		Verbal	-

Board of Directors

Meeting Minutes (Part One)
Tuesday 24th November 2015, 2.00 – 4.20pm

Present:			
Mr Paul Burstow Trust Chair	Prof. Dinesh Bhugra NED (left at 4.00pm)	Ms Jane Gizbert NED	Dr Sally Hodges CYAF Director (arr. 2.57pm)
Mr David Holt NED	Mr Paul Jenkins Chief Executive (arr. 2.57pm)	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			
Attendees:			
Mr Gervase Campbell Trust Secretary (minutes)			
Apologies:			

Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to be made to the minutes	GC	Immd.

1. Trust Chair's Opening Remarks
Mr Burstow opened the meeting and noted that Mr Jenkins and Ms Hodges were delayed by a prior engagement.

2. Apologies for Absence and declarations of interest
Apologies as above. There were no declarations of interest specific to this meeting.

3. Minutes of the Previous Meeting
AP1   The minutes were approved subject to minor amendments

4. Matters Arising
Action points from previous meetings:
AP1 – (minutes) – completed
AP2 – (Updated QR) – completed
AP3 – (BME figures clarification) – completed
AP4 – (comment on Care Notes) – completed
AP5 – (check DNA rates) – completed

OAP4 – (team descriptions) – not yet circulated.

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5.   Service User Story

Mr F. explained that he and his partner had adopted 3 boys, the eldest of whom, J, was attending the Gloucester House (GH) school. The boys were aged 4, 5 and 6 when they were adopted five years ago, and had experienced neglect and trauma. This had been extremely challenging for the parents. J. was diagnosed with severe attachment disorder and ADHD and needed therapy three times a week, but the CAMHS service in Barnet could only offer it once a week, and he was having serious tantrums every day, sometimes needing restraint. He could not manage in school, and his school would only accept him 2 days a week, adding additional strain to the family.

Mr F. heard about GH from the Barnet adoption team, called up, had an interview and J. was accepted. Since then J's anxiety levels have reduced, he is in a safe and secure environment, and the intensive therapy has helped him manage his emotional feelings to the point he can now do self-repair, and can calm down within minutes instead of hours. Whilst he still has bad days he is emotionally more stable, and has benefitted from boundaries at school and at home. They were now preparing him to transition back into mainstream schooling. GH had helped them as parents too, in understanding and managing his behaviours, and in finding middle ground. GH had a good understanding of them as parents, of what it is like to be an adoptive parent, and they feel they can communicate honestly with the school. They'd also met other parents there, and shared experiences and learning in the group sessions, which provided excellent support.

Ms Gizbert asked how the younger brothers had reacted. Mr F. explained the other boys were changing, were coming out more now, and they were able to give more of their attention to them now that J was doing so well.

Dr McPherson about help they had received before GH. Mr F. said they had been treated really well by social services, given lots of information, but the adoption had been in Yorkshire and there had been no continuation when they moved to London, and they'd found it very hard to get CAMHS help. Dr Senior commented on the importance of post-adoption support, and wondered whether the tools learnt from GH might have meant attending the school in person wasn't required. Mr F. commented that Barnet Council and the pre- and post- adoption support had been excellent, but they hadn't had much knowledge of the GH, and if they had been able to attend the school earlier it would have been easier.

Mr Holt asked about the transition coming, and what support the Trust should offer. Mr J. said they had excellent support and backup in place, and the move would be difficult but they had good counselling and what was being put in place was really good. The transition would be gradual, starting with one day a week in a mainstream primary school, and building from there so he would be ready for secondary next year. The contact with GH would remain, and the therapy would continue, but at a reduced frequency. Ms Nicholson added that it was an anxious time for the whole network, the new school included, and the family would be referred to

Barnet CAMHS when they left GH, but they would also keep informal links in place so the parents or the schools could come to them for advice.

Mr Burstow thanked Mr F. for sharing his story, which was very useful to the Board. He commented on how important it was to work with the whole family, and that it was interesting that the social workers hadn't know about GH at the time.

The Board thanked Mr F.

6. **Gloucester House – Service Line Report**

Ms Nicholson commented on how much stronger the position of GH was now than two years ago, when they had been on the brink of closure. At the moment they were overwhelmed with referrals and enquiries, and had just opened a 3rd class. They had anticipated this would cause unsettlement, but the level of work involved in the transition was having an impact on them all. However, the long term benefits of having more movement between classes, as well as financial security, were well worth it.

Mr Burstow commented that it was a great report, very rich, and he had visited on the first day of the new class so had an idea of the impact it was having. He asked about the dramatic change in IEP targets on p.36 of the appendix, and Ms Nicholson explained that when they had seen the results for March they'd recognised they could improve, and had put a lot of effort into those areas. Ms Gizbert asked if something specific had been done to improve the listening score, and Ms Nicholson explained that it was a really important area for the staff, fundamental to the ethos of the school, so they'd done a lot of work in various forums to address it.

Dr McPherson commented that the report had an excellent depth of detail on the model, and how its implementation had been reviewed and staffing adjusted according to the needs of the service. He asked how staff had dealt with the big changes. Ms Nicholson explained that the changes had empowered staff to feel more power at all levels. They had done impact assessments before and after, looking at quality, pressure, involvement, and the results had been very positive with 92% feeling favourable about the new model.

Mr Holt noted they had taken on a couple of specialist staff as the numbers of pupils had increased, and asked if there were any areas they felt they were missing out on at the moment because of financial constraints. Ms Nicholson said there weren't, and commented that the best move had been adding nurses as they worked so well with teachers. She added that the less experienced staff had a lot of skills and energy to contribute, and they were seeing more links into the other departments, with ideas for placements coming in.

Mr Rock noted their current workload and asked about future needs for movement to new boroughs and into network engagement. Ms Nicholson explained that the latest model with three classes gave them the capacity

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for liaison work, but at the moment the focus had to be on ensuring that the consequences of the existing expansion was allowed to settle down. Ms Jones commented that it was an amazing achievement, but it came at a cost of the pressure on staff, and asked if staff support time was sufficiently protected under the new model. Ms Nicholson confirmed it definitely was, with individual and group supervision protected at all levels. Professor Bhugra noted the stress on staff and asked what Ms Nicholson would like from the Board. Ms Nicholson commented that she understood the pressures on the Trust, and was content with the increased contribution, but requested this should be all for now, and the level of work and commitment appreciated.

Mr Rock asked whether E&T could give support in finding a wider market. Ms Nicholson commented that they were keen to do more outreach and get involved with training and to work alongside other parts of the Trust, and had in fact done a piece of consultation recently, but there were knock on effects, so capacity was something for the steering group to consider. Mr Young commented that it was difficult for consultancy and outreach to contribute to the finances. He added that they should be willing to review all models in the Trust in the light of the success that GH had seen in their radical changes to an old model which had been functioning, but not as well as it could, and expensively. Dr McPherson commented that the outreach work also acted to raise the profile of GH. Mr Burstow added that there was a discussion to be had about how to maximise what could be learnt from the model more widely, and how to develop outreach both for its direct impacts and also its impact on the profile of the service.

The Board **noted** the report.

[Mr Jenkins and Dr Hodges joined the meeting at 2.57]

7. Trust Chair and NEDs' Reports

Mr Burstow welcomed Mr Jenkins, and welcomed Dr Hodges to her new role. He noted that he had attended the NHS Providers Conference two weeks ago, and had visited GH and Tavistock Consulting since his start, both of which had been valuable experiences. He had also chaired a round table for young carers at the Carers Trust, and was keen that Trust explored what contribution it could make in this area.

Ms Murphy reported that she had:
- Visited Camden TAP, which was a new group based in surgeries, which was developing techniques to engage with GPs and get their confidence. The team were keen to engage with the centre, and she was reassured by their ability to raise concerns and issues.
- Facilitated a meeting between our PPI lead and the new PPI lead at UCL medical school, to look at helping students understand complex patient groups. There was scope for development and research work in this area.

Mr Holt commented that he had found the 'Café Style' service session after the joint meeting valuable, and the interactions direct and open, and thought it should be repeated, perhaps annually. Dr McPherson added that it had been valuable for staff too, allowing them to talk to each other.

Ms Gizbert reported that she:

- Visited the Family Mental Health Team and heard a case discussion at their team meeting.
- Attended a meeting at the DoH where it was discussed that the CQC were to be asked to review the safety of patient information, by looking at a sample of 20 trusts, and would report in January.

The Board **noted** the reports.

8.   Chief Executive's Report

Mr Jenkins took the report as read, but highlighted the launch of Haringey Thinking Space, which builds on the Tottenham Thinking Space, and is an exciting blend of clinical work with a community initiative. Replication is possible, whether led by the Trust or by sharing out insight and knowledge.

Professor Bhugra asked what effect the junior doctor strike would have. Dr Senior explained that they were discussing it with junior doctors, who were responsible for making arrangements to cover their patients, and the Trust did not anticipate much impact, and there would be no impact on safety. Ms Murphy suggested that there might be a potential for indirect impacts from patients not being able to find emergency care in other Trusts. Dr Senior agreed this was possible, and noted that back up for the day rota was provided by consultants, who would ensure they were properly available to attend neighbouring trusts if required.

The Board **noted** the report.

9.   Strategy – Two Year Objectives

Mr Jenkins noted the objectives were returning for approval after discussion at the October Board meeting, and November Joint Boards meeting, so that they could be communicated widely to staff and focus moved to delivery. He noted that for objective D3, the geographic reach of training, they would look to replace percentage targets with numerical ones, and might adjust the plan further if HEE required it as part of discussions on the National Contract.

He commented that the targets were ambitious, but necessary, and that a pragmatic approach would be required in taking it forward. There was a commitment to driving and monitoring progress more systematically than in the past, and the Strategic & Commercial Board would take on this review role. Work needed to be done on how to judge progress and set milestones, but a review would be done in March 2016. The NEDs gave their full

support to the plan, and commented that the objectives were very clear and laid out in a way that was easy to put into practice. Mr Burstow added that he would also ensure that a focus, and time for reflection, was maintained in the board meetings.

The Board **approved** the objectives.

10 Finance and Performance Report

Mr Young introduced the report by addressing the vacancies, noting they broke down into four categories. Firstly there was turnover, where it can take time to replace clinical and academic posts. This had been traditionally covered in budgets with a 'vacancy factor', and with no redundancy schemes in place it might be time to reintroduce this. Secondly, there were some posts that managers kept vacant longer whilst they took the opportunity to re-shape the roles. Third was growth, where new services such as TAP require staff from existing services, who then need to be replaced. Lastly there were FNP and GIDS, both of which were forecasting significant underspend at years end for reasons internal to those services, which they had discussed before. Dr McPherson asked if there might be some miscommunication between managers and finance, as some teams didn't seem to understand the situation. Mr Young confirmed that managers had access to finance, and agreed it was puzzling. Ms Lyon and Ms Hodges confirmed that managers were aware, but perhaps more needed to be done on communicating with their staff.

Mr Holt noted that they were still showing £300k put aside for restructuring, and if this wasn't needed now, asked if it should be invested. Mr Young confirmed that there were no plans for wider restructuring but he was unaware of a number of individual areas where some restructuring costs might be incurred. Mr Burstow noted that the vacancy discussion was an ongoing one, and tied into the strategic goal of promoting the health and wellbeing of staff. He emphasised the existence of this sum of money available for strategic investment.

The board **noted** the report.

11 Training and Education Report

Mr Rock gave a marketing update, noting the new prospectus had been completed in time for the open evening, and had seen a positive response. All the courses would be open for applications from January. Fees would be updated at that point, work was being done now to review their internal consistency and map them to competitors, and they seemed to be about right.

The reconfiguration of the office was underway, following the agreement by email. The restructuring consultation had begun, with constructive engagement with the Portfolio Managers and active involvement from Angela Haselton on staff side, and good support from Susan Thomas in HR.

It was a difficult process, especially for staff whose roles had not been scrutinised for some time, and they had agreed to extend the consultation period to the 10th December.

Professor Bhugra asked what support was currently available for overseas students who required visas. Mr Rock explained they had a number of staff skilled in Tier 4 visas, and the recent QAA review had focussed on their suitability to accept international students and been fully satisfied.

Dr McPherson praised the prospectus, and especially the inclusion of student stories. He noted that the library services were critical, and the satisfaction results they got were excellent. Ms Murphy echoed the importance of library staff. Dr Hodges noted the library was also working with them on patient experience, and were pro-actively looking to offer a separate area for patients. Mr Rock agreed they did excellent work and were always innovating, and added that they planned to have a report for the project board in the new year on possibilities for growth and support to the regions.

The Board **noted** the report.

12 Clinical Governance, Safety & Governance (CQSG) Quarter 2 Report

Dr Senior presented the report and invited questions.

Mr Holt asked for further information on the implications of the delay to the implementation of the Data Loss Protection, p63, as the Audit Committee were concerned with cyber security more widely. Mr Young explained that this referred to systems and other safeguards to reduce the risk of person identifiable information being sent over unsecured channels, and whilst they did have safeguards in place, the more comprehensive methods they had agreed might not be completed on time. Dr Senior confirmed that this would be green on the action tracker by the end of the year.

Mr Burstow asked for an update on ligature points. Ms Lyon confirmed the external audit had been completed and they were now looking at what proportionate changes should be made to address any risks identified.

The Board **noted** the report.

13 Equalities Monitoring of Clinical Services

Ms Lyon introduced the report, noting that it was important for the Board to know about our performance on inclusiveness, but also whether the right data was being collected in the most helpful way. She thanked Mr Young for his help in finding the comparators and especially for the variation by

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age group, which was important as there was a changing demographic. Mr Burstow suggested that it would also be important to consider associative discrimination, and whether it would be possible to gather data on carers.

Dr McPherson commented that they offered limited services for older adults, but the demographic was shifting that way, and it might be time to reconsider this. Ms Jones commented that Claire Kent was working on scoping what we currently do and what our contribution could be. The Trust did not historically have expertise in this area, but we did in supporting families, so they were working to find a thoughtful way in. Dr McPherson added that it was important to get the message they had services, such as for depression, that were already available and would be useful to this group.

Mr Holt noted that at the other end of the age range only 10% of those seen were under 5, and asked if we could offer our services earlier to greater effect. Dr Senior commented that the profile fits what would be expected from epidemiological studies, but there was a push to do more earlier, and it was harder to help later adolescents. Ms Hodges added that the transformation plans had an emphasis on earlier intervention.

Mr Burstow summarised that there was an opportunity for service development, it was possible a focus on dementia was overshadowing the other contributions the Trust could make to older patients, and there was room for discussion of the impact on carers. He suggested that Camden TAP and City and Hackney could use their links with GPs to see what the needs of families were.

The Board **noted** the report.

14   DET office reconfiguration – phase 2 of capital project

The Board **ratified** the approval they had made via email on the 5th November to proceed with Phase 2a and 2b of the project.

15   Procurement of New Intranet

Mr Jenkins introduced the report, noting that the current intranet was not fit for purpose, and did not help staff in the way that it could. The Management Team had considered the problem, and would like to commit to a new system. He noted that this work would be done alongside the move of the website to a new provider, and commented that for both they would ensure that the customer voice was properly represented, and they had looked at products in use by other organisations to get an idea of what was possible and desirable.

Dr McPherson noted that the current system was a source of dissatisfaction to staff, and strongly supported the move to replace it.

The Board discussed the phases of the project, and agreed the importance of involving staff and getting the specification right.

The Board **approved** the procurement of a new intranet.

16   Corporate Governance – NED Links and Committee Memberships, Charitable Funds Annual Report, SCPB ToR, Use of Trust Seal and Register of Interests.

NED Links and Committee memberships.
Mr Campbell explained that Mr Burstow was taking on the roles previously held by Ms Greatley, and Dr Hodges was taking on those previously held by Dr Harris. The Board noted that the PPI committee was being wound up in its current form, so the list should reflect this as a NED link rather than a membership, and that Ms Gizbert should not have been listed as a member of the Education and Training Programme Management Board.

The Board **approved** the list, with these amendments.

Charitable Funds Annual Report and Accounts
Mr Young commented that the accounts had been to the independent auditors and approved, and noted that on p.108 it should read 'none received' under the heading of Material Legacies Received. He noted that normally the report would be recommended by the committee, but they had not been able to meet before Mr Burstow had been confirmed as the Chair today, however the report and accounts had been reviewed by the CEO and Deputy CEO who recommended them for approval.

The Board **approved** the Annual Report and Accounts of the Charitable Funds.

Terms of Reference of the Strategic and Commercial Board (SCB), previously the SCPB.
Mr Holt noted the new focus of the committee was reflected in the changes to the terms of reference, and noted the change in name. He raised the question of whether it was necessary to have 3 NED members, as was currently the case. After discussion it was agreed that it should remain as 3 for the time being. Mr Holt also noted that he was currently Chair of both the Audit Committee and the SCB, which was not an ideal situation. It was agreed that this was acceptable, but should be changed with the recruitment of the next NED in 2016, who should have a commercial background. Dr Senior noted the role of the committee in considering quality and safety in bids, and requested that the Medical Director be added to attendance in para. 2.2.2 so that issues of clinical governance and risk were appropriately addressed.

With this amendment, the Board **approved** the new ToR of the Committee.

Use of the Trust Seal
Mr Campbell explained the use of the Trust Seal, and asked for retrospective approval.

The Board **approved** the use of the Seal.

Register of Interests
The Board **approved** the Register of Interests.

17   Any other business
The Board noted its future meetings.

Part one of the meeting closed at 4.20pm.

Outstanding Action Part 1

Action Point No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
4	Apr-15	11. Draft Annual QR	Produce summary sheets for each service	Louise Lyon	Jul-15	Complete: Team Descriptions circulated 27.11.15

Outstanding Actions

Board of Directors : January 2016

Item: 6

Title: Service Line Report: Primary Care Services; PCPCS and TAP.

Purpose:

This report is written to provide the Board of Directors with assurance of achievements and progress towards meeting Service and Trust-wide objectives by the Team Around the Practice (TAP) service

This report has been reviewed by the following Committees:

- Management Team, 12th January 2015

This report focuses on the following areas:

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

For: Discussion

From: Tim Kent, Primary Care Service Lead.

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Service Line Report – Primary Care Services; PCPCS and TAP.

Executive Summary

1. Introduction

The Primary Care service includes the City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) and the Camden Team Around the Practice (TAP).

The PCPCS team based in the East London borough of Hackney has been running for 6 years. TAP is the new baby sibling having started out in July 2015 (approximately 6 months to date) but with a great deal of preparation and work behind the scenes over the last 2 years.

Primary Care is a newly formed department in its own right within the Adult and Forensic directorate.

There are approximately 50 staff across the serviced including clinical, administrative, management and trainees.

Most of the PCPCS core team staff are now on permanent contracts after a number of years on rolling, renewable one year contracts. The rest of the service including Care Planning and TAP are on temporary contracts. I address the significance and impact of this later.

The core contracts are with Camden and Hackney CCGs respectively but we also hold a contract with the 'One Hackney' organisation and until recently with the Homerton University Hospital Psychological Medicine service

Areas of Risk and/or Concern

1.1 .

The most significant risk is our waiting list for treatment at PCPCS which has grown steadily over the past 2 to 3 years and now reaches 10-12 months for some patients. Considerable staffing changes have added to the insecurity with 4 pregnancies, the consultant Psychiatrist being seconded to work in another trust area, the service lead, service administration, and manager

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changing, senior staff unplanned extended leave and the clinical operations manager promoted but without a suitable replacement for 4/5 months.

The other significant risk is the short-term funding and potential end (in September 2016) of the One Hackney project which currently resources our Care Planning and One Hackney services. There are seven staff in this part of the service, most of their contracts end in March 2016 but will be extended until September 2016. One member of staff, Dr Kim Barlow, has already found new permanent employment elsewhere and it may prove difficult to retain staff over such an unstable period. Previously City and Hackney CCG had funded the Care Planning service directly and had asked us to set up the service at very short notice with pressure from NHS England to achieve Care Plan targets in a short period of time. The change of funding and accountability to the One Hackney organisation effectively limits the service to the life of One Hackney's funding stream.

2. Proposed Action Plan

The waiting list is being addressed in a number of ways;

- Addressing patient complaints and concerns about waiting times and reviewing when clinical priority justifies being seen more quickly.

- Ongoing recruitment of new staff and maternity cover (approximately two posts cover are financially possible for 3 maternity periods).

- Written updates and information for patients about extended wait.

- Waiting list support group in place for the more anxious waiting patients

- The possibility of referring some less complex patients to colleagues in member services of the Hackney Psychological Therapies Alliance. Unfortunately most of these allied services have their own waiting lists and challenges.

- We are suggesting to the CCG that the service use some existing but as yet unused resources from another associated project in order to prioritise a waiting list blitz and recruit a small additional team to take this forward.

Main Report

3. Overview of the Service

3.1 Core identity and purpose

The primary care services offer specialist mental health input for adults from 18 yrs upwards within their local GP practice. We aim to help reduce health inequalities for groups of people who may not have traditionally sought or been considered for psychological therapies. Our base within the community allows access at a familiar point of contact and encourages the development of relationships between our clinical staff and surgery staff. In the current climate of overwhelming pressures on GPs and primary care we are well placed to help look after the mental health of surgeries as well as the patients.

We offer a range of assessment, consultation, case management and treatment options including couple & family work as well as professional training and joint consultation. There is no upper age limit and we actively encourage appropriate referral of older adults whose care tends to be over medicalised, and under referred for psychological therapies patients and their referring GPs and practices. The Team Around the Practice, similar to Team Around the Child in CAMHS services aims to scaffold and look after patients and the healthcare interface with GPs and primary care staff. Key to the model is the awareness and use of relationships as a key tool to building capacity through collaboration, modelling, consultation, support and informal contact (the all-important corridor and tea room conversations.)

The service is especially conscious of the significant role that GPs play in the lives of their patients and the importance of this attachment. The GP, and often the wider surgery team, occupy a pivotal link for the individual. GPs are among the few if not only professionals who have an overarching view, often developmentally and over a long period of their patients' difficulties from the personal to the familial and the wider community; from physical problems to emotional distress. This distinctive position offers the potential to provide and promote integrated care. We aim to work alongside the GP in this endeavour & in practice, even if our input is modest relative to the scale of patient's multiple problems the difference and input is often valued and felt. Of course, we will not always come up to others expectations or standards but are able to work with knowledge and understanding of this reality.

Team Around the Practice.

TAP Camden aims to bring high quality mental health care, consultation and psychological therapies into primary care settings which can be accessed by people who might otherwise not feel able or be able to use and indeed approach such services. Our physical, professional and psychological proximity to GPs and primary care staff is our greatest tool towards parity of care for mental health difficulties,

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particularly in relation to the very large percentage of cases where over-investigation, polypharmacy, medically unexplained symptoms and frequent attendance contribute towards expensive, inefficient and worrying situations for patients and professionals alike.

Our aim and practice has been to form respectful, transparent and supportive relationships with practice staff, in particular the admin and support teams who provide such important support to GPs and patients. Any issues or difficulties are quickly escalated and given careful thought so that we do not seem demanding or precious as the 'new kids on the block.' We understand that primary care is under great pressure and our approach to making arrangements for use of rooms and other practical matters is necessarily polite, friendly and straightforward. It seems likely that in Camden at least that the local Mental Health Trust is re-organising around primary care services, placing an immense pressure on space and accommodation. As GPs know and report at will, primary care settings were not built to accommodate multi-disciplinary teams and services for 24/7 access across the range of pathologies that exists within the human condition.

Care Planning Service

The multidisciplinary Care Planning team works with GPs to engage their most 'difficult to reach' patients with very complex physical and/or mental health needs. This work is often undertaken in close collaboration with the patients' family and/or carers as well as their GP. The Care Planning clinicians visit patients in their homes and aim to reach those patients who struggle to attend at the surgery. Sometimes such patients attend A&E frequently instead and often find their needs are not best met, causing distress and frustration.

3.2   Overall vision and strategy.

We have a model that works well, is supported by an excellent, independent study from the Centre for Mental Health and has found critical acclaim evidenced by frequent requests for us to speak at conferences and consult to NHS colleagues considering similar ideas.

Our strategy is to promote and grow the service within other CCG areas alongside developing consultative arrangements with areas that wish to develop their own services using our expertise and experience. For example, in Sheffield on January 14th 2016 we met with a group of approximately 50 clinical, managerial, administrative and commissioning staff from across primary care, CCG, Mental Health Trust and other associated services towards a new model of system wide provision. This work developed from existing links developed by the Dean with help from the primary care service lead who gave a Sheffield GP masterclass for a group of 20 or so GPs with a particular interest in mental health and complexity. We hope that this work will lead to a close working relationship with Sheffield and some

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ongoing consultancy. This work, and scoping for potential new areas has been fully supported by the commercial team.

We note that in recent months local Mental Health Trust services in Camden and Islington are actively considering their own reorganisation closer to primary care services, a trend that may develop elsewhere and open up further interest.

We are proud to have established a Primary Care Service that has two large teams in prominent inner London boroughs with some very creative, thoughtful and interested commissioners, many of whom are experienced GPs who understand and appreciate the important function of our applied models for their patients as well as themselves.   Our aim is to reproduce this model elsewhere with creative and bespoke changes / additions according to local need and priority.

MIND in TAP – Social Prescribing.

We wanted to use this reporting opportunity to say something briefly about a new part of the service that brings T&P alongside MIND in Camden in an innovative partnership. There are a multitude of models and frameworks which have developed under the banner of social prescribing, within community psychology, peer support schemes and primary care.

Mind was involved in producing the Building Resilient Communities 2013 report, cited in the TAP specification as guidance for non-medical approaches for mental health. This referenced the five ways to achieve positive wellbeing; Connecting, Being Active, Taking Notice, Learning and Giving. In particular, it described the important role communities can play in supporting our mental health. In order to promote this relationship to service users accessing social prescribing, TAP was aware of the need to develop a real relationship with the Camden community, and for all the link workers to understand and know the 'patch' they were working within. Therefore an early priority was to visit and talk to as many community projects as possible, creating a database of real connections, which we could then describe to those we were working with (see Appendix X).

At the heart of the effectiveness of social prescribing is the ability to make meaningful connections. TAP envisages building equally strong relationships with community services and service users. In this way, the link that link workers support service users to make with community resources will have more chance of holding.

An early challenge was to reconcile a short number of allocated sessions with a client, due to activity assumptions based on the contract, and to build these strong person-centred connections and relationships with our service users. This is still work in progress, but we are using a model based on motivational interviewing and solution-focused approaches, and provide flexibility in the number of sessions where we can.

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3.3   Progress to date and current position

PCPCS & Care Planning Service

As a significant new development working with CCG colleagues we developed a new careplanning service, initially by appointing to a senior clinical and managerial role leading a small but growing team of clinicians as a distinct service within the wider PCPCS model.. The CCG commissioned the Tavistock and Portman to assist them in developing a creative and responsive service that could assist GPs with some of their more worrying, time consuming and costly patients. In the early development of the service any potentially creative vision was limited by the short turn around for targets to be met by GPs. In practice most GPs went forward in creating care plans themselves for the majority of patients however a small and gradual stream of referrals started to come in with an implicit request for a slightly different type of therapeutic resource than PCPCS had traditionally offered. Many of the patients referred are not able, willing or safe to attend surgery based consultations so are often seen at home, many being effectively 'disabled' in multiple senses by their co-morbid physical, emotional and undetermined difficulties.   In essence the Care Plans themselves were often hard to define and the work of this growing arm of PCPCS began to take shape as a 'PCPCS +' type service that would see even more complex cases, make home visits and typically become involved in the wider systems and networks around their patients.
     The Care Planning Service includes the following provision:

- **Psychotherapeutic assessments** of complex patients, including joint assessments where appropriate with colleagues from other mental health provider services.
- **Extended consultations**. These can be discrete pieces of work in themselves or used as a way of preparing people to fit into appropriate mainstream provision.
- **Supportive interventions**. These 'treatments' are discrete, maybe crisis interventions or a more supportive approach that helps prepare people with complex needs for psychological treatment.
- **Couple or family assessment and treatment**.
- **Consultations to professionals**. These consultations may or may not include the patient. The recipient may be the GP or other professional engaged in the care of the patient. It may include joint work with other One Hackney staff.
- **Support, consultation and supervision for One Hackney staff**, particularly the care coordinators and quadrant staff. Currently we provide weekly individual reflective supervision for the care coordinators, plus a monthly group supervision. We also attend and contribute to the weekly Mental Health Intake Meeting for coordinators.
- **Training and consultation** for other One Hackney staff, with a proposed focus on enhancing skills and building confidence to support One Hackney staff in working with complex and high risk patients.

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- **Signposting** to other services **with** <u>regular feedback to GP</u>

In September 2015, the Care Planning Service joined the One Hackney and City provision and as such its funding stream has changed from direct CCG funding to time limited funding of the Hackney organisation. In effect, this transition was a non-negotiable shift of immediate service accountability outside of the CCG and implicitly limited the life of our Care Planning contract to the short-term funding of One Hackney services – due to end in September 2016. Prior to this, the Tavistock and Portman's contribution to One Hackney had focused on facilitating referrals meetings, providing reflective supervision to One Hackney care co-ordinators, and support and consultation to multidisciplinary teams.

Since the beginning of September, there have been steps taken to integrate the Tavistock and Portman PCPCS Care Planning Service more fully into One Hackney. This has included meetings between the Care Planning team and One Hackney and City to discuss working together more closely, as well as weekly attendance at One Hackney intake meetings and participation in quadrant meetings.

PCPCS A&E project- working with Homerton Psychological Medicine.

The A&E project was launched in July 2012 and was developed as an extension of the existing provision in PCPCS for patients with complex difficulties. The A&E project aims to provide a service for patients who attend A&E frequently through direct patient contact and work with GPs. The second aim is to work with partners in the system to create a shift in the pathway through greater collaboration and liaison, and increase the sharing of knowledge and resources.

PCPCS Community Project.

This innovative, mainly Turkish speaking horticultural therapy project was conceived in response to the need to extend the service's psychological provision to non-English speaking patients who are focused on persistent physical problems.

The project extends our provision beyond the consulting room with a horticultural therapeutic programme in partnership with Spitalfields City Farm.

The project was established with the intention of extending the service's psychological provision to certain non-English speaking patients who can be "harder to reach" and who present with difficulties moving beyond their presenting problems/persistent physical symptoms. This group presents a challenge to those professionals trying to help them, including their GPs and PCPCS clinicians.
These patients are also known to have difficulties in the interpersonal domain that mean more direct psychotherapeutic intervention is not the most appropriate treatment; therefore, they are more likely to derive benefit from an alternative form of therapeutic input.

The Community Gardening Project has been running for 15 months, and currently has over 30 patients participating in three groups, which run on a weekly basis.

Team Around the Practice

TAP has established a secure base at the Monroe Centre in Daleham Gardens NW3. As the team has grown and developed since July we are very nearly at full capacity and have taken over more of the space. The TAP service administration manager Charlotte and administrator Sonia have worked hard to create a welcoming base for the team and are currently reviewing accommodation, health and safety and staff training issues such that staff are well cared for and feel able to carry out their tasks effectively. As the Monroe Centre is very close to the Tavistock main building in Belsize Lane it is conveniently located for access to training, staff support services etc. The table below details which members of staff have been allocated to each locality/clinic.

3.4   Performance against contracts

TAP

The data relates primarily to Q3 and as such is not completely up to date hence our notes where possible and helpful about the current situation. As part of our trial of using the EMIS (primary care) electronic patient record system as opposed to a separate database we currently have access to some reports but not others. We address our efforts to resolve this dilemma further on.

It was expected that TAP would reach up to 600 referrals within its first year. At the time of writing in early January 2016 the service has received approx 430 referrals, all from GPs and mostly appropriate. TAP staff are based in around 30 of the 36 surgeries.

As well as the management of intake, referral quality and treatments we are directing attention to surveying and understanding GP training needs as part of our contract. We were not surprised that most surgeries did not initially return a training needs analysis form as we believe this was most likely to be made possible through the offer of surgery team consultation and work alongside GPs to gain their trust before they might discuss and 'expose' the areas that they want help with.

1.   **The number of patients accepted by TAP via GP referrals.**

Action	Number of patients Q3 (%)
Accepted	299 (70%)
Accepted (discharged)	27 (6%)
Rejected	71 (17%)

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Service Line Report

Pending	31 (7%)
Total referrals to date	**428 (100%)**

2. The number of referrals received from individual localities

Locality	Total number of GP surgeries (%)	Q2	Q3	To date (%)
North	13 (35%)	31 (27%)	112 (36%)	145 (34%)
West	7 (19%)	13 (11%)	56 (18%)	69 (16%)
South	17 (46%)	72 (62%)	144 (46%)	216 (50%)
Total	**37 (100%)**	**116 (100%)**	**312 (100%)**	**428 (100%)**

3. The number of GP surgeries, and the consortium localities, which referred to TAP

Date	Q2	Q3	To date
No. referring surgeries	18	27	**27**
No. referring localities	3	3	**3**

4. The number of referrals received by treatment type

Treatment Type	October (%)	November (%)	December (%)	Total Q3 (%)
Therapy	90 (80%)	80 (76%)	74 (79%)	244 (78%)
Social Prescribing	21 (19%)	24 (23%)	19 (20%)	64 (21%)
Not stated	1 (1%)	1 (1%)	1 (1%)	3 (1%)
Total Q3	**112 (100%)**	**105 (100%)**	**94 (100%)**	**311 (100%)**

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5. **The number of GP surgeries, and the consortium localities, which received an intervention from TAP to support the management of complex patients.**

Intervention	October	November	December	Total Q3 (hours)
Collaborative relationship building (1)	41	19.5	24.75	**85.25**
Practice meetings (2)	11.5	2	6.5	**20**
Case-based discussions (3)	12	3.5	9	**24.5**
Mental health referral meetings (4)	4	0	0	**4**
Formal training sessions (5)	0	0	0	**0**
Other meetings	2	0	0.5	**2.5**

(1) E.g. engaging and supporting reception staff, informal discussion, setting up EMIS, liaising with Practice Manager
(2) Regular practice meetings where referrals may or may not be discussed; usually attended by one clinician
(3) Meeting with a group of GPs where specific patients (who may or may not be referred) are discussed in detail (at least 15 min per patient)
(4) Surgery referral meetings attended by representatives from MHS
(5) For GPs or practice staff

6. **Liaison and development of relationships with other services.**

Service	October	November	December	Total Q3 (hours)
Voluntary Organisations	29	7	15	**51**
CCG	15.5	12	12	**39.5**
Primary Care/Local Authority	17	5	7	**29**
Other NHS Services (MH)	30.5	2	10	**42.5**
Other NHS Services (non-MH)	0	1	3	**4**
Other	6	0	10	**16**

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Hackney PCPCS

The number of people accepted by the PCPCS

Quarter	Number accepted patients	% accepted
Q1	194	84%
Q2	183	72%
Q3	113	51%
Q4		
Total	490	69%

The proportion of patients accepted by the service has decreased from 72% in Q2 2015-16 to 51% during Q3 2015-16. At the time of reporting, 65 referrals from Q3 were still pending acceptance; therefore, the percentage of patients not accepted is based on the total number of referrals which passed through the intake process during Q3 (220 patients), and will be subject to amendment and reported in Q4. We will wait to see whether this year's trends so far indicate an overall decrease in the number of referrals accepted by the PCPCS. One possible analysis

2014-15:

Number of patients accepted	% accepted
806	89

2013-14:

Number of patients accepted	% accepted
552	94

2012-13:

Number of patients accepted	% accepted
392	87

7. Quarterly cancelled by the psychological service (appointments cancelled by the PCPCS)

Quarter	% appointments cancelled by PCPCS
Q1	3%
Q2	4%
Q3	4%
Q4	
2015-16	4%

The percentage of appointments cancelled by the PCPCS remained low over Q3 2015-16, with an average of 4% of appointments cancelled by the service. This is slightly higher than the previous financial year (see below), in which a 3% of appointments were cancelled by the PCPCS. In Q3 these cancellations can largely be accounted for by sickness absence and the team required to attend training session at the Tavistock.

2014-15:

% appointments cancelled by PCPCS
3

2013-14:

% appointments cancelled by PCPCS
3

2014-15:

% appointments cancelled by PCPCS
2

The number of people who have entered treatment during the reporting quarter

Quarter	Number of patients who have entered treatment during the quarter
Q1	54
Q2	22
Q3	
Q4	
2015-16	76

2014-15:

Quarter	Number of patients who have entered treatment during the quarter
Q1	47
Q2	70
Q3	57
Q4	42
2015-16	216

The number of people who entered treatment in Q2 2015-16 was 22. This is a marked decrease from the previous financial year, in which 70 people entered treatment in Q2 2014-15. This can be explained by the fact that there have been a

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number of pregnancies in the PCPCS which has meant that these clinicians have not been able to take any new patients on. In addition there have been changes to the staffing structure at the PCPCS, with some PCPCS staff joining the Camden Team Around the Practice service, as well as new staff recruited to the PCPCS.

The number of patients who dropped out of treatment during the reporting quarter

Quarter	Number of patients who dropped out of treatment during the quarter
Q1	14
Q2	3
Q3	
Q4	
2015-16	17

The number of patients who dropped out of treatment has significantly decreased this quarter to 3, from 14 in Q1 2015-16. This is largely explainable by the fact that the process for discharging patients has changed since the service moved away from using Rio to Carenotes. The reasons for discharge are now more clearly defined.

2014-15:

Number of patients who dropped out of treatment
156

2013-14:

Number of patients who dropped out of treatment
122

2012-13:

Number of patients who dropped out of treatment
102

Note: It was agreed that patients who drop out of treatment are recorded on Carenotes as having been 'discharged against professional advice'; however, it may be that those patients who 'drop out' of treatment prematurely may do so for beneficial reasons. In other words, they may feel that they have derived sufficient therapeutic benefit from their contact with the service, and thus not consider it necessary to continue with their sessions.

PCPCS

The service intake culture has been established since 2009 as quite an inclusive and porous boundary that welcomes a high percentage of referrals, particularly GPs and provides a 'mind the gap' type service for complex patients who GPs can find hard to be accepted into some mental health services. In effect we have never yet actively tightened referral criteria such that (as many MH services) we restrict referral numbers and reasons. In many ways this strategy proved popular with GPs and some of the local psychiatrists, one of whom recently commented to our own Consultant Psychiatrist "you're great, you take anyone". I understand that the tone of this remark was said in response to the great difficulty that many services have with very significant cuts, savings and organisational changes in the wider NHS service provision of mental health services.

Our inclusive and accessible stance has created other difficulties with waiting times becoming unreasonably long for many patients. Our analysis of this dilemma points to the difficulties experienced by soaking up some of the deprivation of resources in the wider system and being perhaps too open to complex co-morbidity without very much regulation of numbers and in some cases levels of risk. It is important to note that we try to remain GP centric in terms of having an understanding that GPs are one of the very few groups of NHS clinical staff who can't and often won't easily exclude people from their services.

TAP.

In nearly two years from conception to birth of the new service the CCG and local GPs had a long time awaiting their new service and we believe that many were feeling overwhelmed and frustrated by the high levels of co-morbidity, complexity, risk and mental illness. CCG and GP colleagues advised us of the likely complex dynamics with other local services (to be expected initially) and in particular the impact of large scale re-organisation of local mental health services away from the traditional, locality based CMHT model. In summary, the moderate Tsunami of initial referrals into TAP seemed to reflect a level of unmet need, GP anxiety/strain and the gap in services that we were commissioned to mind.

Camden CCG have been collaborative, communicative and helpful in monitoring activity as we grow, they hold operational meetings to discuss the service development and tasks alongside more formal contract monitoring meetings.

TAP

Following acceptance, the average waiting time for a first assessment with TAP is currently 11.7 working days, and the longest time a patient has waited to date is 33 working days (data collected 07.12.15).

PCPCS

DNA rate broken down by 1ˢᵗ & subsequent appointments

Quarter	Overall DNA rate (%)	1ˢᵗ appointment DNA (%)	Subsequent appointment DNA (%)
Q1	13	21	12
Q2	15	23	13
Q3	16	19	16
Q4			
2015-16	15	21	14

The DNA rate for first appointment for Q3 2015-16 has decreased from the Q2 2015-16 rates of 23% to 19% (by 4%). In addition, the subsequent appointment DNA rate has increased from 13% in Q2 2015-16, to 16% in Q3 2015-16 (by 3%). DNA rates tend to fluctuate each quarter however, we hope the opt-in system will ensure the services DNA rates remain low. The opt-in system means that patients who are reluctant to engage may not respond to the letter inviting them to call to arrange an assessment, and will therefore be discharged from the service.

2014-15:

Overall DNA rate (%)	1ˢᵗ appointment DNA (%)	Subsequent appointment DNA (%)
16	23	15

2013-14:

Overall DNA rate (%)	1ˢᵗ appointment DNA (%)	Subsequent appointment DNA (%)
14	25	13

2012-13:

Overall DNA rate (%)	1st appointment DNA (%)	Subsequent appointment DNA (%)
17	26	17

TAP

Currently no dormant cases.

PCPCS
Dormant cases

	Since last attended appointment		Since last offered appointment	
	No.	% of open cases	No.	% of open cases
6 months	111	16%	54	8%
3 months	174	25%	89	13%

* patients without activity since last attended or offered appointment

3.5   IT System

PCPCS uses the Care Notes system and was one of two pilot sites within the trust. The trial was helpful in staff becoming used to a new system and being well supported by informatics and IT with training and support. However as many IT systems it has numerous glitches that can for example lead to reporting data being wrong, missing or unavailable. It also does not allow for patients to input their own outcomes monitoring scores which seemed an excellent function when we first considered the system. PCPCS staff also log basic clinical notes and messages into the GP EMIS system which allows for close communication with GPs and practice staff.

TAP (only) uses the Camden GP system EMIS. Alongside other community based services EMIS community was selected by commissioners to facilitate communication between TAP and GPs, and to simplify the process of electronically referring to TAP. It should be noted that EMIS community is rather different to the primary GP EMIS system and as such most GPs do not log into EMIS community most of the time. Hence there is a question as to what real added value the system offers if GP is unlikely to use or read the patient data?

The great strength of this system in principle is that patients can know that their GP and TAP clinician use the same IT system and can exchange and reflect on

information as needed. The boundary between helpful access to personal data across services and safe keeping of confidential details that patients do not wish to share is something we take most seriously and have given much time and consideration to. Our patients often wish their GP to know that they are being seen and GPs may gain some relief and satisfaction from knowing that sessions are going ahead as planned however some patients do not want their GP and potentially other health and social care professionals knowing, for example the traumatic details of childhood abuse.

3.6   Supervision / reflection

The services places an emphasis on staff supervision and whole team as well as individual reflective practice. All clinicians and MIND link workers have at least weekly individual or group supervision and the majority of band 7 clinicians seeing the majority of complex cases have weekly individual and group supervision. We also provide fortnightly whole team clinical seminars to hear and work together on the most complex cases.

PCPCS and TAP each have a fortnightly team business meeting that includes some aspects of training and development and a separate clinical academic seminar when outside speakers and colleagues from local and national services come to discuss their ideas and services. We are currently sourcing an additional group analytic supervisor for PCPCS and re-building the senior staff team at PCPCS which will helpfully share out some of the supervisory pressures and responsibilities.

There is weekly group supervision for the Care Planning team. The first team meeting of the month is also dedicated to reflecting on the development of the service and team. In addition, we have offered weekly, individual and group supervision to the One Hackney co-ordinators since the beginning of June 2015. This was negotiated with One Hackney management and it was agreed that the sessions had a number of functions for staff, individually and organisationally.

4.   Financial Situation and relationship to contractual developments.

PCPCS and TAP are both in a healthy financial situation but referral numbers and the waiting list in Hackney suggest a need for increased resource alongside the other service develops and efficiencies we have worked hard on over the past years.

The Tavistock and Portman NHS FT have held the PCPCS City and Hackney Contract since 2008 and year on year have achieved an expansion of the service reflecting both public and commissioner demand. The commissioners have subsequently requested complementary services such as the Care Planning and One Hackney MUS services recently, highlighting their trust and satisfaction with our service. The latest budget report signed off by the Contracts and Finance Department and the service manager, show a steady, healthy financial position so far for the service.

City and Hackney commissioners during 2015-16 brought together the main providers of mental health care across the boroughs to develop an alliance, creating a joint contractual responsibility for providers to achieve a number of key performance indicators. This has been reflected in a separate contract which is in place until at least September 2016 for the Care planning and One Hackney services. There is additional risk present in that a larger proportion of the funding is based on the achievement of the key performance indicators, however this is being closely monitored through regular meetings between the providers, and once again regular internal meeting between Contracts, Finance and the service to discuss the budget.

The Tavistock and Portman NHS FT Camden Tap service was the result of a tender in 2014, successfully awarded in 2015 for 2 years with the option of another 2 years extension. The service went live in July 2015 and has received constant positive feedback from commissioners and GPs. The contract has been meticulously drawn up by external lawyers reflecting the innovative outcome based commissioning by the CCG and is being signed off by the end of January. There is a larger proportion of performance based payment than other contracts (15% of the total contract value) however the Trust is confident that through the negotiation of targets and budget setting that the risk of underachievement and financial risk to the service is low.

4.1   Plans for productivity / service redesign

In response to the PCPCS waiting list and over performance we have considered a number of strategic and clinical changes that might optimise efficiency whilst not making unrealistic expectations of staff. Presently both teams expect a full-time band 7 clinician to offer approximately 18 vacancies per week depending on other tasks (e.g group work or supervisory responsibilities).

We have developed a group work programme with a view to providing more treatment vacancies to more waiting patients. In practice and based on historical service experience group attendance can vary and if using two facilitators (one experienced and one trainee or honorary) with perhaps 5 or 6 members the level of return on resources used is not greatly different to offering individual vacancies. Importantly we have also developed the group programme so that clinicians 'think group' rather than being or becoming stuck in the idea that individual therapy is the only or best option.

The groups provided include:

Waiting List Support Group

Group-analytic Psychotherapy Group.

Community Photography Group.

The Photography group is a 10 week group programme where patients are loaned a camera and tasked with taking images that are their interpretation of a theme set by the group each week. The group is not treatment group as such but has therapeutic benefits for people who might otherwise feel too fearful and anxious about more formal 'therapy'. It uses the medium of photography and imagery to explore experiences, places, events, and emotions that are meaningful to patients. Group members are commonly referred to the group as they have been experiencing significant depression and/or anxiety and most have been isolated in connection to this – patients may not be working or may have withdrawn from social activity. The group therefore provides a relaxed space with a focus away from the task of socialising that might otherwise inhibit the participants. As a useful side effect however, this set up seems to enable members to feel increasingly comfortable in being and speaking in a group and recovering confidence. We have found that photography can be a very powerful means of communication in this setting and help draw out some very complex and sensitive issues for the group. Whilst it is not a NICE recommended treatment option it can help provide access to help for people with psycho-social co morbidities who would fall between different treatment types due to their multi-0factorial presentation.

5. Clinical Quality and Outcome Data

5.1 Description of what has been used

Administered at assessment sessions:

- The Patient Health Questionnaire (PHQ9)
- The Generalised Anxiety Disorder Assessment (GAD7)
- The Work and Social Adjustment Scale (WSAS)
- Equality Monitoring Form
- Physical Health Form
- Goal Based Outcomes (GBO) (social prescribing only)

Administered at treatment sessions:

- PHQ9
- GAD7

Administered at discharge:

- PHQ9
- GAD7
- WSAS
- Experience of Service Questionnaire (ESQ)
- GBO (social prescribing only)

Care Planning Service

The following outcome measures are administered at assessment sessions:

- The Patient Health Questionnaire (PHQ9)
- The Generalised Anxiety Disorder Assessment (GAD7)
- The Patient Health Questionnaire (PHQ15)
- The EQ-5D Health Questionnaire
- Equality Monitoring Form
- Physical Health Form

The following outcome measures are administered at the end of treatment:

- The Patient Health Questionnaire (PHQ9)
- The Generalised Anxiety Disorder Assessment (GAD7)
- The Patient Health Questionnaire (PHQ15)
- The EQ-5D Health Questionnaire

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5.2 Comment on the quality of reporting

PCPCS is not able to currently report on quantitative outcomes (PHQ9, GAD7, WSAS) as a result of reports not functioning correctly and the transition from RiO to Carenotes.

TAP OM Data

Mean Scores for First Assessment Session	
Measure	**Mean Score**
PHQ9	18 (moderately severe depression)
GAD7	16 (severe anxiety)
WSAS	25 (severe functional impairment)
GBO	-

The above table details the average scores provided for the outcome monitoring measures (PHQ9, GAD7, WSAS) collected during the first assessment session. As TAP is a new service, the majority of patients seen during Q2 were only seen for a first assessment, so data for the small number of subsequent assessment and treatment sessions that took place has therefore not been provided.

1. **PHQ9**

The Patient Health Questionnaire (PHQ9) is a measure of depression and includes nine items, each of which are scored 0 to 3, providing a 0 to 27 severity score. The PHQ9 is administered during every assessment and treatment session. PHQ9 data was collected for 23 of the 27 patients seen for a first assessment during Q2. Although the PHQ9 was administered to all patients, 4 patients chose not to complete the form. The mean score was 18 (moderately severe depression) and the scores ranged from 2 (minimal depression) to 26 (severe depression). **83% of the patients who completed the PHQ9 scored higher than 10 (moderate depression).**
2. **GAD7**

The Generalised Anxiety Disorder Assessment (GAD7) is a measure of anxiety and includes seven items, each of which are scored 0 to 3, providing a 0 to 21 severity score. The GAD7 is administered during every assessment and treatment session. GAD7 data was collected for 21 of the 27 patients seen for a first assessment during Q2. Although the GAD7 was administered to all patients, 6 patients chose not to complete the form. The mean score was 16 (severe anxiety) and the scores ranged from 2 (mild anxiety) to 21 (severe anxiety). **86% of the patients who completed the GAD7 scored higher than 10 (moderate anxiety).**
3. **WSAS**

The Work and Social Adjustment Scale (WSAS) is a measure of impairment in functioning and includes five items, each of which are scored 0 to 8, providing a 0 to 40 severity score. The WSAS is administered once during assessment and once at the end of treatment. WSAS data was collected for 23 of the 27 patients seen for a first assessment during Q2. Although the WSAS was administered to all patients, 4 patients chose not to complete the form. The mean score was 25 (severe functional impairment) and the scores ranged from 4 (mild functional impairment) to 40 (severe functional impairment). **91% of the patients who completed the WSAS scored higher than 11 (moderately severe functional impairment).**

4. **GBO**

The Goal Based Outcomes (GBO) form is used by Social Prescribing (Mind) as a measure of goal achievement. Up to three goals are identified, and goal achievement is scored 0 to 10 (0 = goal not at all met; 10 = goal reached). Goals are set using the GBO during assessment, and the GBO is completed a second time during the last treatment session to establish how close the service user is to reaching their goals following the social prescribing intervention. As a small number of patients were seen for assessment and treatment during Q2 (a total of 3 patients), the GBO data has not been included in this first report.

Note: In some cases, service users express that they would prefer not to complete outcome monitoring or equality monitoring forms. In a small number of cases, TAP clinicians have judged it inappropriate to administer outcome monitoring forms, as for example if the patient is highly distressed there is a concern that the forms might act as a trigger.

These figures broadly support our knowledge that most patients fit the moderate to severe difficulties which are typically not limited to single diagnostic areas but complex, multi-factorial and co-morbid with a range of psychological, physical and socio-economic issues.

6. **Feedback**

PCPCS – patient complaint about a lack of communication regarding his next appointment and follow up following an assessment and consultation with recommendation that he join a group within the local secondary care service. The complaint happened just around the time of transition to the Carenotes and there was very little recorded on file to understand what had happened or not and why. The service lead liaised with T&P complaints team and consulted widely with staff, requesting information from any team members that had contact and checked that no further records were available. The patient received a written apology and an offer of a face to face meeting with the service manager, which he took up. This led to him re-considering a group treatment and a preliminary meeting with a group therapist 10 days later.

7.   Serious Untoward Incidents and Safety Issues

PCPCS

We have experienced two suicides of patients, once in 2014 and again in 2015, one was in the transition to and was beginning to engage with another service (Personality Disorder Unit) and the other was on voluntary home leave from hospital having been admitted during an acute episode of more severe depression, anxiety and suicidality.

Alongside the necessary early reporting of such serious incidents, submitting detailed reports and liaising closely with risk lead Jane Chapman we have met as clinical teams within the service, as senior clinical staff and with clinicians from other services involved to review, assess and reflect on these tragedies. We understand that the board will have already been advised of our detailed reports. In one of the cases we wrote to the family involved and offered an opportunity to be in contact should they wish. The parents took up this opportunity and appreciated making contact, they explained that they had felt on their own and without contact from services after the initial activity and shock. We met the family at and after the coroners court and were able to reach some sort degree of resolution in thinking through and trying to understand their daughters actions and what might be learnt from the experience for all concerned.

7.1   How have issues been dealt with

TAP

Two incidents were reported during Q2 (09/09/15 and 16/09/15). Both related to the neighbouring Tavistock Children's Day Unit, as children had exhibited threatening behaviour towards staff members. On one occasion Police were called and one child absconded. Please note that the Monroe centre west wall and windows directly border the school playground.

7.2   What action is to be taken

TAP

An incident form was completed on both occasions and submitted to the Tavistock Health and Safety Manager within 48 hours. Appropriate investigations were carried out promptly in both settings and measures were put in place to prevent the occurrence of future incidents.

The service lead met with the school head and invited her to join a TAP team meeting to talk about our different teams tasks, working environments and culture in relation to managing the physical and emotional boundaries between the Monroe building and the school. This was very helpful and gave an important perspective on the nature of work with the children and the importance of engaging and collaborating with school staff but not responding to the children in any way that could be construed as provocative. Staff do not open windows during school playtime and use blinds discretely as necessary.

7.3   What has been learnt

TAP

Before TAP arrived all of the rooms at the Monroe centre facing the school playground were not being used for some time – probably several years. We think the children were probably experiencing a sense of psychological and perhaps even physical threat from the presence of these new adults so close to their 'home' within the school. TAP service lead advised all staff to refrain from engaging the children, to discuss any ongoing issues within the team and to report any incidents through the usual channels. TAP staff have been offered a reciprocal visit to the school.

8.   Clinical Governance and Audit.

8.1

- We continue to provide quarterly update and service audit reports to Camden and Hackney CCG.
- TAP EMIS project – we have audited the accuracy and availability of data for the various reports needed for data submissions and met with trust wide leads for governance and risk to think through the complexities of using an unfamiliar IT system.
- We have achieved close to 100% IG training across both teams and updated staff on clinical governance at the departmental half-day training session November.
- We have reviewed the PCPCS treatment opt in system and have reduced the amount of separate communications that we send to patients which we hope will decrease response times and therefore breaches to waiting times for assessment.

8.2   Challenges and achievements – what has been learnt.

Please see section 3.8 on page 74 for a detailed discussion about clinical governance issues.

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8.3   Plans

We plan to audit the TAP service clinical vacancies available per WTE staff in the different geographical areas of Camden in relation to demand per surgery as a % or the overall primary care population and compare this with referrals numbers per surgery as a % of total and in relation to how many clinical appointments we can finitely offer. We hope this will be useful information for the service and CCG when thinking through waiting time management and the finite possibilities of referral numbers per surgery area.

9.   Education and Training

Camden CCG – GP mental health training.
Our strategy in both services has been to use the formal and informal discussion about complex cases between GPs, surgery staff and our clinicians as a springboard to suggest wider, surgery-based consultation for clinical or even whole teams. These complex case consultations build capacity and give an all-important opportunity for reflective space to consider the bio-psycho-social and in particular the relational aspects of patient presentation and its impact on GPs, personally as well as professionally. This model allows for training around all aspects of complexity; personality disorder, non-verbal communication, anti-social presentations, medically unexplained symptoms (MUS) etc. to be included implicitly in the on-going case discussion model.

Where practices request a more specific training session we will provide for this according to the particular practice needs - i.e. a bespoke package. We will also re-approach all surgeries who have not responded to the training needs analysis, and use our personal contacts to facilitate discussion and encourage GPs to consider the training opportunities on offer. It is important to note that we would ask colleagues in PICT if they are already engaged in training before offering our services.

Staff Development

All staff undertake clinical governance training, IG training and other statutory requirements. TAP has already held a half-day away-day/training session for staff from which we are taking forward some suggestions to improve quality, safety and patient as well as staff experience. One immediate requirement is a 'TAP' sign on the external front door to our offices to show that we have arrived and created a service.

PCPCS & TAP are holding bi-weekly clinical/academic seminars during which external organisations are invited to present and discuss the services that they offer and their referral processes. We value the importance of seamless communication within and across services and is using this opportunity to build positive working relationships with various NHS, non-NHS and voluntary services across Camden.

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The table below shows a list of the organisations which attended TAP clinical seminars during Q2, and those which are due to attend during Q3.

Clinical Seminar Schedule	
Date	**Organisation**
11th August	Voice Ability
25th August	Women & Health
1st September	PICT (Personality Disorder Service)
8th September	Crisis Team
15th September	Alcohol and Substances Service
22nd September	Social Care in Primary Care Project
29th September	REST Project (Mind in Camden)
13th October	Mind
20th October	IESO Digital Health
3rd November	Training Session: Personal Safety
11th November	Visiting Psychotherapist
8th December	IRIS Project (Domestic Violence)
5th January	Patient and Public Engagement
12th January	Training Session: Concept & Practice of Joint Consultation
19th January	Social Work: Think Ahead
2nd February	Royal Free Hospital Pain Team
9th February	London Irish Centre
8th March	UCL Medical School Academic Presentation: Junior doctors' experiences of managing patients with medically unexplained symptoms

9.1   Description of range and direction of travel

- Teaching delegation of Chinese doctors about our primary care work.
- Medical students and GP registrars in Hackney.
- Presenting a session on working with MUS and complexity as part of ST 4-6 doctors' vocational training scheme.
- Conferences – see below.
- Teaching trainees and honorary staff at TAP and PCPCS.
- Teaching elements within primary care team consultancy.
- At least one current expression of interest from another CCG for some primary care teaching on our PCPCS / TAP clinical models.

9.2   Activity and financial performance against targets

Teaching activities currently contribute little to the overall revenue of the service but are highly valued as opportunities to disseminate information and data about the service.

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9.3   Quality indicators / issues

We have recently received good feedback from the Kings Fund (teaching) and Sheffield (teaching and consultancy) and have been invited back to both in the near future. Additionally, the Kings Fund are soon to publish a further study in our area of work and although we are not currently at liberty to reveal any details we know that some details about our service provision will be included in the forthcoming publication – hopefully now to include something about TAP as well as PCPCS.

9.4   Issues relating to trainees – management, satisfaction etc.

PCPCS has 2 Clinical Psychology trainees for the first year, last year we had our first trainee who went on to gain a job in TAP. The team enjoys having trainees around, they are creative, invigorating and idealistic. They also help to keep the more experienced and older staff on our toes and helpfully challenge our views and ideas. Clinicians enjoy having the opportunity to supervise, for some this will be their first and only experience of providing supervision until they move to a more senior post.

9.5   Conferences

- Sheffield Primary Care Masterclass November 2015 -   our service lead was invited to give a talk about our primary care work, including the theory and practice of joint consultation, working with complexity, personality disorder and using the relationship and one's own emotional responses as clinical data in the consulting room.

- King's Fund Primary Care 'GP Pressure Points' Conference. 24/11/15. Staff from the commercial directorate helpfully worked alongside clinical staff to speak to interested parties about our work, promote TAP/PCPCS type services as well as the TADS study and our training and education services. November 2015.

- Royal College of Psychiatrists December 2015 – Dr Stern gave a talk and presentation about our primary care work, the model, practice and implications for health benefits and cost savings.

- Social Prescribing Conference January 2016. Having met an influential and interested GP, Dr Michael Dixon (chair of the NHS alliance) at the November Kings Fund Conference we were alerted to this new conference and its pivotal role in the formation of a Social Prescribing hub and organisation within the NHS and particularly primary care. Our

social prescribing staff will attend and hopefully we might make some further links and developments relating to the Kentish Town City Farm project.

- Kings Fund Physical and Mental Health conference March 2016 – Tim Kent and Dr Julian Stern will present our approach to working with the often neglected and unmet physical healthcare needs of people with mental illness and poor mental health including our thoughts on people who confuse feelings and states of mind for physical illnesses or symptoms.

10. Research

Towards the end of last year we met Professor Allan Abass from Canada who was giving a scientific meeting presentation on the use of Intensive Short Term Dynamic Psychotherapy with Medically Unexplained Symptoms. He is a well-known and experienced clinician / researcher with a library of large scale RCT studies and had been featured on Canadian TV News as providing a proven, cost saving intervention to complex needs patients. Prof Abass is keen to develop research partners and opportunities and we are considering some potential collaboration in 16/17. We have recently agreed to fund a brief, three day training programme for primary care staff to learn some of the clinical techniques involved in ISTDP which we will open up to other applicants within and outside of the Tavistock.

TAP is currently working with an independent organisation called OPM who are conducting a small scale study on behalf of Camden CCG into the impact and effectiveness of the TAP service from set up to implementation in the first year. A number of staff have been interviewed and volunteered their experience of the project alongside patient stories, GP feedback and views expressed by our commissioners, members of the public and service user representatives.

11. Consultancy

11.1 Description of current activity and aspirations

Please refer to introductory sections, vision and strategy.

11.2 Financial reporting

The service is well supported by finance, contracts & commercial departments. The service lead meets regularly with colleagues to review and reconsider expenditure and staffing. We note that TAP and PCPCS have to function tightly within the constraints of our contractual envelope and have not been financially assisted as other departments have historically been effectively scaffolded by additional sources of revenue. E.g. training contracts. The numbers overall of patients seen, caseloads

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and fast pace of the work may reflect these differences in practice compared to complex needs.

11.3 **Future projects / prospects and issues in developing these – particularly developments across the Trust**

Sheffield 2016 – consultancy to their primary care group, CCG colleagues and wider system on developing a TAP / PCPCS style model in harmony with the wider provision of liaison psychiatry

TAP- city farm based horticultural group for Bengalis speakers +. We are in negotiations with the city farm, have secured a reasonable plot, have appropriate premises and our staff would run groups with some professional / horticultural input from farm staff with appropriate checks and perhaps in the future some patient led group work.

TAP – surgery based garden planned at Bloomsbury practice, they have a large and mainly unused courtyard. We are discussing he project with GPs with a view to hopefully locating some raised beds for hers and small plants for a community and patient led initiative as part of our social prescribing work.

PCPCS-

- New space within St Leonards Hospital has been identified and agreed – critical to our growing size / needs and the possibility of our waiting list task force using some central space.
- Psychological Therapies Alliance – PCPCS has been the first organisation to help colleagues in similar services complete the 'IAPT compatible' upload of data to HSCIC.
- One City and Hackney – ongoing collaboration with local services.
- Homerton University Hospital collaboration on safe and timely discharges.
- NEW Therapeutic Reading group
- Ongoing Photography group

11.4 Developments across the Trust.

TAP were invited by Dr Andy Weiner of CAMHS community services to join a network of multi-agency professionals working with young people between 16 and 25 to assist in those complex cases where young adults can fall through gaps in provision and the wider systemic and family related issues can sometimes be less focal for adult services. A useful development linking Adult and Child services in keeping with our ethos of 'think family' alongside attention to distinct adult needs.

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The service has invited our Trust wide artist in residence Rachel Causer to meet with both teams and talk about her important work in capturing the imagination and curiosity of patient and staff feedback in her creative ways. I was so impressed by the Found project and the new possibilities for PPI work alongside harnessing staff ideas in more creative

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Team Around The Practice (TAP) Staff
Band 8c Service Lead: 0.6 WTE
Band 8b Clinical Operations Manager and Highly Specialist Clinical Psychologist: 0.8 WTE
Band 8a Highly Specialist Clinical Social Worker and Clinical Co-Ordinator: 1 WTE
Band 8a Highly Specialist Clinical Psychologist: 1 WTE
Band 7 Counselling Psychologist: 0.7 WTE
Band 7 Clinical Psychologist: 1 WTE
Band 7 Clinical Psychologist: 0.7 WTE
Band 7 Clinical Psychologist: 0.7 WTE
Band 7 Counselling Psychologist: 1 WTE
Band 5 Assistant Psychologist: 1 WTE
Consultant Psychiatrist: 0.1 WTE
Consultant Psychiatrist: 0.4 WTE)
Senior MIND link worker: 0.9 WTE
MIND link worker: 0.8 WTE
MIND link worker: 0.8 WTE
Specialist Registrar in Medical Psychotherapy: 0.2 WTE
Honorary Counselling Psychologist in Training: 0.4 WTE City University.
Honorary Psychotherapist: 0.4 WTE SAP Jungian Training.

Care Planning Service Staff List by Band

Care Planning Service Staff
Band 8c Service Lead – service overview as part of 0.4 WTE in City and Hackney
Locum Consultant Psychiatrist: 0.3 WTE
Band 8a Clinical Psychologist and Psychotherapist: 1 WTE
Band **8a** Clinical Co-ordinator/Psychotherapist: 0.4 WTE bank staff
Band 7 Clinical Psychologist: 1 WTE
Band 7 Clinical Psychologist: 0.5 WTE Systemic
Band 6 Psychotherapist: 1 WTE
Band 6 Psychotherapist: 0.5 WTE
Band 6 Psychotherapist: 0.5 WTE
Band 5 Assistant Psychologist: 0.5 WTE

11.5   Staff Statement

The views of staff members have been requested without censorship or influence as far as that is possible.

'It's been a real mixed bag being involved in the start of TAP. There has been the frustration of working with EMIS, a system not designed for the purpose we need it, though the effort being continually put in to try to make it work is heartening, and improvements are beginning to show. There has been the challenge of building relationships with GPs, some of whom have such a volume of demands that we are still finding the time to work out where exactly TAP might fit between ICope and secondary care, what the profile of a TAP patient might be and how else GPs can use the service. There has also been the complex and difficult to quantify patient work: many patients might never be seen for therapy, but nonetheless require substantial professional liaison and care co-ordination. But mostly there has been the excitement and pleasure of working in a team that values reflection and thought – this for me is what makes TAP a rewarding place to work, particularly as a new qualified clinician; from weekly team meetings to individual supervision and peer

support, the emphasis placed on thinking through clinical decisions and the space provided for this is invaluable – long may it continue.'
Clinical Psychologist (band 7)

Contributing to the development of TAP has been a fulfilling and unique experience, particularly as staff members have been encouraged to put forward suggestions and ideas to help improve the service and encourage room for growth. As we have all been here from the beginning we have become close as a team and are keen to support one another through the challenges of setting up a new service, and even as one of the most junior members of staff I feel I am a valued member of the team. Working through issues involving the IT system EMIS has been a learning curve, and I hope these issues will soon be resolved in order to improve TAP's day-to-day functioning, to secure patient confidentiality and to increase the accuracy of reports moving forward. There is a positive and friendly atmosphere within the Monroe Centre, and we look forward to welcoming newcomers and strengthening our positive relationships with GPs, commissioners and other services within the community as TAP expands. **Assistant Psychologist**

Since joining TAP at the end of July 2015 I have been involved with the initial setting up of the service. This has been a tremendous experience where I was able to touch base and make direct contact with individual surgeries and practices. We have experienced an amazing response which proves I believe the need and demand within the community. Being a part of such an innovative new model and approach to mental health within the community is refreshing and valuable. To also be a part of a continually evolving/growing department is also exciting. In the future I hope to continue to strengthen our relationships with GPs and professionals in the community and further develop our service. My previous experience was within CAMHS so on my learning curve of moving departments various things are very different, however it interesting to see and feel the essence of what we do is always the same. Patient focused. **Service Administration Manager**

My experience or should I say journey so far working for PCPCS who are a part of the make- up of the Tavistock and Portman Foundation Trust has been highly progressive.
The team is like a family, we work well together. I have also been able to advance on my own as I joined the team at a changing and maybe some- what a challenging time. The team is well lead by the service lead, we are a well driven team that want to achieve the very best and provide an exceptional outstanding service to our patients and colleagues. We meet regular for team meetings, I don't feel like I am out of the loop with anything as my manager, the service lead strives on treating us all equal regardless of what role I play in the team. I look forward to building and growing with my PCPCS family. **Service Administration Manager**

Being a part of TAP has been both an exciting and challenging experience, as I had a chance to be a part of the project from the very beginning.

First, there was the great unknown of what a new service has to encounter- lots of unanswered questions, decisions to be made, expectations, negotiations and frustration of waiting.

Additionally, being also a part of Mind in Camden, a significantly smaller partnership organisation within TAP, it meant facing the challenge of becoming one team and in the same time preserving the difference that Mind brings with its non-medical, alternative approach.

However I feel that the more we worked along each other, the more we learnt to appreciate our differences, also find similarities and in the same build a unified identity of one TAP team. There is a genuine atmosphere of openness, acceptance and mutual support in the team and between members and a dedication to the project. **MIND Link Worker**

13.8 Case vignettes – Appendix 1

Brookfield Park

Clinician 1: A GP saw a patient who had been see for Social Prescribing and talked about how the patient seemed positively different and how the patient had talked about the positive impact of social prescribing. The GP also said she was impressed by the service and what TAP is offering.

James Wigg

GP 1 (email quote): "I have been in contact with the TAP service on many occasions and am extremely grateful for all your hard work."

Clinician 1: Following referral of a complex patient, I phoned the GP to discuss the patient's care plan and offered a consultation with the GP and practice staff to assist with on-going management. The GP noted how helpful it had been to discuss the patient over the phone and agree a plan.

Clinician 2: The GP said it was helpful to have me in the building, so when we both had a few minutes spare we could speak to each other face to face and think together about the patient and how to take it forward.

Parliament Hill

GP 1 (email quote): "The access and shape of the service – and the people involved – are marvellous."

12. Cross-Directorate and Trust

12.1

TAP clinical staff attends Camden 'Minding the Gap' transition meetings for young adults at risk of falling between services.

The service lead contributes to Adult and Forensic directorate senior management meetings and agendas.

The service has recently presented at a trust wide Scientific Meeting**.**

For the first time in Primary Care Services we have an M1 / ST6 trainee on clinical placement with the possibility of developing clinical placements for internal as well as external trainees. The service lead is negotiating with training leads with a view to developing mutually helpful and resourcing conduits that provide training experience alongside additional clinical resources.

12.2 Prospects

At the time of this final draft the service lead and T & P Dean have taken part in a very successful collaboration and consultation with Primary care Sheffield which we hope will develop over coming months. SLAM have recently been in touch about their own interest in the service and hope to visit soon.

Challenges

The trust has an opportunity to think through and consider whether we would be interested in the Camden IAPT contract which is out for tender soon with a view to re-commissioning for 2017.

Mr Tim Kent
Primary Care Service Lead
17/01/2016

TAP - Case Vignettes

A series of qualitative vignettes representing all aspects of the service have been put together to illustrate the key interactions that are taking place between TAP staff, GPs and service users during these important early stages of engagement. These are organised below in relation to therapy and social prescribing. The vignettes have been anonymised, blended together and amended to ensure that patients remain non-identifiable.

Therapy: the case of Mr T
Mr T was referred to the TAP team for a psychological assessment due to his chronic depression and prominent symptoms of social anxiety. He had been referred for CBT in the past but did not find this useful, and had trialled a number of different antidepressant medications. Mr T did not attend his initial appointment, and did not contact TAP to rebook an appointment. The TAP clinician assigned to his case felt that due to his social anxiety issues a more personal approach was suitable to engage this service user, so decided to phone Mr T to discuss what might be making it difficult for him to attend his first appointment. The clinician attempted to phone on four different occasions spread over a week, but Mr T did not answer the calls. The clinician decided to write a letter to Mr T suggesting that he might have found it difficult to attend the appointment, or was perhaps unsure about doing so, and encouraged him to call her to discuss what might be going on for him. Mr T did not respond to the letter, so the clinician phoned his GP to discuss the case. The GP was surprised to hear that Mr T hadn't attended, as he had seemed very keen to engage and had said he was "ready to give therapy a go" at the time of referral. The GP also explained that the patient feels very anxious and often does not answer phone calls. Mr T's longstanding mood and anxiety issues were discussed with the GP, and the interpretation that the service user and GP appeared to be quite stuck. The clinician expressed that herself and the GP are trying to help Mr T, but that Mr T conveys that nothing is good enough for him, something which could provoke a sense of inadequacy in people trying to support him. The GP found this interpretation useful. The clinician proposed to the GP that a three-way consultation involving both him and Mr T might be a useful way to help him engage with therapy. The GP thought this could be a useful way to help him engage with TAP, so agreed to write to Mr T to suggest the consultation and to contact the TAP clinician a week later to review.

Therapy: a joint consultation
Mr M was initially referred to TAP with a chronic history of complex comorbidities (including severe depression, anxiety, BPD and bulimia) and a history of difficulties accessing appropriate services. He presented with chronic suicidal ideation and the GP's referral painted a picture of a needy patient who is denied help and who gets inappropriately rejected.
The GP requested a therapeutic intervention and was initially surprised by the psychologist's suggestion (by letter, followed by a telephone call) for a joint consultation, but set aside some time to meet with the psychologist and patient together. The GP came across as caring and involved, and rather frustrated with unresponsive services.

In the presence of his GP, Mr M spoke to the psychologist about his own frustration towards rejecting services, and about his suicidality. He was subtly furious with his brother for deciding to move out of the flat they shared and into supported accommodation, a decision that was leaving him feel rejected and unsupported, and at the mercy of his suicidal impulses. The GP worked hard to offer Mr M rationalisations and gentle reminders about the more independent part of the patient that could sustain a career and valued hobbies. Mr M would respond to these interventions by insisting that he would not be able to survive alone.

Meeting jointly with patient and GP gave a window onto the complexity of this patient's attachment to his GP as a parental/caring figure. This conscientious GP worked hard at helping his patient find a supportive internal place, although this ran the risk of excluding the more critical and blaming parts of the patient that seemed to come to life when the parental figure threatened him with unwelcome independence and which needed to be heard and taken seriously. The consultation gave a useful opportunity to demonstrate to the GP a way of interacting with Mr M in a supportive and empathic manner, whilst at the same time allowing him to express his feelings of disappointment and anger with caring figures in a safe and containing environment.

Social Prescribing: the case of Mr A

Mr A presented with moderate anxiety and depression, and was allocated to social prescribing (SP) to assist him with the social aspect of his difficulties. His GP informed TAP that Mr A felt reluctant to engage in therapy, but was keen to receive some support with his social situation in the form of social prescribing (SP). He completed his goal action plan (GBO form) the night before the second meeting, and identified goals including paying off debts and engaging in a meaningful activity. Mr A was keen to receive information from the SP clinician about services which provide free legal advice in Camden, and through discussions with the SP clinician realised that stress and anxiety appeared to be impacting his ability to progress further in his career. Mr A also decided to attend a course at the Recovery College about managing anxiety in the context of peer support, Mr A and his SP clinician looked together at different options available in the community which could help Mr A achieve his goal of engaging in a meaningful activity to bring a sense of enjoyment to his life, and with the clinician's assistance decided to contact his local community centre to volunteer as a tennis coach. It seemed that having somebody to listen to his worries and struggles was an important aspect of the work with Mr A, and keeping focused on achievable goals helped him to access structured support in these areas. With further encouragement, Mr J became open to the idea of an internal referral for therapy. He explained that he was initially pessimistic about trying therapy again, but felt more comfortable with the idea after spending some "extremely helpful" time talking to the SP clinician in a professional setting. In his feedback, Mr A said that talking to the clinician and discussing different ideas was very helpful, and that as a result he felt less overwhelmed by stress and anxiety. The SP clinician spoke about feeling fulfilled by his work with this service user, particularly due to the flexibility of spreading out appointments, the varying types of support he was able to offer (motivational, discussion-based and referrals) and the holistic approach taken by all parts of the service when addressing Mr J's difficulties.

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The Tavistock and Portman
NHS Foundation Trust

in Camden

TAP Community Photography Group

The Team Around the Practice (TAP) service is running a Community Photography Project. The group will offer you the unique opportunity to take photographs and use them to express and reflect on your experiences. It will celebrate how modern media makes it easier than ever before to make and share images, and harness the process of creativity and sharing in the interest of promoting your personal wellbeing.

The group will benefit you if (not all have to apply to you):

- You are interested in a more creative therapeutic approach
- You would enjoy exploring your creativity with others in a community setting
- You have found traditional talking therapy (either on a 1:1 basis or in a group) difficult.

The group will run on a weekly basis for a period of 12 weeks at a South Camden Centre for Health (SCCH). It will be run by a clinical psychologist and an assistant psychologist from TAP. Before the group starts, you will be invited to attend a brief meeting with them. This will give you the opportunity to find out more about the group and ask any questions.

Digital cameras will be loaned to you for the duration of the group. Each week a theme will be introduced and then you will take photos in response to the theme. These will then be shared and discussed with the rest of the group the following week.

We hope it will prove an enjoyable and creative experience for you.

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in Camden

The Tavistock and Portman NHS
NHS Foundation Trust

TAP Community Photography Group - GP information leaflet

The Team Around the Practice (TAP) service are setting up a Community Photography Group. The group will offer patients the unique opportunity to take photographs and use them to express and reflect on their experiences of mental illness and/or medically unexplained symptoms. It will celebrate how modern media makes it easier than ever before to make and share images, and harness the process of creativity and sharing in the interest of promoting personal and community wellbeing.

The group will benefit patients:

- Who may be interested in a more creative therapeutic approach
- Who are socially isolated and would benefit from a community-based approach.
- Who have struggled to engage with more traditional forms of therapy (either 1:1 or group)

The group will run on a weekly basis for a period of 12 weeks, culminating with a small exhibition of the patients' photographs. It will be run by a clinical psychologist and an assistant psychologist from TAP and will take place at South Camden Centre for Health (SCCH). Digital cameras will be loaned to patients for the duration of the group. Each week a theme will be introduced and then patients will take photos in response to the theme. These will then be shared and discussed with the rest of the group the following week.

If you would like more information about the group or would like to discuss a possible referral please email Ellie Cavalli, Clinical Psychologist, at tpn-tr.CamdenTAP@nhs.net. If you would like to refer someone, please use TAP's

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regular referral form via EMIS, stating that you would like to refer to the photography group. Once the referral is received by the service, your patient will be invited for a brief 1:1 assessment prior to commencing the group.

Board of Directors: January 2016

Item : 8

Title : Chief Executive's Report (Part 1)

Summary:

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

For : Discussion

From : Chief Executive

CEO Report

Page 1 of 4

Chief Executive's Report

1. CQC Inspection

1.1 CQC will be beginning their visit to us on 25th January. I would like to offer my thanks to Louise Lyon and other colleagues who have led work in preparing for the visit.

2. Mental Health Taskforce

2.1 The Mental Health Taskforce is due to publish its report shortly. In advance of the publication report the Prime Minister made an important speech on mental health on 11th January.

2.2 In the speech the Prime Minister called for an end to mental health stigma and offered his commitment to taking forward the recommendations from the taskforce report.

2.3 He also announced a range of investment in mental health:

- £290 million to provide specialist perinatal care.

- nearly £250 million for psychiatric liaison services

- £400 million to enable 24/7 treatment in community services as safe and effective alternatives to hospital

2.4 There has been some uncertainty about how this announcement links to previously announced investment in the Spending Review statement and elsewhere.

3. North Central London Mental Health Programme

3.1 As part of a range of work being taken forward by the 5 CCGS in North Central London a Mental Health Programme has been established. It will aim to identify whether there are initiatives which can be taken to co-ordinate services across North Central London in ways which improve outcomes and deliver financial savings. This is one of four programmes which will feed into the delivery of a Sustainability and Transformation Plan for North Central London.

3.2 An initial clinical and stakeholder event for the Programme was held on 14th January which I attended with Rob Senior and Sally Hodges.

4. Family Nurse Partnership

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4.1 I attended on 7th January, with members of the FNP National Unit, a roundtable discussion hosted by Jane Ellison MP, the Minister for Public Health at the Department of Health on the development of FNP in the wake of the results of the RCT. The meeting was also attended by representatives of Public Health England, a number of local authority commissioners and by other national stakeholders.

4.2 Notwithstanding the RCT results, the meeting was generally very positive about FNP and the potential to develop it in a more flexible manner going forward. In particular LA representatives reinforced the view that the programme should take a primary focus on child development outcomes.

4.3 We are hopeful that we can work with DH and PHE to issue a public communication on the future direction of the programme. We plan to have a fuller report on next steps at the February Board meeting.

5. i–Thrive collaborative

5.1 We have been taking forward our interest in the Thrive model of provision for Children and Young People's Mental Health services working with partners in the Anna Freud Centre, UCL Partners and the Dartmouth Center for Health Care Delivery Science.

5.2 On 27th November we launched the i-Thrive Community of Practice with 10 sites from across the country committed to implementing the Thrive model.

5.3 On 2nd February we have an interview for a significant Health Foundation grant to support aspects of the programme.

6. IM&T Strategy and Care Notes

6.1 Toby Avery, our Director of IM&T has been leading work on the development of the Trust's IM&T strategy. He is due to present this to the Management Team on 21st January prior to bringing proposals to the Board of Directors.

6.2 The work has identified a number of a number of urgent areas for investment in our infrastructure. These were discussed at the January meeting of the Audit Committee and it was recommended that in an number of areas investment should fast tracked to deal with identified risks.

6.3 We are also planning a programme of work to optimise the use of Care Notes. While in general the system is well established there are

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CEO Report

a number of on-going issues with its use. This has been highlighted by difficulties in generating Q3 outcome monitoring reports which are in the process of being addressed.

6.4   To support work in Care Notes and other clinical IT applications we have appointed, on a permanent basis, Dr Myooran Canagaratnam as Chief Clinical Information Officer for the Trust. Myooran was one of a number of clinicians who have supportws the selection and implementation of Care Notes.

7.   Leadership Conference

7.1   On 15th December we held the second Trust Leadership Conference. The day focused, amongst other things, on issues relating to the Trust's 2 Year Strategy and on our preparations for our CQC Inspection.

7.2   In the afternoon the event was broadened to include an invitation to all clinical team leaders. It was felt particularly helpful to include this group and highlighted the importance of supporting the development of this level of the organisation.

8.   Workplace Race Equality Standard

8.1   On 2nd December we welcomed Roger Klein who is leading national work on the Workplace Race Equality Standard to lead a seminar on this issue at the Trust. Roger also attended a session at the Leadership Conference on 15th December.

8.2   We have identified the need to address the underrepresentation of BME staff in more senior levels in the organisation and Roger's presentation highlighted good practice from other NHS organisations which we could look to implement. We have identified this as a priority in the Trust's 2 Year Strategy.

9.   Mental Health Network

9.1   I have been elected to join the Board of the NHS Confederation's Mental Health Network.

Paul Jenkins
Chief Executive
18th January 2016

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

Board of Directors : January 2016

Item : 9

Title : NHS Planning Guidance 2016/7 – 2020/21

Purpose:

This paper summaries the key messages in the "Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 which was published just before the Christmas break.

This report focuses on the following areas:

- Quality
- Risk
- Finance

For : Information

From : Paul Jenkins Chief Executive

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NHS Planning Guidance 2016/7 – 2020/1

1.   Introduction

1.1   "Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21" was published on 22nd December on behalf of all the National Arm's Length Bodies. In the wake of the results of the Spending Review its sets out some key messages for both commissioners and providers, both for the current financial year, and also for how the NHS should go about delivering financial sustainability and the transformation of services over the next 5 years. The guidance, which has been previously circulated to Board members, is attached at **Annex A**.

2.   Key messages

2.1   There are a number of key messages which are worth highlighting:

- There is a strong focus on place based rather than organisation based planning with a requirement for the production, by the summer, of five year Sustainability and Transformation Plans (STPs).

- Overall there is a significant focus on mental health in the document linked both to existing priorities such as the new waiting times standards and transforming children and young people's mental health services but also flagging up priorities likely to be identified in the Mental Health Taskforce.

- There is a further opportunity relating to seeking expressions of interest for secondary mental health providers taking control of tertiary mental health budgets in relation to both CAMHS and adult services.

- A key priority relates to returning the provider sector to financial balance. £1.8 billion of funding will be available to support Trusts in deficit. The release of these funds will be linked to the delivery of recovery milestones in relation to both financial and operational performance.

- There will be a further pot of transformation funding to support actions in the best developed STPs.

- There are in total 9 national "Must dos" for 2016/7. These include the delivery of the new waiting times standards for mental health.

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- There are messages about the limited access to capital and the need, with a small number of exceptions, to fund capital investment from within the Trust's own internally generated capital resource.

3.   What does this mean for the Trust?

3.1   The STP footprint with which we are involved is very likely to be North Central London. This matches with the growing focus on joint work across the sector which has been developing in recent months. This includes the NCL mental health programme being led by Dorothy Blundell, Chief Officer at Camden CCG.

3.2   In the short term we are still required by NHS Improvement to submit a one year organisational plan for 2016/7. We need to submit a first draft of this by 8th February with a final draft due on 11th April. The detail of this is addressed in the Finance and Performance report.

3.3   There is significant interest in North Central London in submitting an expression of interest for the devolution of tertiary mental health budgets (for both CAMHS and adults services). We are actively involved in this work.

4.   Conclusion

4.1   The Board of Directors are invited to note the content of this paper and the planning guidance.

Paul Jenkins
Chief Executive
January 2016

NHS

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

December 2015

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

Version number: 1

First published: 22 December 2015

Prepared by: NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

This document is for: Commissioners, NHS trusts and NHS foundation trusts.

Publications Gateway Reference: 04437

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.

2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new Mandate to NHS England (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.

4.   We are requiring the NHS to produce two separate but connected plans:

    • a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and

    • a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016[1] and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.

8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement[2] will need to help secure remedies through more joined-up and effective system oversight.

9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

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[1] For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.

[2] NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.

13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:

    (i)   the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;

    (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;

    (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and

    (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of 'national challenges' to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.

15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing 'transformation footprints'

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.

17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.

18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the 'six principles' created to support the delivery of the Five Year Forward View. By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.

20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title 'STP feedback'. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National 'must dos' for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.

22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

(i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;

(ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and

(iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine 'must dos' for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:
    • secondary mental health providers managing care budgets for tertiary mental health services; and
    • the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.

26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:

    • how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);

    • their planned contribution to the efficiency savings;

    • their plans to deliver the key must-dos;

    • how quality and safety will be maintained and improved for patients;

    • how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and

    • how they link with and support with local emerging STPs.

    The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

    • greater equity of access through pace of change, both for CCG allocations and on a place-based basis;

    • closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and

    • faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

    NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.

33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.

34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.

35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top- ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.

38. As notified in Commissioning Intentions 2016/2017 for Prescribed Specialised Services, NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.

39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.

40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.

42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.

43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.

44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?

    • How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?

    • What action will you take to address obesity, including childhood obesity?

    • How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, accountable consultants?

3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1   What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?

3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?

4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?

5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?

6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?

8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?

9. What steps will your local area take to improve dementia services?

10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support

11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?

12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?

13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?

14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?

15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?

16. How will you put your Children and Young People Mental Health Plan into practice?

17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?

19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?

20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?

2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?

3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?

5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full Mandate to NHS England

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	**Overall 2020 goals:** • Consistent improvement in performance of CCGs against new CCG assessment framework.
	2016-17 deliverables: • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.	
2.1 Avoidable deaths and seven-day services	**Overall 2020 goals:** • Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. • Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures. • Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020. • Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients. • Measurable improvement in antimicrobial prescribing and resistance rates.
	2016-17 deliverables: • Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline. • Rollout of four clinical priority standards in all relevant specialties to 25 percent of population. • Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety. • Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

2.2 Patient experience	**Overall 2020 goals**: • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
	2016-17 deliverables: • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
2.3 Cancer	**Overall 2020 goals:** • Deliver recommendations of the Independent Cancer Taskforce, including: o significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and o patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
	2016-17 deliverables: • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

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3. To balance the NHS budget and improve efficiency and productivity	
3.1 Balancing the NHS budget	**Overall 2020 goals**: • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.
	2016-17 deliverables: • With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in: o securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending; o delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and o reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament. • Roll-out of second cohort of RightCare methodology to a further 60 CCGs. • Measurable improvement in primary care productivity, including through supporting community pharmacy reform. • Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients. • Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.		
4.1 Obesity and diabetes	**Overall 2020 goals:**	
	• Measurable reduction in child obesity as part of the Government's childhood obesity strategy.	
	• 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme.	
	• Measurable reduction in variation in management and care for people with diabetes.	
	2016-17 deliverables:	
	• Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese.	
	• 10,000 people referred to the Diabetes Prevention Programme.	
4.2 Dementia	**Overall 2020 goals:**	
	• Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including:	
	o maintain a diagnosis rate of at least two thirds;	
	o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and	
	o improve quality of post-diagnosis treatment and support for people with dementia and their carers.	
	2016-17 deliverables:	
	• Maintain a minimum of two thirds diagnosis rates for people with dementia.	
	• Work with National Institute for Health Research on location of Dementia Institute.	
	• Agree an affordable implementation plan for the Prime Minister's challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.	

5. To maintain and improve performance against core standards	
5.1 A&E, ambulances and Referral to Treatment (RTT)	**Overall 2020 goals:** • 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population. • 75 percent of Category A ambulance calls responded to within 8 minutes. • 92 percent receive first treatment within 18 weeks of referral; no-one waits more than 52 weeks.
	2016-17 deliverables: • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E. • Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact. • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out. • With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.
6. To improve out-of-hospital care.	
6.1 New models of care and general practice	**Overall 2020 goals:** • 100 percent of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.

	2016-17 deliverables:
	• New models of care covering the 20 percent of the population designated as being in a transformation area to:
	o provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and
	o make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing.
	• Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists.
	• Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
6.2 Health and social care integration	**Overall 2020 goals:**
	• Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution.
	• Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.
	2016-17 deliverables:
	• Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17.
	• Every area to have an agreed plan by March 2017 for better integrating health and social care.
	• Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision.
	• Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals.
	• Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	2016-17 requirements:
	• NHS England is required to:
	o ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care;
	o consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and
	o consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
6.3 Mental health, learning disabilities and autism	**Overall 2020 goal:**
	• To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce).
	• Access and waiting time standards for mental health services embedded, including:
	o 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and
	o 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	2016-17 deliverables:
	• 50 percent of people experiencing first episode of psychosis to access treatment within two weeks.
	• 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	• Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care.
	• Agree and implement a plan to improve crisis care for all ages, including investing in places of safety.
	• Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018.
	• Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.	
7.1 Research and growth	**Overall 2020 goals:** • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
	2016-17 deliverables: • Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.
7.2 Technology	**Overall 2020 goals:** • Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations.
	2016-17 deliverables: • Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020. • Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016. • Robust data security standards in place and being enforced for patient confidential data. • Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care. • Significant increase in patient access to and use of the electronic health record.

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| 7.3 Health and work | **Overall 2020 goal:**
• Contribute to reducing the disability employment gap.
• Contribute to the Government's goal of increasing the use of Fit for Work. |
| | **2016-17 deliverables:**
• Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce.
• Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment. |

#FutureNHS

Board of Directors: January 2016

Item : 10

Title : Draft Clinical Quality Strategy – version 2

Purpose:

This paper sets out the Trust's clinical quality strategy for 2015-7. It sets the strategy in the context of the Trust's five year ambitions and two year strategic objectives. The paper describes the Trust's overall clinical quality objectives and its two year aims for quality improvement and development. It describes the governance arrangements and reporting processes that will underpin and support the delivery of high quality care to all our services users and carers, in line with the Fundamental Standards (2014) of care which we are required to meet. Our quality improvement priorities are framed by the five key lines of enquiry within which the Care Quality Commission monitors our performance against national standards. This strategy is subject to annual review.

At this stage the strategy is presented to the Board of Directors as a draft for discussion prior to further consultation with staff and stakeholders and to allow us to take account of any additional issues identified by Care Quality Commission CQC in their inspection visit.

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

For : Discussion

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

Draft Quality Strategy

Clinical Quality Strategy 2015-2017 – 2nd Draft

1.   INTRODUCTION

1.1   The Tavistock and Portman NHS Foundation Trust aims to deliver high quality healthcare to our patients.   This clinical quality strategy supports the ambitions and objectives of the Trust to innovate, to grow and to improve healthcare and outcomes.

1.2   The clinical quality strategy has been developed in the context of our five-year ambitions and supports our two year strategic objectives to develop and extend our clinical services for Children, Young Adults and Families and for Adult and Forensic Services.

1.3   Our clinical quality strategy is also supported and strengthened by our strategic objectives for research, patient experience and participation, use of information, equality and diversity, workforce development, communications and accommodation.

2.   QUALITY DRIVERS

2.2   Quality is defined as care that is safe, effective, responsive, well-led and provides a positive patient experience. This powerful definition was set out in *High Quality Care for All* in 2008, following the NHS Next Stage Review led by Lord Darzi. This definition is now used in legislation and has the patient and the NHS Outcomes Framework at its heart. Following from the Francis Report (2013), the Berwick Report (2013), reviewing safety in the NHS, identified organisational culture and leadership as additional significant elements of quality, a point reinforced by Lord Rose in his report, Better Leadership for Tomorrow (2015). See Appendix 1 for an overview of national drivers of the quality agenda.

2.2   Within the context of key national drivers, our strategy reflects local priorities and the expectations of service users, carers, staff, commissioners, our Governors and other stakeholders all of which contribute to our strategy.

3.   OUR MISSION AND VALUES

3.1   Our clinical quality strategy is built on our Trust's mission and values.

3.2   Through delivering high quality clinical services our mission is:

- To make a measurable difference through what we contribute to the health and wellbeing of individuals and communities and the value we offer our commissioners.

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

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

3.3   Our clinical quality strategy is informed by and reflective of the values which run through all areas of the work of our Trust.

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

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

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

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

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

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

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

4. KEY OUTCOMES

4.1 The key outcome expected as result of our clinical quality strategy is to be able to qualitatively and quantitatively demonstrate maintenance of high quality care and continuous quality improvements within services and improved outcomes for patients. The ten key areas outlined below give an overview of the quality of care we aim to deliver

4.2 Ten key areas for Quality Improvement and Maintenance

1. To provide services which are caring, safe, effective, responsive and well-led.

2. To ensure that our patients have the best possible experience of our services and are treated well by all staff; front of house, administrative and clinical.

3. To provide our services in accessible, safe and comfortable settings affording patients privacy and dignity at all times, ensuring that services are accessible to all members of the diverse communities we serve including those members with protected characteristics who may experience barriers to receiving appropriate care

4. To base our services on the best available evidence and to ensure we adhere to best practice.

5. To learn continuously from; feedback from service users and carers, staff, commissioners and other stakeholders; incidents and near misses: formal and informal complaints, concerns and compliments.

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

7. To communicate our learning across the Trust ensuring that everyone from the frontline staff to the Board of Directors and the Council of Governors are aware of the areas we have identified as needing improvement and the quality improvement plans we have developed in response.

8. To support and promote a culture and ethos where everyone may speak up about concerns, compliments, novel ways of working, and to encourage constructive and respectful challenge, ensuring that our response to service users when things go wrong or they are dissatisfied is candid, timely and compassionate.

9. To learn from the health care community and to contribute to health care improvement through participating in benchmarking, audit and research initiatives.

10. To ensure our workforce is well-trained, highly-skilled and motivated to deliver high quality, compassionate care. To sustain compassionate care through ensuring that our long tradition of reflective practice is fully supported. To promote staff health and well-being and to promote inclusion through tackling inequalities and discrimination.

5.   THE CARE QUALITY COMMISSION (CQC) AND OTHER EXTERNAL BODIES

The Fundamental Standards of Care 2014 sets out the standards of care to which all health and social care providers must adhere.

The CQC monitor our services' performance against the national standards. They do this by monitoring providers' performance through inspections, data analysis and other checks and can take action, including enforcement, when services are found not to meet the standards.

Inspectors use professional judgement, supported by objective measures and evidence, to assess services against five key questions:

- Are they safe? Are people protected from abuse and avoidable harm?
- Are they effective? Do people's care, treatment and support achieve good outcomes, promote a good quality of life and are based on the best available evidence?
- Are they caring? Do staff involve and treat people with compassion, kindness, dignity and respect?
- Are they responsive to people's needs? Are services organised to meet people's needs?
- Are they well-led? Does the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, support learning and innovation, and promote an open and fair culture?

These questions provide a useful framework for judging our performance over time and for setting our annual and long term Quality Aims (see below). Preparation for CQC inspections gives an opportunity to carry out highly focused quality assessment and improvement. The CQC inspection report will help us test and refine our quality improvement priorities.

Other external bodies such as Monitor (regulator of Foundation trusts) and the Health and Safety Executive all contribute to ensuring the delivery of high quality and services that are safe for both service users and staff. An annual Quality Report is submitted to Monitor and Quality Accounts uploaded on NHS Choices. Local user groups including Health Watch provide valuable feedback for improvement.

The Clinical Quality Review Group (a group which includes representatives of the Clinical Commissioning Groups, the Commissioning Support Unit and the Trust) assures our Commissioners of the quality of our clinical services and plays a key role in determining our quality priorities and performance targets

and metrics. They receive quarterly performance reports on our clinical services and are closely involved in monitoring the safety of our services.

6. SUMMARY OF AIMS FOR EACH KEY QUALITY DOMAIN

6.1 Caring

- We want all our service users and carers to feel they are treated with kindness, dignity and respect. We want them to feel individually cared for and to feel confident that their care is our highest priority. We show our care for our services users by ensuring we attend to their individual needs, making provision for service users who may have difficulty accessing our services.

- We help service users understand and engage with our services through providing relevant information in a range of formats so that they can make informed choices.

- We ensure patients do not have a lengthy wait for an initial appointment and keep them informed and supported if they have wait for treatment (because for example they need a specific treatment). We encourage service users to feel free to let us know what we are doing well and what might be improved.

- We listen to feedback from our service users, their carers and organisations and groups representing the community, including those who are harder to reach.

6.2 Safe

- We want all our service users to be safe and protected from avoidable harm and abuse, in whatever form that takes. Ensuring patient safety is an essential and integral component of all of our patients' care at every stage of their treatment pathway. We encourage staff to report incidents and manage risks appropriately - clinical or non-clinical. . We are committed as an organisation to learning from incidents.
- We have robust systems in place to safeguard adults and children, including mandatory training for all staff about safety systems, processes and practices. We ensure that all service users have a detailed clinical risk assessment to identify any clinical risks and vulnerabilities, and undertake actions to mitigate these risks. This will inform the patient's care plan which is continually reviewed with the patient.

- We strive to ensure that the therapies we deliver are of the highest quality and safety, and that all of our clinicians and therapists are appropriately trained and supervised. We ensure that our individual care record keeping is accurate and safe, and that we operate within agreed parameters of confidentiality.

- We believe that creating and fostering a safe and containing therapeutic setting, which includes establishing trusting relationships between the service user and those involved in their care, is essential for positive therapeutic outcomes. Providing containment for staff through, for example, reflective practice is essential to creating a safe environment for patients.

6.3 Effective

- We aim to provide our service users with care, treatment and support that achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- We have joined the NHS Benchmarking Network and we will continue to make use of benchmarking data for our Child and Adolescent Mental Health Service. We make use of benchmarking data for our adult and forensic services where suitable data is available.

- We recognise the importance of making the most effective use of resources available to us. We commit to reviewing the cost-effectiveness of our interventions, to demonstrating value for money and adapting and developing services to maximise their impact.

6.4 Responsive

- To organise our services around the needs of the user, involving them and their carer at all points of service design and delivery including recruitment, training, evaluation and service development. We aim to have truly patient centred services, which adapt to meet the changing needs of their users through a process of participation, involvement and feedback.

- We are mindful that a 'one size fits all' model is not appropriate and we actively seek feedback from a wide range of users, including those who are most vulnerable and difficult to access.

6.5 Well-Led

- We aim to work within clear and effective governance structures to deliver safe, effective, responsive and caring services.

- We promote good communication between various levels of management and leadership from team, to service line, to Trust Board and Council of Governors, and ensure that there are good systems in place for gathering and using feedback.

- We promote an open culture where staff are encouraged to report incidents or propose improvements.

Draft Quality Strategy

- We support all staff to maintain and develop their skills and ensure that they receive clinical supervision. We ensure that our service line and team managers are well-trained, supported and valued.

7. TWO YEAR QUALITY AIMS 2015-17

7.1 Our quality aims have been developed through consultation with stakeholders, review of performance data, issues and concerns. They will be further refined following feedback from the Care Quality Commission inspection and further consultation with quality stakeholders, service users and carers, staff, Clinical Quality, Safety and Governance Committee, Clinical Quality Review Group, Governors, Health Watch, GPs and other local stakeholders.

7.2 Aims and indicators: (please see page 9)

7.2: Aims and Indicators

Domain	No	Aim	Example of Interventions	Indicators
SAFE	1	To improve the identification, assessment and management of patients where there is evidence of domestic violence and abuse.	- Baseline review of data - CareNotes review/ amendments - Patient involvement - Staff interventions	Safety improvement plan to be drafted by April 2016 using quality improvement methodology. This forms part of the Trust Sign up to Safety Campaign commitments. Link work into NICE Quality Standard for this area – due in 2016.
	2	To improve the identification and management of high risk patients.	- Introduce Mandatory Attendance at Clinical Risk Assessment Training to improve clinician's knowledge of self-harm and suicide. - Assessment of staff knowledge - Review patient records and possible CareNotes review/ amendments - Clinical Audit	Safety improvement plan to be drafted by April 2016 using quality improvement methodology. This forms part of the Trust Sign up to Safety Campaign commitments.
	3	To improve awareness among clinicians of the role patients digital lives can have on mental health	- Raise awareness of the impact of patients' digital lives on well-being through conferences and training events. Digital lives assessment included in risk assessment for under 18s. - CareNotes review / amendments.	Safety improvement plan to be drafted by April 2016 using quality improvement methodology. This forms part of the Trust Sign up to Safety Campaign commitments.
EFFECTIVE	4	To improve awareness of best practice and use of guidance and research to inform clinical practice	- Further embed NICE Guidance awareness, research and service development e.g. IMPACT study, MBT for ASPD, i-Thrive - Increase adherence to evidence based guidelines and practice where appropriate but evidence too of a culture that is interested in documenting and measuring "real world" practice just as it occurs, i.e. practice based evidence.	CareNotes records to demonstrate awareness of best practice. Practice based evidence of increased effectiveness.
	5	To develop further effective clinical practice: best value, patient determined outcome indicators, and impact on wider health economy	Consultation with health economist, work with service users and carers to develop indicators of the outcomes that matter most to the lives of service users and carers	Small scale projects Training attendance and increase in use of clinical audit and quality improvement projects.

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			• A focus on measurement for improvement – demonstrating that change is going in the right direction i.e. demonstrating that change is an improvement. • Clinical audit and quality improvement methodology training and implementation	
	6	Effective physical health care assessment and intervention, mental and physical well-being.	• Interventions will be agreed supporting staff to recognise physical health issues relating to known public health areas that link with mental health e.g. alcohol, smoking, nutrition and signposting patients to appropriate support services internally and externally to the Trust. • Establish links with relevant third sector organisations.	Safety improvement plan to be drafted by April 2016 using quality improvement methodology. This forms part of the Trust Sign up to Safety Campaign commitments.
CARING	7	To improve service and support provision for carers.	Carers' needs assessments • carers involved in staff selection, carers as members and governors • carers involved in patient involvement activities e.g. word of mouth and improved information for carers, especially young carers.	Carers survey shows that over 75% of identified carers believe their needs have been taken into account.
	8	To ensure that staff will always be compassionate and caring.	• Implement value based recruitment • support for staff • reflective practice • staff well-being	• Staff survey results indicate high levels of engagement and well-being. • Staff and Patient FFT results show that that our results match or exceed benchmark data. • Patient survey results show that 95% feel treated well by the people who saw them.
RESPONSIVE	9	To improve patient access through improved management of waiting times.	• Issues raised with Commissioners models of waiting list management in development • Service redesign to make best use of resources • Service user and care consultation on waiting list management.	Minimal waiting time target breaches for Trust reasons. Progressive targets to be agreed with relevant local and national Commissioners.

	10	To improve patient and carer involvement in care planning.	Review current shared decision making and agree interventions to improve this.	ESQ shows that 90% service users and carers feel involved in important decisions about their care.
	11	To increase learning from complaints, compliments, concerns and incidents across the organisation.	Qualitative and quantitative data gathered from Experience of Service Questionnaires (ESQ), PALs, incident reports, staff 'Worries and Concerns' six-monthly survey.	• Evidence of change, where feasible, in practice in response to feedback • Evidence that improvements in practice are shared across the Trust.
	12	To have excellent communications with referrers and discharge/onward referral management and post treatment support.	• GP communication survey • Discharge audit • Development of service user community through 'word of mouth' project.	• GP survey indicates improvements • Discharge audit
WELL-LED	13	To develop excellent team level leadership and management to deliver improved, measurable quality outcomes.	• Leadership and management training • Training in Quality Improvement methodologies, including clinical audit at team level.	• Increased use of performance data to improve measurable, quality outcomes. • Training to inform team development with evidence of participation in learning across the Trust • Completion of one team quality improvement project in four clinical teams.
	14	Accessible and intelligible quality indicator data available at patient, team, service line, directorate, management team, Board and Commissioner levels.	• Performance dashboard development • Appointment of Clinical Information Development Lead (CCIO) • Consultation with Commissioner • Consultation with staff	• Fully compliant with Monitor Quality Assurance Framework • Data dashboards validated as clinically and managerially useful.

Draft Quality Strategy

8.   DEVELOPMENT OF ANNUAL CLINICAL QUALITY PRIORITIES

8.1   We are fully committed to improving quality across every aspect of the
      Trust's work, building further on previous achievements. Clinical quality
      priorities are determined through consultation with stakeholders including
      Clinical Commissioners, service users, carers, staff, Healthwatch and the
      Overview and Scrutiny Committee. Priorities take into account the
      overarching quality strategy as well emerging priorities based on findings
      from our quality reports from the previous years.

      Action plans for each priority area are developed and are monitored on a
      regular basis by our Management Team and our Trust Board.

9.   PROCESSES AND STRUCTURES SUPPORTING THE DELIVERY OF HIGH QUALITY
      CLINICAL SERVICES

9.1. Governance Structures

9.1.1 Board of Directors: The Board of Directors is ultimately responsible for
       ensuring that we continue to raise the bar on all our quality initiatives. The
       Board receives regular reports from the Clinical Quality, Safety and
       Governance Committee (CQSG), set up in 2010 to oversee all the most
       important quality initiatives.

9.1.2 Clinical Quality Safety and Governance Committee (CQSG): The CQSG chaired
       by the Medical Director, is a Board appointed committee with Executive and
       Non-Executive Director members and Governors, which meets quarterly to
       receive and consider assurance of progress against requirements and action
       plans across the core of our quality improvement agenda, and to review
       work stream reports submitted to this committee. These key work streams,
       which are at the heart of our quality commitment, cover areas such as clinical
       effectiveness, patient experience, safety and staff training, with quarterly
       reports to the Board of Directors.

       These work streams are:

       • Patient Safety and Clinical Risk
       • Corporate Governance and Risk
       • Clinical Quality and Patient Experience
       • Information Governance

       See Diagram 1 on page 14: CQSG work streams and reporting relationships.
       The CSQG will have a key role in providing assurance to the Board of
       Directors on the delivery of this strategy.

9.1.3 Audit Committee: The Chair of the CQSG sits on the Audit Committee (see
       Diagram 2 on page 15, which sets out the responsibilities of the Audit
       Committee and the CQSG).

9.1.4 Data Analysis and Reporting Committee: The Director of Quality and Patient
       Experience leads the Clinical Quality and Patient Experience (CQPE) work
       stream and chairs the Data Analysis and Reporting Committee (DARC). This
       committee sets the data collection strategy in line with the Trust's strategy,

the clinical service delivery objectives, NICE guidelines, commissioner requirements and regulatory expectations.

9.1.5 <u>Quality Stakeholders Group</u>: The includes service users and cares, members of the Clinical Quality Review Group, Governors, patient and public involvement team members and other local stakeholders. The Group is chaired by the Director of Quality and Patient Experience and provides a forum for closer examination of our quality data and contributes to the development of our quality priorities.

9.1.6 <u>Council of Governors</u>: Governors are responsible for the selection of local indicators for external audit for inclusion in our Quality Report and Accounts.

Draft Quality Strategy

Diagram 1

Clinical Quality Governance Reporting

The Board of Directors

Clinical Quality, Safety & Governance Committee

Management Team

Assurance through accountability

Authority through delegation

Corporate Governance and Risk
Lead: ADQG

- To scrutinise prospective submissions to NHSLA
- To ensure non-clinical risks are managed
- To monitor the corporate risk register
- HR compliance data
- Estates compliance data
- Report on corporate governance quality targets

Information Governance
Lead: SIRO

- To ensure that the highest regard is given to the safety and security of confidential information.
- To report on the progress towards completion of IG returns
- To facilitate compliance with national standards
- To review policies and procedures to ensure compliance
- To facilitate IG training
- To liaise with the Caldicott Guardian

Clinical Quality and Patient Experience
Lead: Director of Quality & Patient Experience

- directors of clinical services have plans in place to improve the culture and practice of data collection, management, and quality
- reports provide assurance that outcome data has improved outcomes at individual and patient group levels and that the results, where they can be benchmarked, compare favourably against those of other providers
- outcome monitoring methodology and practice best suits the Trust's patient population
- data to be collected have been agreed the commissioners and other appropriate external parties
- the annual audit programme is aligned with organisational priorities as set out in the annual operational plan
- the implementation of outcomes of the recommendations of clinical audits leads to improvements in patient care
- information on outcomes facilitates patient choice and that any published information is of consistent good quality and is accessible and available to prospective patients and referrers
- the feedback from Experience of Service Questionnaires is dealt with effectively, both individually, and by analysing trends and common issues
- members contribute to strategic discussions to aid planning based on data from all available sources
- the Trust has prepared for inspections from the regulator of clinical services

Patient Safety and Clinical Risk
Lead: Associate Medical Director

- Review reports on patients safety, clinical incidents, clinical complaints and clinical claims
- To review the effectiveness of safeguarding arrangements
- Advise on supervision and arising issues relating to patient safety
- Review clinical risks
- Complaints
- Medical revalidation
- Records

Diagram 2

Management

Assurance

Provision of assurance to the BD - the role of the respective BD committees and their interrelationship

DH

NICE

National Information Board

guidelines

NHS England

Targets

HSCIC

commissioners

CQRG

KPI outcomes or action plans

CQC

KPIs

Management Team

Clinical data requirements

DARC

parameters

Quality Group

Monthly dashboards

Process Assurance to leads

CQPE

Reports

Annual Strategic Plan

Board of Governors

BG consulted on annual plan and risk strategy

BG receives reports on performance and outcomes

Board of Directors

TOR & ad hoc objectives

TOR & ad hoc objectives

Reports

Clinical Quality, Safety, and Governance Committee

Corporate governance assurance
Information governance assurance
Clinical outcomes assurance
Clinical audit assurance
Quality report assurance
Patient safety and clinical risk assurance
Patient and public involvement assurance

Committee governance and process assurance provided annually by chair of CQSG

Work stream governance and process assurance provided by internal and external audit

Audit Committee

Financial assurance
Internal control assurance

Key
DARC - Data Analysis and Reporting Committee
CQRG - Clinical Quality Review Group (of the CSU on behalf of the CCGs)
CQPE - Clinical Quality & Patient Experience Work Stream

Draft Quality Strategy

9.1.7   <u>Directorate Clinical Governance and Quality Committees</u>: The Director of Children, Young Adult and Families (CYAF) and the Director of Adult and Forensic Services (AFS) are responsible for ensuring services are delivered according to our quality standards and in line with external regulation. They are supported in this through Directorate Clinical Governance and Quality Leads and the directorate clinical governance and quality committees.

9.2   Data

9.2.1   Relevant, valid and accessible data is essential to the demonstration of improvement (or setbacks in achieving improvement) and maintenance of the quality of our clinical services. The Trust has made significant progress with increasing its capacity to collect and analyse clinical effectiveness data. Through our newly configured Clinical Quality and Patient Experience work stream we aim to work with our service users and our commissioners to find innovative ways of evaluating our services; ensuring we answer the questions most relevant to our patients and providing the practice based evidence and information our commissioners need to ensure our services are delivered in line with their priorities and responsibilities. The new workstream places patient experience and user and carer participation as central to clinical effectiveness and clinical audit.

9.2.2   The implementation of the new CareNotes clinical record system will further improve our capacity. Further developments of the system will include a patient portal. The recent appointment of a Clinical Information Development Lead (Chief Clinical Information Officer) will allow the development of the use of information to support innovative health care and self-care for service users.

9.2.3   Having established improved systems for data capture, the focus of our work over 2015-7 will be on embedding new systems for ensuring the most useful data is generated, is validated and is reported on in a timely and accessible way. On this secure basis, quality development or improvement projects can be co- produced with clinical staff, service users and other stakeholders.

9.3   Engagement

9.3.1   Our commitment and impetus for continuous quality improvement operates through all levels of the organisation, with staff aware of the importance of the need to challenge the ways in which we work, with an on-going effort to improve quality across all aspects of our services. In the light of the Francis report we encourage staff to speak up and to feel confident in sharing concerns. Our 6 monthly 'Worries and Concerns' consultation, the staff Family and Friends Test, and the Staff survey provide opportunities for staff to make sure that concerns are heard at a senior level. The Management Team and the Board strive to communicate responses to concerns and issues as effectively as possible. We have appointed a Trust "Freedom to Speak Up" champion, who will work to

champion an open culture in the organisation and work with staff who wish to raise concerns.

9.3.2   Our Council of Governors is fully committed to our quality agenda and Governors actively participate in the process and structures underpinning the delivery of excellent care. Governors are invited to participate in key quality governance and reporting fora.

9.4   Sharing

9.4.1   Over 2015-17 our intranet will be redeveloped to provide a more accessible and flexible means of communicating with staff and providing ready access to policies, procedures and updates.

9.4.2   Quality News was established in 2014 and we plan to produce 4 issues a year each with a specific focus. Quality News is a vehicle for recognising and sharing good practice, disseminating learning from clinical incidents, complaints and service user feedback across the Trust.

9.4.3   We have a programme of performance dashboard development underway. Working with Commissioners, staff and in due course service users, we aim to provide accessible and relevant performance dashboards at trust, directorate, team and patient level. This will make a very significant contribution to our capacity to assess trends and to triangulate data from multiple sources, including qualitative data

9.5   Learning

9.5.1   Clinical team monthly and quarterly review templates are in development and will be used in pilot form in 2015-16. The aim of these templates is to ensure that, for example, learning from incidents and complaints is shared and recorded across the Trust. Teams will receive monthly and quarterly data and provide reports to service line managers. In this way we aim to foster ready communication of concerns and innovations up, down and across the whole organisation.

9.5.2   Training and consultation is available to staff on the use of quality improvement tools including clinical audit, process mapping, PDSA cycles and root cause analysis methodology. A series of projects led by the CYAF clinical lead for quality is about to get underway in consultation with a health economist (October 2015-March 2016), which aim to identify cost effective practices to enable services to be more responsive to the needs of the patient groups.

9.5.3   A well–trained and up to date work force is essential to the delivery of high quality services. A programme of mandatory and optional training is made available to staff in support of our clinical quality strategy. Over 2105-17 we aim to review and enhance the scope of training and the methods of delivery. Training will be delivered in ways which fit best with needs of our busy workforce based on several sites.

Draft Quality Strategy

9.6   Leadership

9.6.1   Leadership is provided through a range of roles and responsibilities supported by the Board including the Medical Director, the Associate Medical Directors, the Director of Quality and Patient Experience, the Associate Director of Governance and Quality , the Director of Children, Young Adults and Families and the Director of Adult and Forensic Services.

9.6.2   We aim to strengthen and support leadership at the Team Manager level to support the delivery of our clinical quality strategy

10.   TWO YEAR STRATEGIC OBJECTIVES SUPPORTING THE CLINICAL QUALITY STRATEGY

10.1   Research

10.1.1   Participation in research can ensure a high standard of clinical service is delivered to participating patients as well as the longer term benefits of contributing to improving mental health and well-being through supporting the extension of evidence based practice.

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

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

10.1.4   To embed research competencies across all our training portfolios with particular emphasis on our clinical trainings.

10.1.5   Current research projects include:

- Mentalisation Based Therapy for people with Anti-Social Personality Disorder
- Personalised interventions for conduct disorder
- Adolescent Depression study (IMPACT)
- Dynamic Interpersonal Therapy for depression

10.2   Patient Experience and Participation

10.2.1   To develop and implement a new strategy for patient involvement which encourages innovation driven by the involvement of people with lived experience of mental health problems.

10.2.2   Service users, cares and the community will be at the heart of   Determining the design and delivery of Safe, Effective, Caring Responsive, Well-led services

10.2.3 Over 2015-7 we will further develop a community of people with lived experience connected to our Trust through a range of activities. Service user involvement will be embedded throughout all we do with directors and managers held accountable for this.

10.3. Use of information

10.3.1 To develop and implement an IM&T strategy for the Trust.

10.3.2 To encourage greater adoption of technology for delivering patient care, improving experience and driving efficiencies.

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

10.4 Equality and Diversity

10.4.1 To develop an Equality and Diversity Strategy building on the Annual Equality Plan for 2015-16.

10.4.2 To promote the use of data to highlight areas where improvements in access are indicated and to work with staff, service users and community group to development plans to improve access tailored to the needs of those with protected characteristics or others for whom there are barriers to access to appropriate services.

10.5 Workforce Development (including Training)

10.5.1 Improve staff health and well-being through introducing initiatives to address issues raised through review of the staff survey results.

10.5.2 Strengthening management and leadership through middle management development interventions, extend the use of 360 degree appraisals, developing future leaders, provide coaching.

10.5.3 Identify opportunities for staff development in order to improve staff survey results and seek innovative ways to develop staff and deliver training, including e-technologies.

10.6 Communications

10.6.1 Improve internal and external communications through the development of the website and the intranet.

10.7 Accommodation

10.7.1 To agree a full business case for the best long term accommodation for the Trust's business.

10.7.2   Process of Workplace Development has included and will continue to include extensive consultation with stakeholders including staff, students and service users.

10.8   **Service Redesign and Quality Improvement Projects**

10.8.1   Our mission is to be a pioneer in the development and delivery of effective clinical interventions, which improve the mental health and wellbeing of children, young people and adults.

10.8.2   We do this through developing and implementing new systems of service delivery and new models of clinical practice.

10.8.3   We are piloting a Quality Impact Risk Assessment tool for use in service redesign projects. This will be rolled out to all service developments once it has been fine-tuned.

In each Directorate, clinical Team Managers are either implementing, or plan to implement, Quality Improvement Projects.

11.   REVIEW OF THE STRATEGY

This strategy will be reviewed on an annual basis by the CQSG and the Board of Directors. The strategy may be reviewed and updated in the light of changes in Trust strategic direction, findings emerging from reports to the Clinical Quality Safety and Governance Committee, improvements required or recommended by the Care Quality Commission, national guidance and local commissioning requirements.

APPENDIX 1

National Drivers of Quality

There are a number of key national policy drivers which inform the delivery of the Trust's quality agenda:

The NHS Outcomes Framework: builds on the definition of quality through setting out overarching outcomes or domains, which capture the breadth of what the NHS is striving to achieve for patients:
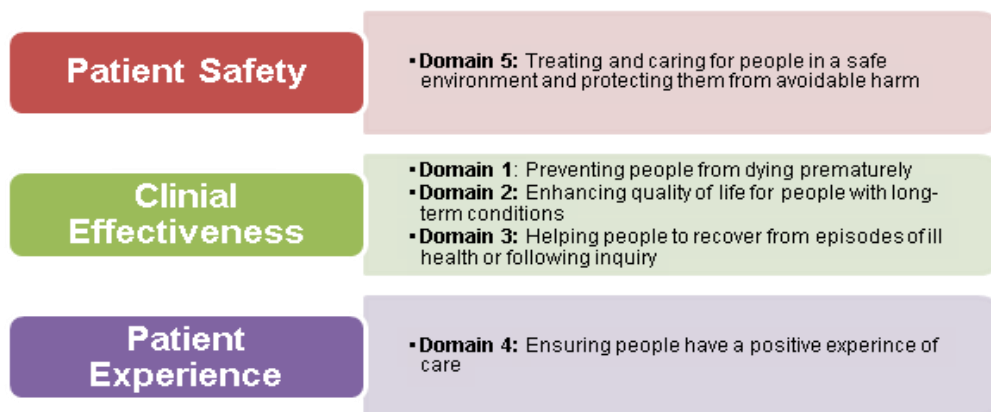
- **Monitor's Risk Assurance Framework:** Foundation Trusts are held to account for the quality of services they provide through this Framework.
- **The NHS Operating Framework: 'Everyone Counts': Planning for patients 2014/19:**
- **The NHS Constitution (2009):** established the principles and values of the NHS in England. It sets out the pledges, the NHS commitment to operate fairly and effectively, and the rights to which patients, the public and staff are entitled.
- **The National Institute for Health and Care Excellence:** the NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care derived from high quality guidance, such as that from NICE.
- **Care Quality Commission:** is the regulator of health and adult social care in England. It is responsible for ensuring that providers meet essential standards for quality and safety and encouraging on-going improvements by those who provide or commission care.
- **Quality, Innovation, Productivity and Prevention (QIPP)** is a large scale transformational programme for the NHS which seeks to improve the quality of care delivered while increasing productivity.
- **Commissioning for Quality and Innovation Framework (CQUIN)** links a proportion of a healthcare provider's income to the achievement of local quality improvement goals.
- **National Quality Reports and Inquiries.** The Tavistock and Portman NHS Foundation Trust is a learning organisation and draws on the learning from National Quality Reports and Inquiries.

Board of Directors : January 2016

Item : 11

Title : Quarterly Quality Report 2015-16 , Quarter 3

Summary:

The report provides an update of the Key Performance Indicators (KPIs), CQUIN and Quality Indicator targets for Quarter 3, 2015-16. The report combines performance data reported to the Board and commissioners (CQRG) for the main contract.

The Outcome Monitoring data is being validated, hence the report is currently draft.

This report has been reviewed by the following Committee:
- **Management Team, 12 January, 2016**

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

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

For : Noting

From : Associate Director of Quality and Governance

Q3 Quality Report

1. Introduction

Detailed service specific information relating to waiting time breaches and DNA rates can be provided on request. A summary is provided below.

2. Waiting Time Breaches 11+ Weeks

A summary of the internal reasons are below.

Reason for internal breach	Number
Delay in assigning patient to clinician	11
Pressures on resources within the team	2
Admin delay / error	10
Clinician availability	2
Referral not suitable	1
Total	**26**

The average time, in weeks, has decreased from 7 weeks in Quarter 2 for AYAS, Adults and CAMHS services to 5.6 weeks in Quarter 3.

The specialist contract average waiting time, in weeks, for the Portman has decreased from 9.9 weeks in Quarter 2 to 6.6 weeks in Quarter 3.

The GIDS service waiting time has a separate target of 18 weeks as part of the National Contract. The average, in weeks, for Quarter 1 was 17.2 weeks, 15.4 weeks in Q2 and 16.5 weeks in Quarter 3.

3. DNA rates

The target for DNA rates is <11%. Details of DNA rates for specific services is available on request. These include AYAS; Adults; Camden CAMHS; Other CAMHS; City and Hackney; Westminster Service; Portman and GIDS.

Those services higher than 11% in Q3 include:
Adolescent and Young Adults (AYAS) = 16%
City and Hackney = 15%
Westminster Service = 12%

Marion Shipman,
Associate Director Quality and Governance
Jan 2016

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

Tavistock and Portman NHS Foundation Trust

Quarterly Quality Report for Board of Directors & CQRG

Quarter 3: January 2016

DRAFT

Q3 Quality Report

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

Quality Key Performance Indicators – KPIs rolled over from last financial year

Target	Monitoring	Target%	Progress Q1 N	Q1 %	Q2 N	Q2 %	Q3* N	Q3* %	Q4 N	Q4 %	% Progress for 2015/16 Q1	Q2	Q3	Q4
Waiting Times Waiting time no more than 11 weeks (77 days from receipt of referral) excluding exceptions where this is outside of the Trust's control.	Quarterly	<77 days (1% threshold)	18	4.3%	15	3.0%	26	4.1%			Red	Red	Red	
DNA Adult DNA rates: Yearly average no larger than 10%.	Quarterly	10%		9%		11%		8%			Green	Red	Green	
Patient Satisfaction Patient Satisfaction: Target 92% or more report satisfied with the service (Q14 from ESQ)	Quarterly	92%	210	92%	102	94%	143	92%			Green	Green	Green	
Personal Development Plan Quality and Development of staff: Target 80% of staff to have a PDP.	Quarterly	80%		99%		99%		99%			Green	Green	Green	
Sickness and Absence Sickness and absence rates. Target: <2% green (2-6% amber, >6% red)	6 monthly	<2%		n/a		0.7%		1.2%			Grey	Green	Green	
Trust Service cancellation rates Target: <5% green (5-9% amber, >10% red)	Quarterly	<5%		2.4%		2.3%		2.5%**			Green	Green	Green	
Staff Training % of staff with up-to-date mandatory training for infection control. Target >95% green. 80-95% is amber < or = 80% red.	Annually	>95%				n/a					Grey	Grey	Grey	
DBS Checks DBS renewals - Copy of certificate submitted to trust within 1 month of renewal date	Quarterly	100%			Please see 'Enhanced DBS Checks on page 7 for further details'									

*For Q3, there were 46 waiting time breaches, where patients were required to wait 11 weeks or longer for their first appointment. However, only 26 of these breaches related to factors internal to the Trust and represented 4.1% of the total number of patients who were offered a first appointment in Q3. Waiting times ranged between 11 weeks (and 1 day) to 30 weeks (internal reasons)/38 weeks (external reasons)

**Data now includes GIDS and Westminster Service cancellation rates.

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Q3 Quality Report

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

Quality Key Performance Indicators

Target	Monitoring	Target %	Progress								% Progress for 2015/16			
			Q1		Q2		Q3		Q4		Q1	Q2	Q3	Q4
			N	%	N	%	N	%	N	%				
Explanation of Service Number and % of children who answer certainly agree that they received a clear explanation of service (Q6 in ESQ)	Quarterly	75%	41	77%	34	97%	30	80%						
Care Plans A - % of care plans evidencing co-production with service users*		n/a	n/a		See narrative below		Report unavailable. Informatics working on pulling this information to report in Q4.							
B - % of care plans evidencing input from primary care (Baseline for 15/16)**	6 monthly		n/a		See narrative below		Report unavailable. Informatics working on pulling this information to report in Q4.							

*Care plan information is completed for each patient following assessment. This is co-produced with the service user and a copy may be sent to them by the clinician. Currently it is possible to confirm if patient records on the new Care Notes system, have the care plan information completed. This is confirmed from Carenotes fields where there is a care plan in place and a consent box ticked with "options discussed".
**Referrals received from GPs are scanned and saved on the patient's electronic file. The clinician seeing the patient will be the most appropriate, given the referral issue. GPs are sent a summary of the care provided and kept up to date during the course of their care. The definition for this metric is taken from patients with a care plan and a GP letter at end of assessment.

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Quality Key Performance Indicators

Target	Monitoring	Target%	Progress				% Progress for 2015/16			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Complaints **% Response to Complaints** A - 90% of complaints acknowledged within 3 working days.			100%	88%	100%*					
B - 80% of complaints responded to within 25 working days.	Quarterly	>90%	100%	100%	100%					
C - Achieve a downward trajectory of number of complaints that have a concern about staff attitude by end of Quarter 3			n/a	n/a	0					
D - 100% of upheld complaints identify learning and improvements as a result.			100%	100%	100%					
E - Trends and themes of PALS concerns and complaints identified and published on a quarterly basis.			n/a	Annual PPI report published this quarter	Report submitted to Care Quality Patient Experience Workstream Lead**					
F - Implementation of actions plan			n/a	n/a	n/a					
Complaints and Claims **A - Provide quarterly complaints and claims update to include:** i) no. of complaints where response is outstanding at 3 months and reasons why	Quarterly	n/a	0	0	0					
ii) Number of complaints reported to CQC			0	0	0					
iii) Numbers of complaints partially and fully upheld by Parliamentary Ombudsman			0	0	0					
iv) Number of re-opened complaints.			0	0	0					
v) all legal claims acknowledged within 14 days			0	1	n/a					

* In Q3 there were 3 complaints received by the Trust. All complaints acknowledged within 3 working days. Please see CGR Report for further details.
**CGR report covers complaints – a separate PALS report will go to Quality & Patient experience workstream meeting.

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Q3 Quality Report

The Tavistock and Portman NHS Trusts
NHS Foundation Trust

Quality Key Performance Indicators

Target	Monitoring	Target %	Progress Q1	Progress Q2	Progress Q3	Progress Q4	% Progress for 2015/16 Q1	Q2	Q3	Q4
B - Provide bi-annual complaints and claims lessons learnt report with: i) Themes of lessons learnt including breakdown of clinical policy/clinical pathway areas where complaints are made	Quarterly	n/a	n/a	Achieved	Achieved					
ii) Detail of actions undertaken as a result of complaints			n/a	Achieved	Achieved					
Serious Incidents **Improvement trajectory agreed for the following:** A- No. of Serious Incidents (SI) submitted within the designated timescale	Monthly		October 15 0	November 15 0	December 15 1					
B - Where SI reports are returned incomplete, % returned complete within 10 working days.	Quarterly	n/a	0	n/a	n/a					
C - Evidence of implementation of action plans*	6 Monthly Audit		n/a	n/a	n/a					
D - Organisational learning identified and actions embedded as a result in 100% of SIs.	Q4		n/a	n/a	n/a					
Safeguarding Completion and submission of the NCL Safeguarding Children and Adult Metrics Return	Quarterly	n/a	Achieved	Agreed submission date: 17/10/15 Submitted Children's Metrics 23/10/15	Achieved: Submitted 5th January 2016 to CCG (Jackie Dyer)					
Female Genital Mutilation** A - To include FGM as part of mandatory safeguarding training levels 1, 2 & 3, 80% of staff will be trained in safeguarding		80%	L1: n/a L2: 98% L3: 94%	L1: n/a L2: 98% L3: 93%	L1: n/a L2: 97% L3:89%					
B - Safeguarding alerts raised and number counted within service in accordance with NICE guidance***	Quarterly	n/a	3 Adult and 17 Safeguarding Children alerts	2 Adult and 10 Safeguarding Children alerts	1 Adult and 24 Safeguarding Children alerts					

*SI Action Tracker in place (Q3)

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

*** Results published in Q3 Corporate Governance and Patient Safety and Risk Compliance Report

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Quality Key Performance Indicators

Target	Monitoring	Target %	Progress Q1	Progress Q2	Progress Q3
Compliance Compliance with relevant standards of the Mental Capacity Act are completed and DOL applications and outcomes.*	Quarterly	n/a	Yes	Yes	Yes
Audit of Trust Consent Policy standards To perform an audit on 20 patient notes in Q2.	Q2 Audit	n/a	n/a	Small audit completed	Completed - reported in comprehensive case note audit report
Assessment Reports Provide CCGs with a copy of all internal process and compliance assessment reports, action plans and progress updates	Quarterly	n/a	Achieved	Assessment Report submitted to regular CQRG Meetings.	Achieved
Clinical Audit A - Provide CCGs with copy of Trust wide audit program in Q1.	Q1 Audit		Provided in Q4 14/15	n/a	n/a
B - Provide CCGs with bi-annual findings and recommendations of audits carried out, evidence of action plans and Board Involvement	6 Monthly Audit	n/a	n/a	Updated audit schedule provided to CCG	n/a
C - Provide CCGs with copies of Clinical Audit Annual report to include learning the lessons from audit, demonstrating achievement of outcomes	Annual		n/a	n/a	n/a
Reporting on Guidelines Report on compliance with new relevant NICE Clinical Guidelines, Quality Standards and Technology appraisals within 3 months of publication date.	6 Monthly	n/a	n/a	NICE compliance report to be reviewed by the Trust Clinical Effectiveness lead in Oct 2015	NICE guidance GAP Analysis provided in November CQRG
Mandatory Training** % of eligible staff are currently compliant on all of their mandatory training	Quarterly	80%	93%	94%	91%
Enhanced DBS checks** Enhanced DBS checks for 100% of all relevant staff including renewals every 3 years for all staff in direct contact with Adult at risk, children and patient data. (*Data includes locums, temporary staff and sub-contractors*).	Quarterly	100%	98%	96%	96%

*The Trust to provide 11 MCA training dates to staff over the course of 2015/16. DoLs training is included with the MCA training although DoLs applications are not made by this Trust as it is provided to out patient only services. 35 staff trained in Q3, 10 sessions provided by the end of Q3.

**Please note that INSET/safeguarding training figures are reported on page 26. ***Please note DBS data for all quarters has changed since last published report due to changes in calculations: Q1 100% to 98% and Q2 99.1% to 96%. Please note 100% DBS returns not reached in Q3 due to 22 members of staff absent – 3 career break, 2 secondment and 17 maternity leave.

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Quality Key Performance Indicators

Target	Monitoring	Target %	Progress				% Progress for 2015/16			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Staff FFT and Annual Staff Survey To Improve trajectory from 14/15 baseline and provide organisational response to results Last year result: Fully achieved for Q1, Q2 and Q4	Quarterly	n/a	Increase of 32% compared to Q1 14/15	Increase of 18% compared to Q2 14/15	Staff FFT not sent out in Q3.					
Friends and Family Test (Patient test - from Experience of Survey Questionnaire) % of positive responses on the FFT	Quarterly	90%	94%	93%	92%					
Staff Appraisals Number of Staff Appraisals completed	Quarterly	80%	99%	99%	99%					
Staff Absence % Sickness Absence rate less than 2% for all staff groups	Quarterly	<2%	0.8%	0.8%	1.1%					
Duty of Candour A - 100% of conversations informing patients and/or family that a patient safety incident have taken place within 10 working days of the incident being reported to local risk management systems for Medium harm, Severe Harm, Death or Profound Psychological Harm categories of incidents; and an apology has been given.	Quarterly	100%	0 Incidents	1 Incident	2 Incidents*					
B - 100% of incident investigation reports shared within 10 working days of being signed off as complete and the incident closed by the relevant authority for Medium Harm, Severe Harm, Death or Profound Psychological Harm categories of incidents.**			0 Incidents	100% Support provided via GP with PCPCS service.	0 reports					

*2 incidents in Q3 reported - Confidential patient information stolen from clinicians cars. In both cases, conversations took place within the specified time frame and letters written apologising in both cases.

**2 SI reports going to the January board for sign off. To be sent to CCG following this meeting.

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KPIs Mental Health Trusts

The Tavistock and Portman NHS Foundation Trust

Quality Key Performance Indicators

Target	Monitoring	Target%	Progress Q1	Progress Q2	Progress Q3	Progress Q4	% Progress for 2015/16 Q1	Q2	Q3	Q4
GP satisfaction with communication received from Trusts > above 60% of GPs who respond to be satisfied with communication from MH Trust Services	Annual	>60%	63% GP Satisfaction Rate*			Survey results to be published Q4			(green)	
Local participation in Suicide Prevention Trust will comply with requirements on Mental Health Trusts outlined in the National Suicide Prevention Strategy (2012)	Quarterly	n/a	Achieved	Achieved	Achieved		(green)	(green)	(green)	
Physical Health Care Evidence of physical health addressed across all mental health services	Annual	n/a	n/a	Achieved: Physical health form now implemented on Carenotes. From Q3, all staff now have access. See audit report attached.				(orange)		
Clinical Risk Assessments Annual Audit presented to CQRG	Annual Audit	n/a		n/a		Audit to be undertaken Q4				
Adherence to Crisis Concordat standards Baseline in 2015/16	Annual	n/a		n/a		Results due in Q4				
Crisis Concordat standards - Crisis plan Bi-annual Percentage of patients who have been offered a crisis plan for emergency mental health situation	6 monthly	95%	n/a	n/a	Please see below ***					
Equality and Diversity - BME access to 'talking therapies'** Percentage BME access to 'talking therapies' (Baseline in 2015/16)	Quarterly	n/a			Q1: 40.8% BME Q2: 38.6% BME Q3: 37.2% BME				(green)	
NICE guidance - Bipolar Disorder (CG185, Sept 2014) - CBT/psychological treatment**** Baseline in 2015/16, Proportion of patients with a diagnosis of bipolar disorder offered CBT/psychological treatment	Quarterly	n/a	0.41% (13 patients out of 3135)	0.51% (16 patients out of 3163)	0.61% (18 patients out of 2922)					

*A GP survey was conducted in December 2015 (survey sent to 385 GP surgeries across Greater London)— Two questions surveyed related to communication: (a) how clear the Trust has been about who GPs can contact to gain further information in relation to a referral and (b) how well the Trust communicates with GPs about their patient during the course of their treatment. 63% responded satisfied.

**This KPI is looking at reporting the number of BME patients who attend appointments Trustwide in all services on a quarterly basis.

***We do not currently collect or record any information in a searchable format in relation to crisis plan, or emergency MH treatment on Carenotes. The addition of a searchable field on Carenotes will be considered. The Trust therapy services see patients who are not acutely ill. ****Data is assessed as 'high risk', a plan is put into place for their safety which is recorded in the clinical notes.

****Data changed from last published report = Q1 2141 to 3135 and Q2 1996 to 3163 - Total number of patients is reflective of patients with active referrals and have had one appointment within the given quarter.

Section Two: Generic Service CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q3	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Children Young Adult and Families (CYAF) (Outcome monitoring)	For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at Time 1 and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	Q1-Q4	49%	80%	49% completed GBM at Time 1 and Time 2 with at least 2 goals. This is an increase on Q2 41%. We are trying to improve our results by providing refresher training sessions to our clinicians to improve completion of the forms and emailing reminders.	(grey)	(red)	(red)	
Children Young Adult and Families (CYAF) (Outcome monitoring)	For 75% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).	Q1-Q4	85%	75%	Achieved target: 17 improved out of 20 with 2 goals.	(grey)	(green)	(green)	
ADULT & Adolescent and Young Adult (Outcome Monitoring)	For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.	Q1-Q4	73%	50%	Achieved target: Improvement rate for period October 2015 – December 2015: Adult and Adolescent (combined) = 73% (Cohort 22 Patients – 16 of those had an improvement) Improvement by individual services: Adolescents = 64% Adults = 82%	(green)	(green)	(green)	

Physical Health CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q3	Target %	Progress	Q1* RAG	Q2 RAG	Q3 RAG	Q4 RAG
PHYSICAL HEALTH – Smoking Cessation	Smoking status recorded at time of the first assessment appointment for 95% patients age 14 years and above between 1 April 2015 and 31 March 2016	Q1-Q4	Q1: 23.3% Q2: 26.6% Q3: 23.6% Q1+Q2+Q3: 25.3% (cumulative)	95%	Q3 = All patients 14+ that attended first appointment between 01/10/2015 to 31/12/2015 = 508. Of these 23.6% (120) have smoking status recorded. 30 have smoking status='yes' (30/120=25%) . 388 (76.4%) not recorded. **Q1+Q2+Q3 (Cumulative)** = All patients 14+ that attended first appointment between 01/10/2015 to 31/12/2015 = 1511. Of these 25.3% (382) have smoking status recorded. 119 have smoking status= 'yes' (119/382=31.2%) . 1129 (74.7%) not recorded.	(grey)	(green)	(green)	
	Very brief advice for 95% of patients recorded as current smoker	Q1-Q4	Achieved	95%	Q1 = Some education in the form of a presentation to clinicians has been undertaken to make them aware to ask the question and give brief advice. Education ongoing. Q2 = Referrals made to the Physical Health Nurse for further intervention/ NRT Q3= 0% (Out of 30 smokers - 3 patients wanted help to quit – no recorded advice given)	(amber)	(green)	(red)	
	Percentage of patients who are current smokers with a record of initiation of treatment including setting a quit date or receiving Varenicline or NRT or referred for on-going support.	Q1-Q4	Achieved	n/a	Q1 = Physical healthcare template created on Care Notes and rolled out Q2 = Information is being recorded on the physical healthcare template to support baseline monitoring. Q3= 2 patient referred for further on going support	(green)	(green)	(green)	
	Quit attempts, initiation of treatment and referral of patients by Physical Health Practitioner to community stop smoking centres for on-going support.	Q1-Q4	Achieved	n/a	Q1 = Referral criteria confirmed – forms part of the physical healthcare form. Local stop smoking services have been identified in preparation for new Physical Health Nurse post. Links with services to be confirmed. Q2 = Physical Health Nurse to start on 16th October 2015. Q3= Referred identified patients to community stop smoking centres for ongoing support	(amber)	(red)	(green)	
	Offer Nicotine Replacement Therapy (NRT) for patients wishing to stop smoking (Prescribing to be a pass through cost to the Trust)	Q1-Q4	Achieved	n/a	Q1 = Physical Health Nurse NRT requirement included on JD (substantive post) Q2 = Physical Health Nurse to start on 16th October 2015. Q3= 4 patients referred to local stop smoking services. NRT to be offered as appropriate by external agency	(green)	(red)	(green)	
	Appointment of a BTS clinical champion to promote smoking cessation for patients and staff	Q1-Q4	Achieved	n/a	Q1 = BTS clinical champion to promote smoking cessation for patients and staff included on JD (substantive post for registration) Q2 = Physical Health Nurse to start on 16th October 2015. Q3= Physical Health Nurse is a BTS champion	(green)	(red)	(green)	
	Pro-active promotion of stop smoking to staff through in-house or local stop smoking service	Q1-Q4	Achieved	n/a	Staff Smoking Survey was conducted electronically in Q3. 138 staff members took the survey. 20 staff members confirmed they were smokers (14.5%). 8 of these wanted help to quit. Four of these indicated that they wanted to be referred to a local Smoking Cessation service.	(red)	(red)	(green)	

*Please note that Carenotes and the Physical Health Form was introduced in July 2015. Data prior to July may have not been migrated fully and therefore causing inequalities within our reporting

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Physical Health CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q3	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
PHYSICAL HEALTH – Alcohol Misuse	To ensure the consistent offer of effective, evidence-based screening for increasing risk (hazardous) and high risk (harmful) alcohol consumption to patients presenting with selected conditions in Mental Health Services. Patients (aged 14 years or over).	Q2-Q4	Number of patients assessed using physical health form: Q1+Q2+Q3= 9.6% Q1=0.6% Q2=7.3% Q3=14.5%	n/a	No referrals in Q3 Age 14+= 510 No patients Assessed Q3= 74 (14.5%) No patients referred to Physical Health Nurse= 1	(grey)	(green)	(green)	
	To ensure patients screening positive (who score 16 and above for the FAST score) are referred to in-house Physical Health Nurse for a brief intervention and information concerning sensible/safer drinking.	Q2-Q4	Achieved	95%	Carenotes system has been developed in Q3 to register delivery of brief intervention.	(grey)	(amber)	(green)	
	95% of patients screened, referred to the physical health nurse and referred to local alcohol services where GP communication is undertaken within 1 week.	Q2-Q4	Not achieved	95%	1 patient referred to external alcohol service for treatment.	(grey)	(red)	(red)	
	Referrals made to local alcohol services when identified as appropriate by the Physical Health Nurse.	Q2-Q4	Achieved	n/a	1 patient identified. PHN liaising with external services to increase service provision.	(grey)	(red)	(green)	
	Trust to implement system of recording instances where patients disclose either: A) Being the victim of violence in relation to alcohol or	Q2-Q4	Not achieved	n/a	DV and Physical Health Form information to be reviewed	(grey)	(green)	(red)	
	B) Perpetrating violence in relation to alcohol		Not achieved		DV and Physical Health Form information to be reviewed		(green)	(red)	

Domestic Violence CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q3	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
PHYSICAL HEALTH – Domestic Violence	Evidence that there is a domestic violence lead and a domestic violence programme established at the trust. The domestic violence programme is to be supported by a trust wide multi-disciplinary steering group across the trust.	Q1	Achieved.	n/a	We have a named DV lead in place along with a domestic violence training programme.	(green)			
	Evidence to be provided of a systematic approach to the identification of domestic violence, support and referral to appropriate services.	Q2	Achieved.	n/a	We have now set up a DV sub-committee and we are recording DV on Carenotes. Sarah Helps, the Adult Safeguarding Advisor has commissioned DV training to commence on 30th November.		(green)		
	Evidence of roll out of training programmes to front line staff in the identified cohorts. Sample of training plan provided. Training Plan Reviewed and Agreed.	Q3	n/a this quarter	n/a	In the context of in-house level 2 adult safeguarding training, a brief initial training on Domestic abuse and violence (DA and V) was delivered to staff across the adult services. Training covered definitions of domestic violence and abuse, the social and cultural contexts of DA and V, basic information on how to screen for DA and V as part of clinical work, contact details for local specialist DA and V agencies and small group case discussion of recent clinical examples where DA and V was a potential issue.			(green)	
	Further evidence of roll out of training programme in Q4 with further identification that any actions that have been identified from cases that have been referred to MDT have been followed up and completed. Reporting to be built into the CQUIN and shared with primary care. Safety report to be potentially provided for assessment. Numbers and % of staff trained. Evaluation of training programme submitted.	Q4	n/a this quarter	n/a	n/a				

Q3 Quality Report

Safe and Timely Discharge CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q3	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
SAFE AND TIMELY DISCHARGE	**Planned discharges:** Discharge letters for GPs to be sent within 2 weeks of final appointment for planned discharges	Reported in Q3 after completion of audit	n/a this quarter	85%	Agreed with commissioners to audit Q3 data in Q4.				
	Non-Planned discharges: 85% Patients discharged from Carenotes within 2 weeks of letter to GP	Reported in Q3 after completion of audit	n/a this quarter	85%	Agreed with commissioners to audit Q3 data in Q4.				
	Effective discharge plans in place - mandated fields to be added in Carenotes to ensure consistent, quality of information in discharge summaries.	Q2	Achieved	n/a	Planned discharge tick-box and treatment end date field is now implemented on Carenotes.				

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Portman CQUIN

	Detail of indicator	Reported	Performance at Q3	Target	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Demonstrating improvement in outcomes for over 18s (SWAP)	A SWAP will be completed by clinicians for all patients at assessment who are offered treatment. This will be repeated one year from the patient's first treatment attendance to assess a measure of change. The Provider will provide a detailed ongoing analysis of the results.	Q1-Q4	100%	100%	100% of SWAP's completed by clinicians to date.				
Demonstrating improvement in outcomes by measuring reductions in frequency of presenting problem behaviours (PROM)	All patients who are offered treatment will be assessed at the end of the assessment and after 6 months in treatment using the Presenting Problems Monitoring Questionnaire. The Provider will demonstrate a reduction in the number of presenting problems through this tool for 70% or more cases. (Patients presenting with a primary diagnosis of gender dysphoria are excluded as this is not considered an appropriate outcome measure for this cohort of patients).	Q1-Q4	83%	75%	83% of patients with a PROM for Time 1 and Time 2 shown an improvement. Of the 6 PROMSs completed, 5 improved and 1 patient did not change.				

GIDS CQUIN

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

Q3 Quality Report

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Section Three: Quality Priorities

Quality Priorities

Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2015/16			
								Q1	Q2	Q3	Q4
(1)Outcome Monitoring	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).	Caroline McKenna	Carenotes Monitoring of progress by the OM Lead Quarterly progress report Quarterly basis, providing reports	• OM analysis of the % return rate for Time 1 and Time 2.	1 Oct 2015	31 Dec 2015	49% completed GBM at Time 1 and Time 2 with at least 2 goals. This is an increase on Q2 41%. We are trying to improve our results by providing refresher training sessions to our clinicians to improve completion of the forms and emailing reminders.		(red)	(red)	
	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).		to the Patient Experience and Care Quality Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs.	• OM analysis of the % of patients who achieve an improvement in their score for at least two GBM targets.	1 Oct 2015	31 Dec 2015	85% Achieved target: 17 improved out of 20 with 2 goals.		(green)	(green)	

Quality Priorities

Quality Priorities

Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2015/16			
								Q1	Q2	Q3	Q4
(1) Outcome Monitoring	Adult & AYA Service: For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.	Michael Mercer	Quarterly basis, providing reports to the Experience and Care Quality Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs.	• OM analysis of the % of service users who achieve an improvement in their score from pre assessment to End of Treatment.	1 Oct 2015	31 Dec 2015	Achieved target: Improvement rate for period October 2015 – December 2015: Adult and Adolescent (combined) = 73% (Cohort 22 patients - 16 had improvement) Improvement by individual services: Adolescents = 64% Adults = 82%				
(2) Access to Clinical Services and Health Care Information for Patients and Public	1. PPI team to develop a quarterly PPI newsletter for Trust staff and service users to include updates on patient stories	Sally Hodges		• The PPI team will develop and launch a quarterly PPI newsletter for Trust staff and service users to include updates on patient stories.			Q3 newsletters for CYAF and Adult/Forensic Services are currently on display throughout the Trust				
	2. PPI Newsletters to be available on the Trust website			•PPI newsletters will be posted on the website.			The bulletins are published on the Tavistock website.				
	3. Following launch of the newsletter, a Visual Straw Poll to be run on awareness of the newsletters		The evidence will be the results of the Visual Straw Poll.	•A question on the Visual Straw Poll will be used to evaluate awareness and knowledge of the PPI quarterly newsletter.			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).				

Q3 Quality Report

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

Quality Priorities

Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2015/16			
								Q1	Q2	Q3	Q4
(3) Patient and Public Involvement	1. To provide a service user for every clinical interview panel that requests a service user panel member.	Sally Hodges	• The PPI team will maintain their local spreadsheet containing details of interview panels that have taken place including a service user on the interview panel.	• The PPI team has provided interview panel training sessions for service users who have volunteered to participate and now have a pool of service users who can sit on interview panels.	1 Oct 2015	31 Dec 2015	15 service users were involved in interview panels that requested a service user.				
	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.		• We plan to monitor our progress towards achieving these targets on a quarterly basis, providing reports to the Patient and Public Involvement Committee and other various meetings.	• The evidence will be feedback reports maintained by the PPI team. The PPI team will contact service users to ask them about their experience of being on an interview panel.			Feedback is currently being gained via email, phone and in person. 73% of the 15 service users that were on interview panels have responded with feedback. The comments have all been positive.				

Appendix: Quality Indicator Performance Supporting Evidence

1. Waiting Times

Target less than 77 days (11 weeks)	AYAS	Adult	Camden CAMHS	Other CAMHS	Portman	City and Hackney	TOTAL
				QUARTER 3			
Breaches Cause internal to Tavi	1	9	0	3	1	12	26
Breaches: Cause external to Tavi	0	3	1	8	1	7	20
Total number of breaches (do not include no breaches)	**1**	**12**	**1**	**11**	**2**	**19**	**46**
Number of 'breaches' shown after data validation shown to be 'no breach'	0	0	8	2	0	2	12
Total number of patient attending first appointment in quarter	35	84	262	105	29	114	629
The percentage of patients that are breached in the quarter	2.9%	14.3%	0.4%	10.5%	6.9%	16.7%	7.3%
% internal	2.9%	10.7%	0.0%	2.9%	3.45%	10.53%	**4.1%**
% external	0.0%	3.6%	0.4%	7.6%	3.45%	6.14%	3.2%

Q3 Quality Report

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Waiting Times

Tavistock/National Contract Waiting Times for Q3 - including Mean and Median data

Service*	Q1	Q2	Total Seen Patients Q3	Median (Weeks) Q3	Average (Weeks) Q3
Adolescent and Young Adult	51	30	36	5.1	4.8
Adults	240^	192^	85	6.0	6.4
City and Hackney			115	7.3	8.6
Camden CAMHS	181"	97	263	2.1	3.1
Other CAMHS	92	66	108	6.8	7.5
Total	**564**	**385**	**607**	**6.0**	**5.6**

Specialist Contracts Waiting Times for Q3 - including Mean and Median data

Service	Q1	Q2	Total Seen Patients Q3	Median (Weeks) Q3	Average (Weeks) Q3
Portman	21	39	29	6.1	6.6
GIDS**	143	189	220	17.4	16.5

^includes City and Hackney Data " First Step was included in the Other CAMHS Figures. Data now removed as not included in London Contracts remit.   *Data provided in table includes all teams and services within Tavistock/National contracts. Q1+Q2 were specific to London Contracts. Average waits for Q3 for London Contracts is: **5.7 weeks and Median: 5 weeks** (total of **545** total seen patients Q3).   **Contractually TPFT has agreed to a waiting time no more than 11 weeks (77 days from receipt of referral) for patients. The Gender Identity Development Service (GIDS) waiting time figures are not included as they have a separate target (18 weeks) as part of their National Contract.

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2. DNA Rates

Total DNA Rates*

	QUARTER 3			
Target <11%	2013/14	2014/15		2015/16*
Total 1st appointments attended	354	368		895
Total first appointments DNA's	34	26		138
Total first appointments	388	394		1407
% 1st appointments DNA'd	8.8%	6.6%		9.8%
Total subsequent appointments attended	9211	9561		14236
Total sub. appointments DNA'd	898	699		1378
Total subsequent appointments	10109	10188		14863
% DNA subsequent Appointments	8.9%	6.9%		9.3%
Total % DNA	9%	7%		9%

*Please note total figures now include Gender Identity Service and Westminster Service data

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Q3 Quality Report

3. Patient Satisfaction – See ESQ Report 2015-2016 Q3. A hardcopy of this Report can be provided by Sally Hodges (Patient and Public Involvement Lead).

4. Patient Experience - See Annual PPI Report. A hardcopy of this Report can be provided Sally Hodges (Patient and Public Involvement Lead).

5. Patient Information - See patient leaflets on Trust Website.

6. Outcome monitoring - Please refer to CQUIN Targets in Section Two and see 2015-16 CQUINs Outline. A hardcopy of this CQUINs Outline can be provided by Omer Kemal (Quality Team).

7. Quality and Development of Staff - Patient Development Plans ("PDPs") are managed on an annual cycle with performance reported at end March each year, for implementation over the course of the next year. However, updated figure for Q3 in table below.

Quality and Development of Staff - PDPs:		
Number of staff who require a PDP at 31st December 2015	Number of staff with a PDP	% of staff with a PDP
482	481	99%

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7. Safety – Safeguarding Training

Level 1 Safeguarding Training – Adult + Children (Provided at Trust INSET days – May & November and Clinical and Trust induction days held twice a year)

Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	93%	94%	91%	

Narrative — Quarter 3 results

Total numbers requiring training:	548
Number of staff trained:	500
Number of staff NOT trained:	48
%:	91%
Rationale (Reason for non-attendance):	15 staff exempted by their Directors to attend INSET day held in Nov 15 and will be attending the May 2016 INSET day. 9 new starters to attend the next induction in February 2016 and 24 will attend INSET day in May 2016 as they will be overdue. Reminders to be sent out.

Level 2 Safeguarding Training – Children only

Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	98%	98%	97%	

Narrative — Quarter 3 results

Total numbers requiring training:	39
Number of staff trained:	38
Number of staff NOT trained:	1
%:	97%
Rationale (Reason for non-attendance):	1 staff to complete in January 2016 but this is not in breach of the agreed training requirements. Reminder has been sent.

Level 3 Safeguarding Training – Children only

Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	94%	93%	89%	

Narrative — Quarter 3 results

Total numbers requiring training:	317
Number of staff trained:	285
Number of staff NOT trained:	32
%:	89%
Rationale (Reason for non-attendance):	20 new starters booked for Q4 (Jan or Feb 2016) and 8 outstanding in Q4. All have been given a training date and have confirmed that they will attend. 1 staff leaving in January 2016.

8. Glossary

AYA (AYAS): Adolescent and Young Adult Service
BME: Black Minority Ethnic
BTS: British Thoracic Society
CAMHS: Children, Adolescent, Mental Health Service
Care Plans: A documented plan that describes the patient's condition and procedure(s) that will be needed, detailing the treatment to be provided and expected outcome, and expected duration of the treatment prescribed by the clinician
CCG: Clinical Commissioning Group
Clinical Outcomes in Routines Evaluation (CORE) Form: This is a client self-report questionnaire designed to be administered before and after therapy. The client is asked to respond to 34 questions about how they have been feeling over the last week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'.
CQUIN: Commissioning for Quality and Innovation Payment Framework
CYAF: Children, Young Adult and Family Service
DA: Domestic Violence
DBS: Disclosure and Barring Service
DNA: Did not attend
DV: Domestic Violence
ESQ: Experience of Service Questionnaire
GBM: Goal Based Measure
GIDS: Gender Identity Service
KPI: Key Performance Indicator
MDT: Multi-Disciplinary Team
NCL: North Central London
NICE: National Institute for Health and Care Excellence
NRT: Nicotine Replacement Therapy
OM: Outcome Monitoring
PCT: Primary Care Trust
PDP: Personal Development Plan
PPI: Patient Public Involvement
PROM: Patient Reported Outcome Measure
SWAP: The Shedler-Westen Procedure
TPFT: Tavistock and Portman Foundation Trust
V: Violence
VSP: Visual Straw Poll

Marion Shipman
Associate Director Quality & Governance
January 2016

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Board of Directors : January 2016

Item :   12

Title :   Finance and Performance Report

Summary:

After nine months the Trust has a surplus of £1,574k before restructuring, £1,298k above the planned surplus of £276k.

In December, the surplus before restructuring was £41k. There were 41 wte vacancies across the organisation, but these were largely covered by 26 bank staff and 11 agency staff. The favourable variance on expenditure was offset by shortfalls on income.

The current forecast for the year is a surplus of £816k before restructuring, or £470k after restructuring.

The cash balance at 31 December was £4,304k, but this will reduce by year-end.

This report was reviewed by the Executive Management Team on 19 January.

For :   Information.

From :   Simon Young, Director of Finance

Finance & Performance Report

1. External Assessments

1.1 Monitor

1.1.1 Monitor's assessment on Quarter 2 has 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 November submission the FSRR remained 4.

2. Finance

2.1 Income and Expenditure 2015/16

2.1.1 After December the trust is reporting a surplus of £1,574k before restructuring costs, £1,298k above budget. Income is £322k below budget, and expenditure £1,616k below budget.

2.1.2 The income shortfall at December of £322k is due to shortfalls on Training £284k and Consultancy £196k which is partially offset by a Clinical surplus of £105k.

2.1.2.1 Training is £284k below plan due to Portfolio income being £97k below plan, Fee income is £95k below target and a £67k shortfall on FNP project income.

2.1.2.2 Consultancy is £196k below budget, £113k of which is due to TC.

2.1.2.3 Clinical Income was £105k above budget at the end of December which was mainly due to over performances of £120k for GIDU Named Patient Agreements and £80k for Gloucester House 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.

2.1.3 The favourable expenditure position of £1,616k below budget was due mainly to the following areas.

2.1.3.1 Family Nurse Partnership (FNP) has a cumulative under spend of £378k due to £126k vacancies (4.52 WTE) and lower than expected non pay costs of £218k. This is forecast to reduce to a £245k under spend by the end of the financial year.

2.1.3.2 GIDU are under spent £235k cumulatively; but as discussed at previous meetings, vacant posts have now been filled and the Unit is currently slightly overspending due to employing additional staff or sessions on a temporary basis. The under spend is expected to reduce to £44k by the end of the financial year.

2.1.3.3 Education and Training is under spent by £156k on pay which includes £99k from E-learning (3.00 WTE); this under spend is anticipated to reduce to £94k by year end. The Portfolios are also £186k under spent on pay due to

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previous vacancies and this is expected to be £247k below budget at the end of the year.

2.1.3.4 Complex Needs is under spent £114k on pay cumulatively, due vacancies earlier in the year. The One Hackney project is £130k under spent on pay.

2.1.3.5 Portman is £164k under budget on pay this is due to additional budget for the increased Probation Service income, and a vacant consultant post (0.70 wte).

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

2.2 Forecast Outturn

2.2.1 The forecast surplus allowing for restructuring costs of £345k is £470k, which is £420k above budget.

2.2.2 Clinical income is currently predicted to be £233k above budget due GIDU over performance on NPAs and Gloucester House over performance, offsetting the provision for under performance on the FDAC Service.

2.2.3 There is also a release of a provision of £178k on Clinical Income relating to previous years.

2.2.4 Training Portfolio income is forecast to be £290k below plan for this financial year due to student numbers being below target. Further detail is in 3.1.3

2.2.5 Visiting Lecturer costs are forecast to be £73k below budget.

2.2.6 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.

2.2.7 The Portman Clinic are currently £197k below their expenditure budget and expect this increase to £224k by the end of the year.

2.2.8 Commercial Directorate are currently £82k over budget and this is expected to increase to £97k over spent by the end of the financial year due to temporary staffing requirements.

2.2.9 The forecast assumes that £319k of the contingency remains unutilised.

2.3 Cash Flow

2.3.1 The actual cash balance at 31 December was £4,304k this is an increase of £6k in month and is £2,509k above Plan.

2.3.2 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

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expenditure is £430k below Plan.

		Actual	Plan	Variance
		£000	£000	£000
Opening cash balance		2,761	2,761	0
Operational income received				
	NHS (excl HEE)	14,492	13,851	641
	General debtors (incl LAs)	8,960	9,134	(174)
	HEE for Training	8,451	8,037	414
	Students and sponsors	1,967	2,075	(108)
	Other	0	0	0
		33,870	33,097	773
Operational expenditure payments				
	Salaries (net)	(13,381)	(13,821)	440
	Tax, NI and Pension	(9,720)	(10,039)	319
	Suppliers	(7,360)	(7,887)	527
		(30,461)	(31,747)	1,286
Capital Expenditure		(1,680)	(2,110)	430
Interest Income		8	4	4
Payments from provisions		0	0	0
PDC Dividend Payments		(194)	(211)	17
Closing cash balance		4,304	1,794	2,509

2.4 Better Payment Practice Code

2.4.1 The Trust has a target of 95% of invoices to be paid within the terms. During December we achieved 87% (by number) for all invoices. The cumulative total for the year was 89%.

2.5 Capital Expenditure

2.5.1 Up to 31 December, expenditure on capital projects was £1,685k. This included £894k on the Modular Building and £265k on the IDCR project.

2.5.2 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 £2,440k.

Capital Projects 2015/16	Budget 2015/16	Actual YTD December 2015	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	57	100			57	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	56	240			56	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
Total Estates	1,808	1,264	1,640	12	434	1,710	2,333
IT Infrastructure	350	156	350			156	350
IDCR	400	265	400	-	389	654	789
Student record system	375		50			-	375
Total IT	1,125	421	800	-	389	810	1,514
Total Capital Programme	2,933	1,685	2,440	12	823	2,520	3,847

3. Training

3.1 Income

3.1.1 Training income is £284k below budget in total after nine months.

3.1.2 FNP income is currently being reported as £67k below budget and is expected to be £117k below target by the end of the year.

3.1.3 Training income is significantly below Plan. Recruitment to the new academic year 2015-16 has reached 82% of target, with 514 year 1 students to date, compared to the target of 630. This compares with 474 enrolled in year 1 for academic year 2014-15, and therefore year 1 student numbers are 8% up on last year. The academic year 2015-16 fee income is forecast at £555k below Plan; £324k (7/12ths) of this in this financial year. Overall student numbers are 58 above plan (5% above target). Enrolment into all years at Associate Centres is 175, short of the target of 215

3.1.4 Short courses activity is currently £82k below Plan, and forecast to reach in the region of £100k below the full year Plan of £585k by the end of the financial year. This is due to a number of CPD's and conferences not attracting the level of attendance when compared with previous years and a decline in the levels of bespoke activity.

3.1.5 Training expenditure is currently £745k lower than budget for all areas.

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3.1.5.1 The majority of this is within FNP at £378k.

3.1.5.2 The Department of Education and Training is £77k 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

3.1.5.3 The Portfolio budgets are £193k 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.

4. Patient Services

4.1 Activity and Income

4.1.1 Total contracted income for the year is expected to be in line with budget, subject to meeting a significant part of our CQUIN targets agreed with commissioners; achievement of these is reviewed on a quarterly basis. The majority of contracts are now block rather than cost and volume.

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

4.1.3 The income budget for named patient agreements (NPAs) was increased this year from £131k to £148k. After December actual income is £150k above budget. This is due to £36k from GIDU relating to 2014/15 in addition to continued GIDU over-performance.

4.1.4 Day Unit Income target was increased by £172k in 2015/16 and is £105k above target after November.

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	12,210	12,195	-0.1%	-20	178	Release of prior year credit
NPAs	111	261	135.1%	200	131	Over performed on GIDU
Projects and other	843	808		–	-55	Income matched to costs, so variance is largely offset.
Day Unit	615	720	17.0%	139	125	
FDAC	1,814	1,715	-5.5%	-133	-146	FDAC dispute
Total	15,594	15,699		186	233	

5. <mark>Consultancy</mark>

5.1 TC are £61k behind budgeted target after nine months. This consists of expenditure £52k underspent and consultancy income £113k 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.

5.2 Departmental consultancy is £83k below budget after December; £51k of the shortfall is within Adults and Forensic Services.

Carl Doherty
Deputy Director of Finance
19 January 2016

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST

INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2015-16

APPENDIX A

		Dec-15			CUMULATIVE			FULL YEAR 2015-16		
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	OPENING BUDGET £000	FORECAST OUTTURN £000
INCOME										
1	CLINICAL	1,851	1,688	(163)	15,594	15,699	105	20,674	19,416	20,906
2	TRAINING	1,690	1,594	(96)	15,204	14,920	(284)	20,187	20,783	19,680
3	CONSULTANCY	99	61	(38)	941	745	(196)	1,238	1,640	1,026
4	RESEARCH	7	6	(1)	63	56	(7)	83	123	69
5	OTHER	95	108	13	417	476	59	667	819	734
TOTAL INCOME		3,742	3,456	(285)	32,218	31,896	(322)	42,848	42,781	42,416
OPERATING EXPENDITURE (EXCL. DEPRECIATION)										
6	CLINICAL DIRECTORATES	1,536	1,520	16	14,145	13,240	904	18,864	18,891	18,127
7	OTHER TRAINING COSTS	1,167	1,091	76	10,479	9,734	745	13,934	14,337	13,467
8	OTHER CONSULTANCY COSTS	64	55	8	574	522	52	765	787	651
9	CENTRAL FUNCTIONS	658	653	5	5,571	5,904	(333)	7,724	7,535	8,168
10	TOTAL RESERVES	14	0	14	239	0	239	319	(9)	0
TOTAL EXPENDITURE		3,439	3,319	120	31,008	29,400	1,608	41,607	41,539	40,413
EBITDA		303	137	(165)	1,210	2,496	1,285	1,241	1,241	2,003
ADD:-										
11	BANK INTEREST RECEIVED	0	1	(1)	4	8	(4)	5	5	9
LESS:-										
12	DEPRECIATION & AMORTISATION	71	75	(4)	622	613	9	775	775	775
13	FINANCE COSTS	0	0	0	0	0	0	0	0	0
14	DIVIDEND	35	23	12	316	316	0	421	421	421
SURPLUS BEFORE RESTRUCTURING COSTS		197	41	(158)	276	1,574	1,298	50	50	816
15	RESTRUCTURING COSTS	0	52	(52)	0	146	(146)	0	0	345
SURPLUS/(DEFICIT) AFTER RESTRUCTURING		197	(11)	(209)	276	1,428	1,152	50	50	470
EBITDA AS % OF INCOME		8.1%	4.0%		3.8%	7.8%		2.9%	2.9%	4.7%

All figures £000	Dec-15			CUMULATIVE			FORECAST FOR FULL YEAR			
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	OPENING BUDGET	REVISED BUDGET	FORECAST	VARIANCE FROM REV BUDGET
INCOME										
1 CENTRAL CLINICAL INCOME	617	615	(2)	5,553	5,559	6	7,035	7,404	7,601	197
2 CYAF CLINICAL INCOME	506	534	28	4,552	4,644	91	6,868	5,990	5,966	(24)
3 AFS CLINICAL INCOME	292	287	(5)	3,220	3,124	(95)	2,865	4,322	4,225	(98)
4 GENDER IDENTITY	435	252	(184)	2,269	2,372	103	2,648	2,957	3,115	158
5 NHS LONDON TRAINING CONTRACT	605	605	0	5,441	5,441	0	7,254	7,254	7,254	0
6 CHILD PSYCHOTHERAPY TRAINEES	179	180	1	1,611	1,587	(24)	2,148	2,148	2,117	(32)
7 JUNIOR MEDICAL STAFF	71	71	(0)	639	682	43	900	852	851	(1)
8 POSTGRADUATE MED & DENT'L EDUC	7	3	(4)	63	20	(43)	111	84	79	(5)
9 PORTFOLIO FEE INCOME	496	446	(50)	3,914	3,817	(97)	5,422	5,298	5,008	(290)
10 DET TRAINING FEES & ACADEMIC INCOME	34	(10)	(44)	855	760	(95)	1,373	976	914	(62)
11 FAMILY NURSE PARTNERSHIP	298	298	0	2,680	2,613	(67)	3,574	3,574	3,456	(117)
12 TC INCOME	76	54	(22)	685	572	(113)	925	913	800	(113)
13 CONSULTANCY INCOME CYAF	6	4	(2)	57	25	(32)	91	77	28	(49)
14 CONSULTANCY INCOME AFS	17	3	(14)	199	148	(51)	624	248	198	(50)
15 R&D	7	6	(1)	63	56	(7)	123	83	69	(13)
16 OTHER INCOME	95	108	13	417	476	59	819	667	734	67
TOTAL INCOME	**3,742**	**3,456**	**(285)**	**32,218**	**31,896**	**(322)**	**42,781**	**42,848**	**42,416**	**(432)**
EXPENDITURE										
17 COMPLEX NEEDS	242	251	(9)	2,545	2,266	280	2,662	3,456	3,162	294
18 PORTMAN CLINIC	133	112	20	1,195	998	197	1,421	1,605	1,380	224
19 GENDER IDENTITY	183	190	(7)	1,643	1,409	235	2,079	2,191	2,147	44
20 DEV PSYCHOTHERAPY UNIT	8	7	1	83	93	(10)	106	106	105	0
21 NON CAMDEN CAMHS	531	513	18	4,791	4,635	156	7,222	6,267	6,173	94
22 CAMDEN CAMHS	378	370	7	3,420	3,307	113	4,639	4,549	4,409	140
23 CHILD & FAMILY GENERAL	62	76	(14)	468	533	(66)	762	691	751	(60)
24 FAMILY NURSE PARTNERSHIP	252	203	50	2,293	1,915	378	3,112	3,112	2,867	245
25 JUNIOR MEDICAL STAFF	83	74	9	745	664	81	993	993	925	68
26 NHS LONDON FUNDED CP TRAINEES	179	177	2	1,611	1,638	(27)	2,148	2,148	2,184	(36)
27 TAVISTOCK SESSIONAL CP TRAINEES	2	1	0	14	11	3	19	19	15	4
28 FLEXIBLE TRAINEE DOCTORS & PGMDE	20	25	(5)	176	156	20	309	234	224	10
29 EDUCATION & TRAINING	308	382	(74)	2,802	2,724	77	3,906	3,619	3,635	(16)
30 VISITING LECTURER FEES	111	113	(2)	998	950	48	1,332	1,332	1,259	73
31 CYAF EDUCATION & TRAINING	39	6	33	312	360	(48)	1,503	429	533	(104)
32 ADULT EDUCATION & TRAINING	30	(3)	33	243	221	23	1,015	334	358	(24)
33 PORTFOLIOS	143	113	30	1,285	1,093	193	0	1,714	1,465	249
33 TC EDUCATION & TRAINING	0	0	(0)	0	3	(3)	0	0	3	(3)
34 TC	64	55	8	574	522	52	787	765	651	114
35 R&D	17	10	7	151	78	73	238	201	114	87
36 ESTATES DEPT	159	174	(15)	1,482	1,712	(229)	2,090	2,166	2,463	(297)
37 FINANCE, ICT & INFORMATICS	172	179	(6)	1,595	1,663	(67)	2,295	2,113	2,199	(86)
38 TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	149	138	11	884	896	(12)	981	1,302	1,321	(19)
39 COMMERCIAL DIRECTORATE	37	42	(5)	339	421	(82)	454	449	546	(97)
40 HUMAN RESOURCES	51	43	8	461	493	(32)	652	614	659	(44)
41 CLINICAL GOVERNANCE	67	60	7	606	554	52	824	808	748	60
42 CEA CONTRIBUTION	6	7	(2)	53	88	(35)	0	70	117	(47)
43 DEPRECIATION & AMORTISATION	71	75	(4)	622	613	9	775	775	775	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	14	0	14	239	0	239	205	319	0	319
TOTAL EXPENDITURE	**3,510**	**3,394**	**116**	**31,630**	**30,014**	**1,616**	**42,314**	**42,382**	**41,188**	**1,194**
OPERATING SURPLUS/(DEFICIT)	**231**	**62**	**(169)**	**588**	**1,882**	**1,294**	**466**	**466**	**1,228**	**762**
48 INTEREST RECEIVABLE	0	1	1	4	8	4	5	5	9	4
49 DIVIDEND ON PDC	(35)	(23)	12	(316)	(316)	0	(421)	(421)	(421)	0
SURPLUS/(DEFICIT)	**197**	**41**	**(156)**	**276**	**1,574**	**1,298**	**50**	**50**	**816**	**766**
50 RESTRUCTURING COSTS	0	52	(52)	0	146	(146)	0	0	345	(345)
SURPLUS/(DEFICIT) AFTER RESTRUCTURING	**197**	**(11)**	**(208)**	**276**	**1,428**	**1,152**	**50**	**50**	**470**	**420**

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2015/16 Plan

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	2,761	5,420	4,596	4,150	4,621	3,087	1,788	4,108	3,170	1,794	4,126	3,443	2,761
Operational income received													
NHS (excl HEE)	2,500	1,915	1,923	1,388	1,305	1,275	1,166	1,204	1,175	1,166	1,204	1,176	17,397
General debtors (incl LAs)	1,171	894	1,000	857	985	785	1,470	1,049	923	1,520	1,386	1,023	13,063
HEE for Training	2,457	142	79	2,457	143	79	2,457	142	79	2,457	143	79	10,717
Students and sponsors	325	150	150	100	0	200	800	250	100	750	100	100	3,025
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
	6,453	3,101	3,152	4,802	2,433	2,339	5,893	2,645	2,277	5,893	2,833	2,378	44,202
Operational expenditure payments													
Salaries (net)	(1,622)	(1,422)	(1,433)	(1,833)	(1,633)	(1,454)	(1,485)	(1,471)	(1,468)	(1,462)	(1,462)	(1,462)	(18,207)
Tax, NI and Pension	(1,100)	(1,101)	(1,101)	(1,109)	(1,110)	(1,110)	(1,124)	(1,147)	(1,137)	(1,135)	(1,131)	(1,130)	(13,435)
Suppliers	(1,072)	(838)	(865)	(1,090)	(865)	(565)	(865)	(865)	(865)	(865)	(865)	(865)	(10,481)
	(3,794)	(3,361)	(3,399)	(4,032)	(3,608)	(3,129)	(3,474)	(3,483)	(3,470)	(3,462)	(3,458)	(3,457)	(42,123)
Capital Expenditure	0	(565)	(200)	(300)	(360)	(300)	(100)	(100)	(185)	(100)	(60)	(100)	(2,370)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	0	1	0	1	0	1	0	0	1	0	1	0	5
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	0	0	0	0	0	(211)	0	0	0	0	0	(210)	(421)
Closing cash balance	5,420	4,596	4,150	4,621	3,087	1,788	4,108	3,170	1,794	4,126	3,443	2,055	2,055

2015/16 Actual/Forecast

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	2,761	3,793	2,340	1,592	4,403	2,794	2,360	4,985	4,298	4,304	6,535	5,652	2,761
Operational income received													
NHS (excl HEE)	1,274	2,238	1,379	2,829	1,254	1,309	1,135	1,236	1,838	1,166	1,204	1,176	18,038
General debtors (incl LAs)	1,120	125	828	1,104	495	1,428	1,493	1,211	1,156	1,520	1,386	1,023	12,889
HEE for Training	2,471	118	202	2,597	60	107	2,696	0	200	2,457	143	79	11,131
Students and sponsors	356	87	95	87	121	281	627	92	221	750	100	100	2,917
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
	5,221	2,568	2,504	6,617	1,930	3,125	5,951	2,539	3,415	5,893	2,833	2,378	44,975
Operational expenditure payments													
Salaries (net)	(1,541)	(1,455)	(1,499)	(1,527)	(1,641)	(1,381)	(1,403)	(1,445)	(1,490)	(1,462)	(1,462)	(1,462)	(17,767)
Tax, NI and Pension	(1,068)	(1,127)	(1,062)	(1,086)	(1,043)	(1,110)	(1,040)	(1,103)	(1,082)	(1,135)	(1,131)	(1,130)	(13,116)
Suppliers	(1,317)	(882)	(241)	(1,138)	(752)	(747)	(891)	(605)	(787)	(865)	(865)	(865)	(9,954)
	(3,925)	(3,463)	(2,802)	(3,751)	(3,436)	(3,238)	(3,334)	(3,153)	(3,359)	(3,462)	(3,458)	(3,457)	(40,837)
Capital Expenditure	(264)	(559)	(451)	(56)	(104)	(128)	7	(74)	(51)	(200)	(260)	(300)	(2,440)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	0	1	1	1	1	1	1	1	1	0	1	0	9
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	0	0	0	0	0	(194)	0	0	0	0	0	(210)	(404)
Closing cash balance	3,793	2,340	1,592	4,403	2,794	2,360	4,985	4,298	4,304	6,535	5,652	4,064	4,064

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

Board of Directors : January 2016

Item : 13

Title : Department of Education and Training 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 7th December 2015

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

- Quality
- Risk
- Finance
- Productivity
- Communications

For : Noting

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

Page 1

Department of Education and Training Board Report

1. **Introduction**

1.1 The Training and Education Programme Management Board met on Monday 7th December 2015 and discussed the following areas addressed in this report.

2. **National Training Contract**

2.1 Paul Jenkins explained to the programme board that meetings had been held with Lis Hughes, Director of Education & Quality (Kent, Surrey & Sussex) and Neil Ralph, Programme Manager (Mental Health & Learning Disabilities) of Health Education England regarding our national training contract.

2.2 A task and finish group has been established to address issues coming out of this meeting. The Programme Board will have the opportunity to review a further proposal for HEE on 11th January.

3. **DET Restructure**

3.1 Brian Rock advised the programme board that the consultation period relating to the DET restructure had now ended. The final structure has now been circulated to staff.

3.2 He explained that there had been a high level of engagement in the process. The key concerns raised by staff were discussed at the Programme Board.

3.3 The importance of process and cultural change as well as structural were discussed. BR explained that an Interim Operations Development Lead was being brought in to implement the changes and see the team through the transition period.

4. **Student Recruitment Plan**

4.1 Laure Thomas, Director of Marketing & Communications, presented the student recruitment plan for 2016/17.

4.2 The plan is wide reaching and includes market research to determine the reasons why those that were awarded places on courses did not go on to enrol with us and looking at where alumni went on to work both in terms of the posts and their location.

5. QAA Action Plan

5.1 The Quality Assurance Agency are due to visit the Trust at the end of April 2016. Elisa Reyes-Simpson, Associate Dean (Academic Governance & Quality Assurance) advised the group that a significant amount of work was already underway in preparation.

5.2 Louis Taussig, Head of the Academic Governance & Quality Assurance Unit, attended for this item. He talked the group through the action plan. He suggested that substantial progress had been made in ensuring we were in line with the UK Quality Code as well as in developing the link between academic governance and the research and development committee. We have increased student representation at committees and begun a student experience committee. He also commended the work that has gone into developing the academic quality pages on the website.

5.3 Issues remain surrounding discrepancies in administrative practices and integrity of student data. There is also further work to do with regards to employer engagement which should be addressed in the restructure.

5.4 The programme board commended the work that has been done so far and asked that the Action Plan and risk register was brought back to the Programme Board each month until the visit so this could be monitored.

6. Regional Strategy

6.1 Karen Tanner informed the group that discussions are underway with two possible new alternative centres of delivery.

6.2 The group was informed that a meeting would take place in January with Birmingham and Solihull Meatal Health Foundation Trust.

6.3 There have been some issues in progressing work in Bristol due to issues with their interim provider who already has a relationship with the Trust.

7. Strategic Market Assessment

7.1 Brian Rock advised the programme board that a strategic market assessment was being undertaken by Victoria Buyer in order to assess how our fees compare to other providers.

7.2 In addition the directorate is developing a relationship with a conference organiser to support the delivery of events elsewhere in London and in the regions.

Brian Rock
Director of Education and Training/Dean of Postgraduate Studies
14th January 2016

Board of Directors: January 2016

Item: 14

Title: DET ICT Student Information Management System (SIMS) Full Business Case

Summary:

The current legacy system is not meeting the current operational requirements and is not suitable for the strategic objectives and growth plans for the Education & Training Service Line.

This document sets out the Full Business Case (FBC) for the Tavistock and Portman NHS Foundation Trust's justification and commitment for funds and resources for the recommended bidder through the final stage of the tendering process

A suitable and modern Student Information Management System will facilitate streamlined business processes within DET, improve reporting for key stakeholders and support the programme of expansion of student numbers within Training and Education at the Trust.

SIMS is one part of an extensive transformation programme in DET, along with organisational restructuring, overhaul of working procedures and development of an outward facing commercial development unit.

The difference aspects of the programme are interdependent and come together to meet the ambitious targets of DET.

The Board are asked to endorse the recommendation of the team.

This report has been reviewed by the following Committees:

- Training and Education Programme Management Board, 11 January 2016

- Executive Management Team Endorsement, 19 January 2016

For : Approval

From : Brian Rock, Director of Education and Training

E&T ICT FBC

DET ICT Student Information Management System
Full Business Case

1.   Introduction

1.1   The Trust's current system for the management of student records consists of a core system to hold the data and a number of bespoke platforms to manage particular functions, for example student applications and assessment. The core system is 17 years old. Institutional knowledge of the bespoke systems has been lost through staff turnover in the area of systems support and does not meet reporting and operating requirements.

1.2   The acquisition of a new SIMS will allow DET to harmonise all these disparate functions and support the achievement of DET's ambitious student recruitment target aspirations. As well as staff within DET, we expect Faculty staff to make use of the system to improve efficiencies, flows of data and use of reporting.

1.3   The SIMS would be a managed service eliminating the need to own, maintain and refresh hardware thus reducing risk of failure.

1.4   The Board of Directors approved the Outline Business Case for this project in November 2014.

1.5   The Full Business Case is now presented for endorsement by the Board of Directors with a recommendation of the solution supplier to select and award over the 5 year period. This short paper introduces it. The DET team have sought learning and experience from the recently delivered IDCR 2015 CareNotes project, particularly in light of recent events where apparent ambiguity in the understanding of the supplier's commitments have come to light. This knowledge will inform this project and mitigations will be sought during the contract stage to support progression and ensure approach follows through a desired output.

1.6   It will be seen in the summary below that the proposal recommends a supplier that has obtained scores that have placed them within the position of winning the mini-competition overseen and supported by the London Procurement Partnership (LPP).

1.7   The recommendation submitted to the Management Team and Board of Directors will allow:

- Improved value for money through commercial competitiveness through a formal procurement process; by having suppliers to choose from at the mini-competition stage.

- Greater innovation and better solution provision based specifically around the Trust's requirements.

- Improved appropriateness to the business needs and requirements.

- Reduced IT infrastructure.

1.8   This proposal is supported by NHS London Procurement Partnership.

2.   Summary of the Procurement and Selection Process

2.1   Supported by colleagues from LPP, the Trust utilised a framework of preferred suppliers offered by Crown Commercial Service (CCS). Through this framework, one procurement Lot (Lot 1 - Application) was selected. The Trust aims to procure system/services from Lot 1 and procurement is through a mini competition process.

2.2   The first invitation to tender in February 2015 resulted in no bids within the three-week window so this was then extended to May 2015. Two suppliers entered bids. The recommendation was to go for the lowest cost solution. While functionality for this lower cost solution was scored lower than the other supplier, it was adequate for the Trust's needs but the strict rules of procurement wouldn't allow an award on this basis.

2.3   Following advice from LPP and referring to Capsticks, an independent legal firm used for the procurement of CareNotes, a second invitation to tender with an explicit affordability cap of £750,000 was issued in October 2015. This cap does not include VAT but the Trust is actively exploring ways in which VAT paid can be claimed back. There is a high degree of confidence that this will be achieved, which will also have benefits for the CareNotes project.

2.4   The same two suppliers from the first invitation submitted bids. No additional suppliers entered bids. The first invitation served to help us find an accurate market value for what we were trying to achieve resulting in the realistic cap. A revised weighting table saw greater emphasis placed on the financial element of the bids.

2.5   The evaluation of all bids was undertaken by staff from DET and experience from the wider Trust, together with LPP. Our staff took part in evaluation and scoring of the bids and demonstrations for Lot 1.

2.6   We have conducted a "mini-competition" under the framework agreement for Lot 1, resulting in the recommendation put forward in this paper. An invitation to tenders was issued on 28th October 2015 and closed 18th November 2015. The two suppliers that submitted tenders were Tribal (platform solution **SITS**) and Ellucian (platform solution **Quercus**).

2.7   The written bids were evaluated by 18 DET, IDCR (CareNotes delivery) and IM&T staff, and their ratings account for **30%** of the overall scoring of each bid. In the first invitation, this was 40% of the scores. Since the financial considerations have become more important and our knowledge of available systems is dramatically improved, this was amended to 30%.

2.8   Both suppliers gave demonstrations of their software, focusing on specific tasks that form part of a typical student journey designed by DET. These demonstrations were attended and evaluated by 15 DET,

IDCR (CareNotes delivery) and IM&T staff. Their ratings account for another **20%** of the overall scoring of each bid.

2.9 Site visits were carried out in August 2015 by a team of five DET staff as part of the first tender. Following advice from LPP, these site visits were retrospectively scored and account for **10%** of the overall scoring.

2.10 An affordability cap of £750,000 was placed on the tender. Both suppliers submitted financial costings within this cap so were eligible to continue in the evaluation process. In order to ensure a like-for-like comparison in evaluating the pricing of the two bids, we asked a significant number of clarification questions over details of supplementary charges and what was included. The financial element of the bid accounts for the remaining **40%** of the overall scoring which is higher than the first invitation, when it was 30%.

2.11 This scoring is summarised below and in section 3 of the FBC paper. The comments quoted in Appendix D of the FBC give a further flavour of staff views on the products offered.

3. Evaluation and Costs

3.1 In the evaluation of written bids against the requirements, Tribal (SITS) scored significantly higher.

3.2 In the system demonstrations, Tribal scored higher.

3.3 The site visits were retrospectively scored and both suppliers received the maximum of 10%.

3.4 In the financial evaluation, Ellucian scored marginally higher. The price quoted for Ellucian, £730,500[1] over 5 years, is slightly less than for Tribal, which was just over £745,000. The details are in section 4 of the FBC.

3.5 The scoring is summarised in the table below.

Assessment Stage	Weighting and Total	Ellucian (Quercus)	Tribal (SITS)
Financial scores	40	40.00	38.01
Written bid scores	30	20.47	26.67
Demonstration / site visit scores	30	24.66	27.33
Overall assessment scores	**100**	**85.13**	**92.01**

3.6 In addition to the formal mini-competition process over the two invitations the team undertook due diligence activities across to the two solutions and supplier bidders. These activities included platform demonstrations, site visits and supplier interviews providing a rounded whole view of the solutions and providers. These subsequent - scored and unscored - elements of the evaluation process showed either platform could provide the necessary

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[1] The Ellucian bid includes 25 days assigned to data migration.

functionality that DET requires in a new SIMS to align with current operational requirements and strategic objectives.

3.7 The capital cost is expected to be £511,761. This includes £360,210 of the supplier's quoted price, plus an estimated £151,551 of Trust staff costs for the implementation team from March 2016. Details are given in section 4 of the FBC.

3.8 The opportunity exists to incorporate student debt management at the granular level as part of this procurement. This is outlined in section 4.2.2 of the FBC.

3.9 Revenue expenditure is expected to be just under £200,000 per year with an average of £193,131over 5 years. This includes the depreciation and dividend on the capital spend; plus the annual payment to the supplier (also in the quoted price of £745k); the cost of hosting is incorporated in the proposal. Details are in section 4 of the FBC.

4. Implementation

4.1 The implementation of a new student information management system will underpin fundamental changes in the business processes within DET. It will lay the necessary foundation for competitiveness and growth and support the directorate's ambitions around increased student numbers, a more diversified training portfolio and greater geographic reach.

4.2 The approach will not focus on implementing the software alone, it is also on creating solutions and delivering a return on investment for DET aligned to new processes and ways of working. Implementation of a new SIMS aligns with and underpins the other two areas of the DET Transformation Programme, both of which are underway under the management of the Interim Operations Development Lead:

- The restructure of the Directorate of Education and Training to be consistent with the new portfolio structure and maximise efficiency savings.

- A greater emphasis on financial control, productivity targets and service agreements with Faculty and the wider Trust that further support the directorate's professionalism in supporting training and education.

4.3 We expect our supplier to bring to bear subject matter expertise and experience in the education sector and in student experience management. The awarded supplier must understand DET's strategic context and key success criteria presented in the full business case to ensure value is delivered with the collaborative implementation. The supplier and DET SIMS project team will align to a tailored Prince2 project management methodology to suit the needs of the higher education sector and complex nature of student management and administration system implementation.

4.4 Many staff are impatient to be using modern systems, as is common in other institutions; to support informed decision making, reporting and ensuring the business is managed in a responsive timely manner. There will also be pressure for variability in the way the system is configured; and requests for data from some teams and user groups are managed confidently as part of the DET Transformation Programme. Managing these proposals and making clear decisions on them will be a key function of the implementation team and the project board.

4.5 Involvement of key staff has been a key part of the project from an early stage. In the selection process, a small group were responsible for developing the student journey, before they and others took part in evaluating the bids against these requirements as described above.

4.6 Key members of the staff group are proposed as the core implementation team, which is set out in section 6.2 of the FBC, together with the project governance structure.

4.7 A draft project plan is set out in section 6.7 of the FBC. This is subject to review with the chosen supplier. The target implementation date is also to be confirmed with the supplier.

4.8 No contingency amount has been included in the proposal based on:

- The number of consultancy days included shall be carefully managed to reduce total costs whenever possible.

- The winning bid allows flexible consumption of consultancy days across different skill sets as required. There are no contractual obligations placed on the Trust to consume a minimum level of consultancy days.

- Trust resources consumed in the delivery of the project are shared across the Transformation Programme and there are many shared activities benefitting all parts of the programme therefore there are no additional project resources to charge to the SIMS.

4.9 The Board of Directors is requested to endorse the selection of SITS, provided by Tribal.

4.10 Apart from achieving the highest score and thereby winning this transparent procurement process, there are considerable softer benefits of implementing the SITS platform:

- It has better functionality than the other supplier (reflected in the scoring of functional requirements)

- It falls within the affordability arrangements

- It is a modular system that allows expansion as DET's needs grow.

- The approach of the Tribal bid team has been knowledgeable and professional, which gives us confidence that we can implement the system on time and within budget.

4.11   When negotiation with Tribal is complete, the Board of Directors will be asked to approve the contract before it is signed. If specific issues arise in today's discussion that cannot be fully answered, these will be addressed at that time.

Brian Rock,

Director of Education & Training / Dean of Postgraduate Studies

January 2016

The Tavistock and Portman **NHS**

NHS Foundation Trust

ICT SIMS 2016

Student Information Management System for 2016
Full Business Case

Full Business Case
V1.2
January 2016

Document Information

Work Area:	Tavistock & Portman NHS Foundation Trust				
Title:	Full Business Case				
Ref/Type:	FBC				
Purpose:	To document the justification for the Trust to commit funds and accept the preferred bidder and resources to DET SIMS Project 2016				
Version:	1.2	Date of Issue:	19 January 2016	Status:	Awaiting Approval

Key personnel

Authors:	Simon Kear / Ricky Kothari	Contributors:	John Martin / Carl Doherty / Brian Rock
Reviewer(s):	Brian Rock		

Document History

Version	Production Date	Version Description	Initials
V0.1	21/12/15	First draft structure	SK
V0.2	7/1/15	Inclusion of financial case	SK
V0.3	8/1/15	Project Management section	SK
V0.4	18/1/15	Review comments incorporated project timeline and finance table	SK/JM/RK
V1.0	18/1/15	Final version for Trust Board	SK/RK
V1.1	19/1/15	Update version following Executive MT endorsement	RK/SK
V1.2	19/1/15	Formatting adjustments	RK

Approvals

Version	Name	Title	Approval Date
0.4	TEPMB	Training and Education Programme Management Board approval	11/01/16
1.0	MT prior to board TPFT Board	For approval by MT for submission to Trust Board of Directors following updates	19/01/16
1.2	TPFT Board	For approval by Trust Board of Directors	26/01/16

Contents

Education & Training Report

1. Introduction

1.1 Context and Background

1.1.1 This is the Full Business Case (FBC) to present the preferred supplier of a Student Information Management System (SIMS) to be implemented in the Directorate of Education and Training (DET) before the start of academic year 2016/17.

1.1.2 This FBC is the first presented to the Board on the procurement of a SIMS and includes the evaluation and recommendation drawn from the second invitation to tender. The first invitation to tender in February 2015 initially attracted no bidders and was extended. Following a dedicated supplier engagement effort, two bids for the contract were eventually achieved. The recommendation presented to the Board in October 2015 was to go for the lowest cost solution. While functionality for this solution was scored lower than the other supplier, it was adequate for the Trust's needs and any differences were outweighed by the significant difference in price but the strict rules of public sector procurement wouldn't allow an award on this basis.

1.1.3 Following advice from NHS London Procurement Partnership (LPP) and referring to Capsticks, an independent legal firm used for the procurement of CareNotes, a second invitation to tender with an explicit affordability cap of £750,000 was issued in October 2015.

1.1.4 The same two suppliers from the first invitation submitted bids. No additional suppliers entered bids. The first invitation served to help us find an accurate market value for what we were trying to achieve resulting in the realistic cap. A revised weighting table saw greater emphasis placed on the financial element of the bids.

1.1.5 The Trust utilised a framework of preferred suppliers offered by Crown Commercial Service (CCS). Through this framework, one procurement Lot was selected. The Trust aims to procure system/services from Lot 1 and procurement is through a mini competition process.

- Lot 1 – Application selection

1.1.6 This document contains the information that is necessary for the Board of Directors' approval for investment in student data management. Getting the right student record system for a Higher Education Provider such as the Trust is critical – it has to have the strength and flexibility to cope with the ambitious targets for student recruitment and provide reporting capability to support this expansion.

1.1.7 The Outline Business Case (OBC) signed off on 14th November 2014 contains the Trust's Organisational context. The FBC is building upon the OBC with a recommended preferred application supplier and presentation of the Finance case for Lot 1.

1.2 **Approach to Mini Competition**

1.2.1 The mini competition was managed under the guidance of the NHS London Procurement Partnership. Suppliers were asked to bid from the CSS – Corporate Software Solutions Framework. Suppliers were invited to bid for the contract in a process that began in February 2015 and concluded in May 2015. A second invitation to tender was launched in October 2015 and concluded in November 2015 (see 1.1.2-1.1.3 above), resulting in two bids from whom a preferred supplier is recommended here. The stringent evaluation included a mini-competition assessing each supplier on: their ability to meet the specified brief which is particular to the Trust's needs; a comprehensive demonstration to the staff following a student journey; and a financial evaluation.

Education & Training Report

2.   Strategic Case

2.1   The Case for Change

2.1.1   In addition to the Trust's Board's commitment to the ICT SIMS 2016 Project, which has been endorsed by the management committee, the project is expected to allow the Trust to meet its targets and drivers at both national and local level.

2.1.2   DET attempts to improve its position in the marketplace, characterised by regulatory changes and greater accountability from Health Education England (HEE) and the Quality Assurance Agency (QAA). The achievement of "excellence and continuous improvement in the quality of education and training of the health workforce" (DH, 2012) requires re-design of the workflow and an investment in the technology to support the implementation of the outcomes of the redesign.

2.1.3   The current student record system utilised by DET is fragmented, which limits the expansion of functionality necessary to remain competitive in the higher education market and to meet the new teaching and learning strategy and the Trust's five year ambitions and two year strategic objectives. The current various applications are not fully integrated and require manual processing, reconciliation and manipulation activities. In addition, current reporting functionality is limited and not user friendly. The figures overleaf present the complexity of the current technical landscape and environments, and the situation offered by the solution: 'where we are' and 'where we want to be'.
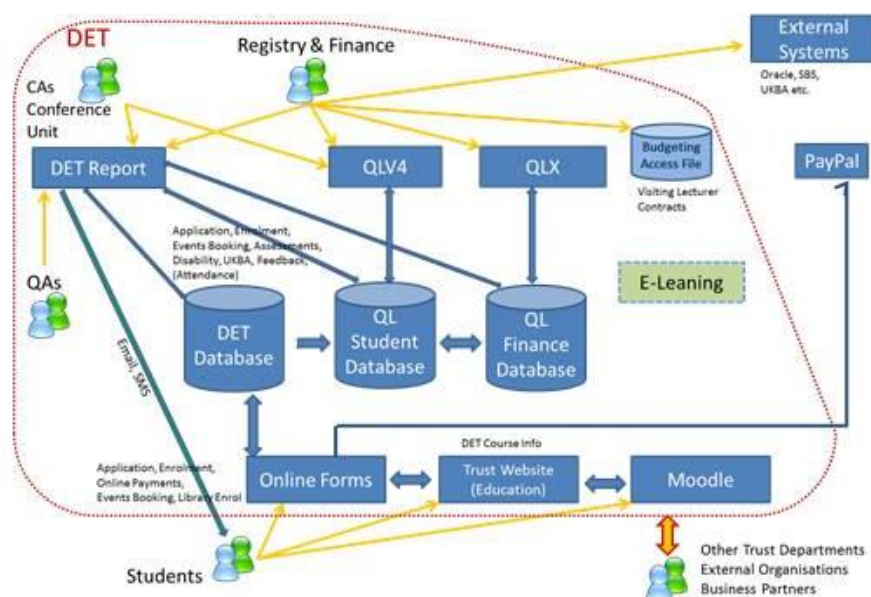

Figure A Where we are
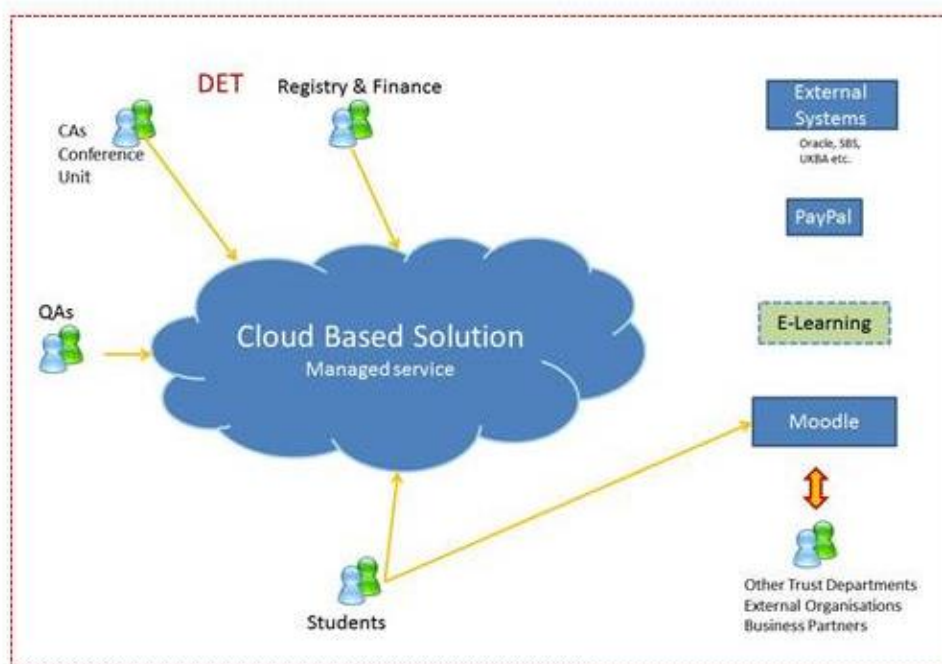
Figure B Where we want to be

2.1.4 Some of the key points and drivers for change are to:

- Create a robust and centralised student data management system to replace current disparate systems

- Assess and restructure current business processes within DET around student recruitment and management to reflect the student journey

- Work with HEE to support Framework 15 and the NHS workforce

- Future-proof and align DET and the Trust with other Higher Education Institutions and Providers

- Improve knock-on efficiencies for other units within the Trust such as Marketing and Communications, and Finance

- Produce high-level reports for key external stakeholders such as individual sponsors, LETBs, Commissioners, the Higher Education Funding Council for England (HEFCE) and HEE

- Offer the student a Web-based portal to manage their learning relationship with the Trust

- Unlock the potential of data for future planning and course development

2.1.5 The Strategic Case demonstrates that SIMS will play an important part in delivering NHS training, business and IT strategy, supported by clear and measurable aims and objectives. The aspiration we are working to is a DET-wide culture in which using a single digital system or platform is a routine and desired part of everyone's

working life with the clear benefits of enhancing the student experience and improved visibility of outcomes.

The Trust is looking to help staff to do their jobs; to improve the quality of service; and also to make savings through, for example, increased efficiency of business processes.

The Trust will be in a better position to understand how investing in, then effectively using, information technology can achieve better student outcomes, reduce bureaucracy, improve student experience of training at the Trust and deliver efficiencies. In addition systems will enable improved and informed decision making

2.1.6   The business case justifies the preferred bidder route to future system selection. Our aim is for the future system to be deployed across all services within DET and the Trust, to use as much of the student data management functionality as possible, with administrative and faculty staff entering as much data as possible where practicable. This will help us overcome some of the challenges the Trust faces as a training provider both internally and externally.

2.1.7   It is expected that all training and education services and faculty will use the SIMS platform.

2.2   Local Context

2.2.1   Trust Objectives - The provision of a new SIMS is to support a number of Trust objectives around training and education outlined in the two year plan.

Trust Objective	Consequences of SIMS for Faculty and Administration teams Deployment
❶ **Increased student numbers** The target for new students is 900 by the start of AY 2017/18	SIMS will lead to more student information being collected and reported. Reporting functionality will improve the ability of the Student Recruitment unit to understand and exploit our key demographic markets. A single SIMS will map coherently onto the student journey, allowing us to offer our learners follow-on courses.
❷ **Diversity of portfolio** Training beyond our traditional workforce by offering an increased diversity of long and short courses (CPD)	SIMS will enable a single student record to have multiple instances. For example, a student on a long course might also take several CPDs during this time. Our current systems lack this capability. In line with Framework 15, training offered for NHS bands 1-4 will be improved through curriculum design in SIMS. SIMS will support the move towards modularisation of the Trust's portfolio. The majority of Trust CPD courses are not managed through the current records systems, resulting in significant lost opportunities for further recruitment.

Trust Objective	Consequences of SIMS for Faculty and Administration teams Deployment
❸ **Flexibility of learning opportunities** Ensuring our training has a national reach by ensuring the target of 50% of learners outside London and the South East by AY 2017/18 is reached	Our footprint outside London in existing and new Associate Centres and hubs will be increased through the use of a single student data management system. Faculty throughout the organisation will have access to key demographic data to enable targeted recruitment.

2.3 Data migration

2.3.1 Valuable lessons have been learned about the importance of this aspect of system implementation from the IDCR (CareNotes) project.

2.3.2 A DET Student Data Group was established in November 2015 to begin the preparation and cleansing of existing data – currently residing in a number of repositories, including Excel worksheets held by individuals – prior to the data migration workshops held with the appointed suppliers.

2.3.3 The group, which meets weekly, is made up of representatives from key units in DET, including Registry, Finance, Recruitment and Course Administration.

2.3.4 The work of the group is necessary outside this procurement as it's output is fundamental to the transformation programme. The process maps developed as part of the DET restructure are in effect workflow diagrams for the new data standard operation procedures.

2.4 Main Benefits

2.4.1 Implementation of a new SIMS aligns with and underpins the other two areas of the DET Transformation Programme, both of which are underway under the management of the Interim Operations Development Lead:

- The restructure of the Directorate of Education and Training to be consistent with the new portfolio structure and maximise efficiency savings.

- A greater emphasis on financial control, productivity targets and service agreements with Faculty and the wider Trust that further support the directorate's professionalism in supporting training and education.

SIMS is one part of an extensive transformation programme in DET, along with organisational restructuring, overhaul of working procedures and development of an outward facing commercial development unit.

The different aspects of the programme are interdependent and come together to meet the ambitious targets of DET.

2.4.2 Main Benefits Table

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

3. Options Appraisal Process

3.1 Evaluation

3.1.1　Supported by colleagues from LPP, the Trust utilised a framework of preferred suppliers offered by Crown Commercial Service (CCS). Through this framework, one procurement Lot (Lot 1 - Application) was selected. The Trust aims to procure system/services from Lot 1 and procurement is through a mini competition process.

3.1.2　The first invitation to tender in February 2015 resulted in no bids within the three-week window so this was extended to May 2015. Two suppliers entered bids. The recommendation was to go for the lowest cost solution. While functionality for this lower cost solution was scored lower than the other supplier, it was adequate for the Trust's needs but the strict rules of procurement wouldn't allow an award on this basis.

3.1.3　Following advice from LPP and referring to Capsticks, an independent legal firm used for the procurement of CareNotes, a second invitation to tender with an explicit affordability cap of £750,000 was issued in October 2015. This cap does not include VAT but the Trust is actively exploring ways in which VAT paid can be claimed back.

3.1.4　The second invitation to tender was issued on 28th October 2015 and closed 18th November 2015. Both suppliers submitted financial costings within this cap so were eligible to continue in the evaluation process. The two suppliers that submitted tenders were Tribal (platform solution SITS) and Ellucian (platform solution Quercus). The same two suppliers from the first invitation submitted bids. No additional suppliers entered bids. The first invitation served to help us find an accurate market value for what we were trying to achieve resulting in the realistic cap. A revised weighting table saw greater emphasis placed on the financial element of the bids.

3.1.5　The written bids for this second invitation were evaluated by 18 DET, IDCR (CareNotes delivery) and IM&T staff, and their ratings account for **30%** of the overall scoring of each bid.

3.1.6　Both suppliers gave demonstrations of their software, focusing on specific tasks that form part of a typical student journey designed by DET. These demonstrations were attended and evaluated by 15 DET, IDCR (CareNotes delivery) and IM&T staff. Their ratings account for another **20%** of the overall scoring of each bid.

3.1.7　Site visits were carried out in August 2015 by a team of five DET staff as part of the first tender. Following advice from LPP, these site visits were retrospectively scored and account for **10%** of the overall scoring.

3.1.8　An affordability cap of £750,000 was placed on the tender. Both suppliers submitted financial costings within this cap so were eligible to continue in the evaluation process. In order to ensure a like-for-like comparison in evaluating the

pricing of the two bids, we asked a significant number of clarification questions over details of supplementary charges and what was included. The financial element of the bid accounts for the remaining **40%** of the overall scoring which is higher than the first round, when it was 30%.

3.1.9 The summary of scores is as follows:

Assessment Stage		Weighting and Total	Ellucian	Tribal
Financial evaluation stage (Pricing on submissions)	Student Information Management System	40	40.00	38.01
Total financial scores		**40**	**40.00**	**38.01**
Written supplier responses to mini-competition as above	Functional Requirement	15	9.00	13.74
	Non Functional Requirement	10	7.00	8.00
	Application compliance	5	4.47	4.93
Total written responses scores		**30**	**20.47**	**26.67**
Supplier product demonstrations and reference site visits, as required	Product Demonstration	20	14.66	17.33
	Site visits	10	10.00	10.00
Total Demonstration scores		**30**	**24.66**	**27.33**
Overall assessment Scores		**100**	**85.13**	**92.01**

3.1.10 The ICT SIMS 2016 Project Team has worked closely with all staff involved. The recommendation submitted to the Executive Team will allow:

- Improved value for money through commercial competitiveness; by having more suppliers to choose from at the mini-competition stage.

- Greater innovation and better solution provision based specifically around the Trusts' requirements.

- Improved appropriateness to the business needs and requirements.

3.2 Due Diligence

3.2.1 Due diligence was garnered through site visits and supplier interviews for both systems although the latter were not scored. A small team representing DET stakeholders visited two institutions of comparable size to the Trust that were using one of the two platforms: the Institute for Contemporary Music Performance (Ellucian) and Regents University London (Tribal). This DET team was able to see the Ellucian platform in action through a demonstration by the superuser at the institution. This illustrated similar functionality requirements to our own. The Tribal site visit consisted of a meeting with the university's head of Management Information Systems but no demonstration.

3.2.2 A senior Trust team led by the Director of IM&T and supported by the DET Programme Director took part in the supplier interviews. These interviews allowed

the Trust to finesse the financial bids and drill down on the discovery and implementation phases, leading to the recommendation of this full business case. Notes from the site visits and the supplier interviews are included in Appendix B.

3.3 Finance Evaluation

3.4.1 The Finance evaluation was conducted following numerous clarification questions with all suppliers with a transparent auditable approach; once responses were received the Trust could conduct a fair analysis and appraisal. The cheapest supplier received the full 40% of the scoring that was available for this Stage.

3.4.2 These first two stages of the mini-competition during the evaluations provided comments and insightful input which have guided the moderation activities. The next stage of evaluation for these supplier bids was the financial evaluation, which took place in early January 2016 following clarifications derived through the supplier interviews.

3.4.3 The costs are based on Full Time Equivalents (FTEs). A significant problem with the current complex system (see section 2) is gathering accurate data. At present, we estimate that we have 900 FTEs. This is made up of approximately 1300 students on long courses which equates to 700 FTEs and approximately 2000 students on short courses/CPD. Each short course student has been assigned a 0.1 FTE, giving a total of 200 FTEs. This is an in-house measure. Costs for 1150 FTEs were asked for to ensure capacity to absorb increased student numbers in line with the ambitions of the Trust.

3.4.4 Hosting costs for Ellucian are included in the cost of support and maintenance (£437,500). Hosting costs for Tribal are itemised as 'Other cost' (£248,761). The Ellucian figure of £7,500 for 'Other cost' refers to 15 days of project coordination.

No.	Item	1150 Students	
		TRIBAL	ELLUCIAN
	SIMS Application Costing		
1	Total cost for one-off implementation services	£185,760	£189,900
2	Project Management	£0	£50,895
3	Licence fee	£137,190	£0
4	Support and maintenance etc. (per annum)	£144,222	£437,500
5	Training and training materials costs	£29,160	£22,500
6	Upgrade costs (Non-bespoke changes)	£0	£0
7	Change management/bespoke	£0	£0
8	Data Migration costs	£0	£22,500
9	Any other costs (preventative maintenance)	£0	£0
10	Integration	£0	£0
	Report writing	£0	£0
	Other cost (if any)	£248,761	£7,500
		£745,093	**£730,795**

4. Financial Case

4.1 Initial Bids

4.1.1 As stated in Section 3, the Trust received two applications when the offer to tender was made. The bids were all challenged to ensure that each element of the tender had been covered and that the bids were comparable. The Financial Case for the tender process accounts for 40% of the scoring and we chose to give the lowest bid the maximum marks and the other bids would be scored as a percentage of that bid.

4.1.2 Ellucian had the lowest bid for Lot 1 and received the full 40%. Tribal was scored as a percentage of that bid.

4.2 Capital Expenditure

4.2.1 The capital funding required for the project will consist of the relevant elements of costs from the preferred supplier, in addition to the anticipated implementation costs of the Trust. A detailed breakdown is below. These costs will be depreciated over five years from implementation in 2016.

4.2.2 During the evaluation process and as part of the supplier interview, it became clear that further functionality around student debt management was required. The Ellucian (Quercus) platform did not offer this functionality. Tribal (SITS) offers the Student Account Management (SAM) module at additional cost. Tribal did not include SAM in the bid in order to remain below the affordability cap.

Capital Requirements	2016/17		2017/18		Total	
Supplier						
Licence Fee	£	166,350				
Implementation services	£	185,760				
SAM Licence	£	8,100				
DET						
Project Manager band 8 (15 Months)	£	59,141	£	17,394		
Project Officer band 5 (15 months)	£	36,013	£	9,003		
Bank staff (Operation backfill)	£	30,000				
totals	**£**	**485,364**	**£**	**26,398**	**£**	**511,761**

4.3 Revenue Expenditure

4.3.1 The revenue funding required for the project will consist of the remainder of the costs from the preferred supplier's product; the anticipated on-going costs of the Trust; depreciation of capital and dividend payment; and the likely cost of the tender. A detailed breakdown is below.

Revenue Requirements	2016/17	2017/18	2018/19	2019/20	2020/21
Support & Maintenance	£ 30,464	£ 30,464	£ 30,464	£ 30,464	£ 30,464
Hosting	£ 49,752	£ 49,752	£ 49,752	£ 49,752	£ 49,752
Depreciation	£ 102,352	£ 102,352	£ 102,352	£ 102,352	£ 102,352
PDC	£ 16,988	£ 14,329	£ 10,747	£ 7,165	£ 3,582
Totals	£ 199,557	£ 196,898	£ 193,316	£ 189,734	£ 186,151

4.3.2 The revenue cost of the DET SIMS project is equivalent to 1.2% of the proposed 2015/16 budget for the whole Trust.

4.3.3 There may be some savings in DET administration staff costs as a result of streamlined business process across the Trust as we move to staff populating the data directly onto the system but this has yet to be quantified.

4.4 Budget Position

4.4.1 The 2015/16 budget includes £20,000 for systems maintenance which will need to be maintained throughout 2016/17 and 2 quarters of 2017/18 since the legacy systems are expected to be maintained for 18 months from April 2016.

4.4.2 Ultimately the current software and hardware on which it runs will be decommissioned following the full migration and/or archive or destruction of legacy data. The decision on which data will be treated and handled will be made during the delivery of the new SIMS solution with the supplier support.

4.4.3 The first 2016/17 budget proposal included a further £50,000 for SIMS however, as can be seen above, the revenue part of the project, based on the move from Trust owned and maintained enterprise applications to an integrated SAAS solution, is higher than initially forecast.

4.4.4 It is the Trust's policy to centrally account for depreciation and PDC at an organisation level and not apply these to the operational budgets. Therefore there are two budget considerations:

- DET budget requires an additional £30,216 per annum to cover the full hosting and maintenance charges from the supplier

- Trust depreciation and PDC lines need to include £119,340 in 2016/17 and sums thereafter as shown in table 4.3.1 above.

4.5   **Recommendations**

The scores achieved by the suppliers and the further clarification achieved through the site visits and supplier interviews were robust enough to conclude that both suppliers met the requirements detailed within the Tavistock and Portman Foundation Trust's Statement of Requirements document.

4.5.1   Based on this, the ICT SIMS 2016 Project Board therefore recommends that **Tribal (SITS) is selected and awarded the Contract.**

- This action will ensure the following: Tavistock and Portman NHS Foundation Trust's student information management requirements will be achieved;

- Improved value for money through commercial competitiveness; by having more suppliers to choose from at the mini-competition stage.

- Greater innovation and better solution provision focused and based on Tavistock and Portman NHS Foundation Trust business needs and requirements.

4.5.2   SITS is one of the world's leading student- and course-management solutions for further (Scotland) and higher education. It is currently used by 60% of the UK HE market and a number of institutions around the world including the University of Sydney. Over the years, SITS has evolved to become the best solution on the market ahead of the competition in terms of meeting statutory reporting requirements and is used by 12 of the 24 UK Russell Group of Universities including the University of Oxford.

4.5.3   Henry Pitman, a member of the family that invented the famous shorthand system, founded Tribal. From its beginnings in 1999, Tribal grew rapidly and was listed on the London Stock Exchange in 2002. It currently employs 1,300 people. Tribal works with a wide range of organisations, including schools, colleges and universities, prisons and social services, government agencies and large and small employers.

Education & Training Report

5.   Commercial Case

5.1.1   The purpose of the Commercial Case is to demonstrate that the procurement has been undertaken according to agreed standards and that the contract is appropriate. The project engaged an independent Procurement Specialist from the London Procurement Partnership to ensure the mini-competition due process has been followed according to the formal Framework guidelines. The project team utilised the LPP's DELTA system to:

- Commence the Mini-competition for Lot 1

- Issuing the Invitation to Tender (ITT) documentation - Statement of Requirements, Student Journey, further details, templates to populate

- Communication which each supplier in a transparent way

- Clarification questions posted and tracked

- Audit trail of queries, questions and responses received

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

5.2   Legal Framework Used

5.2.1   A Framework Agreement is an arrangement whereby one or more suppliers can provide a 'Client' such as The Tavistock and Portman FT with a pre-agreed range of services and or products, which have had their terms and conditions, plus the maximum agreed prices permitted, pre-agreed for the duration of the contract.

5.2.2   The final pricing (actual) is then agreed by running the mini-competition event between the nominated Framework suppliers, which will focus more clearly the pricing against those more specific to The Tavistock and Portman FT requirements. This has also covered other selection criteria and values that are important to The Tavistock and Portman FT services, such as; different system features and system ability, mobile working, assurance, up-time serviceability levels and reporting.

5.2.3   It should be noted that the award criteria has remained consistent with those employed at the time the Framework arrangements were put in place.

5.3   Supplier Challenge(s)

5.3.1   The procurement programme has been undertaken in a robust manner and all of the processes and methodology utilised throughout have been open, fair, transparent and as equally important, consistent. This will ensure that in the unlikely event of a supplier challenge going forward, that every precaution (to include a full audit trial), has been taken to safeguard the Trust.

5.4   **Contract Award**

5.4.1   The Tavistock and Portman FT have used the Framework Agreement when establishing their specific IT requirements; to then re-open competition by way of a mini-competition event.

5.4.2   The Tavistock and Portman FT have conducted the mini-competitions in accordance with regulation 19 (8) of The Public Contracts Regulations Act of 2006.

Education & Training Report

6.   Management Case

6.1   Project Management Introduction

The strategic case describes the arrangements for managing the project and realising the benefits as part of the DET Transformation Programme. This section describes how the Trust intends to manage the ICT project to a successful conclusion.

6.2   Project Organisation

A small project team DET ICT "SMS Project" is in place, which includes the Interim Operations Development Lead, project manager, Head of TEL, Informatics as project lead, and project support. The team has been engaging with Trust staff at levels to gather the Statement of Requirements (SoR) and processes for the Trust. The workshops have been successful with excellent faculty and admin engagement, and have been very helpful in defining the tender documentation.
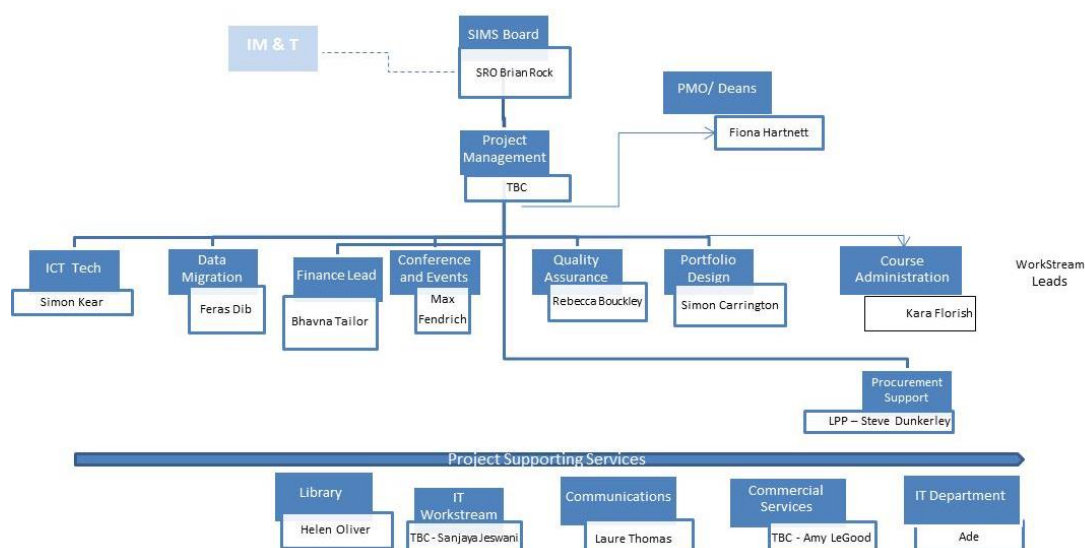
Project delivery structure with named individuals from December 2015 to be reviewed in March 2016. The structure is designed to have a flexible staffing group, time will be released to support the delivery of this project. With similar projects undertaken in the workstream team utilisation of resources will encounter peaks and intense periods to where more thinking and less input required from design, delivery through to testing and live running covering areas of the project lifecycle.

The project team is supported by Central Unit service teams e.g. IM&T, clinical governance, information governance including risk assurance.

The Outline Business Case emphasises the importance of deploying a focused, mandated team to rapidly deliver positive change to the project – using skilled resource for a short focused period and to complete project tasks against the project plan. This will enable the

move rapidly to the ways of working required and the level of information needed from systems to emphasise and realise benefits.

6.2.1 Supplier's Project Team collaboration

Tribal's response has suggested the level of resources required from the Trust which aligns with the team configuration for the recently delivered Trust project, IDCR. Typically, they would expect us to provide a full time project manager with a part time project administrator along with staff expert in the various functional areas seconded (part time) to make up a project team. This team can change as the implementation proceeds as functionality becomes live in stages during the project and should be supported with business analyst expertise.

Tribal can provide additional resources and/or services to support the project however, it has been envisaged the Trust project Team to undertake as much of the system work as possible to facilitate quick and effective knowledge transfer. We have identified our technical resource to manage the database and software.

A project team member would transfer into the 'application' team who can help with system administration and configuration. We have identified work stream leads who will develop own plans to obtain input from their team members e.g. business analysis in workshops and working on process definition and design. The work stream leads would identify training resource from their relevant areas that will be helpful to the project for the delivery of training and deployment stage.

Education & Training Report
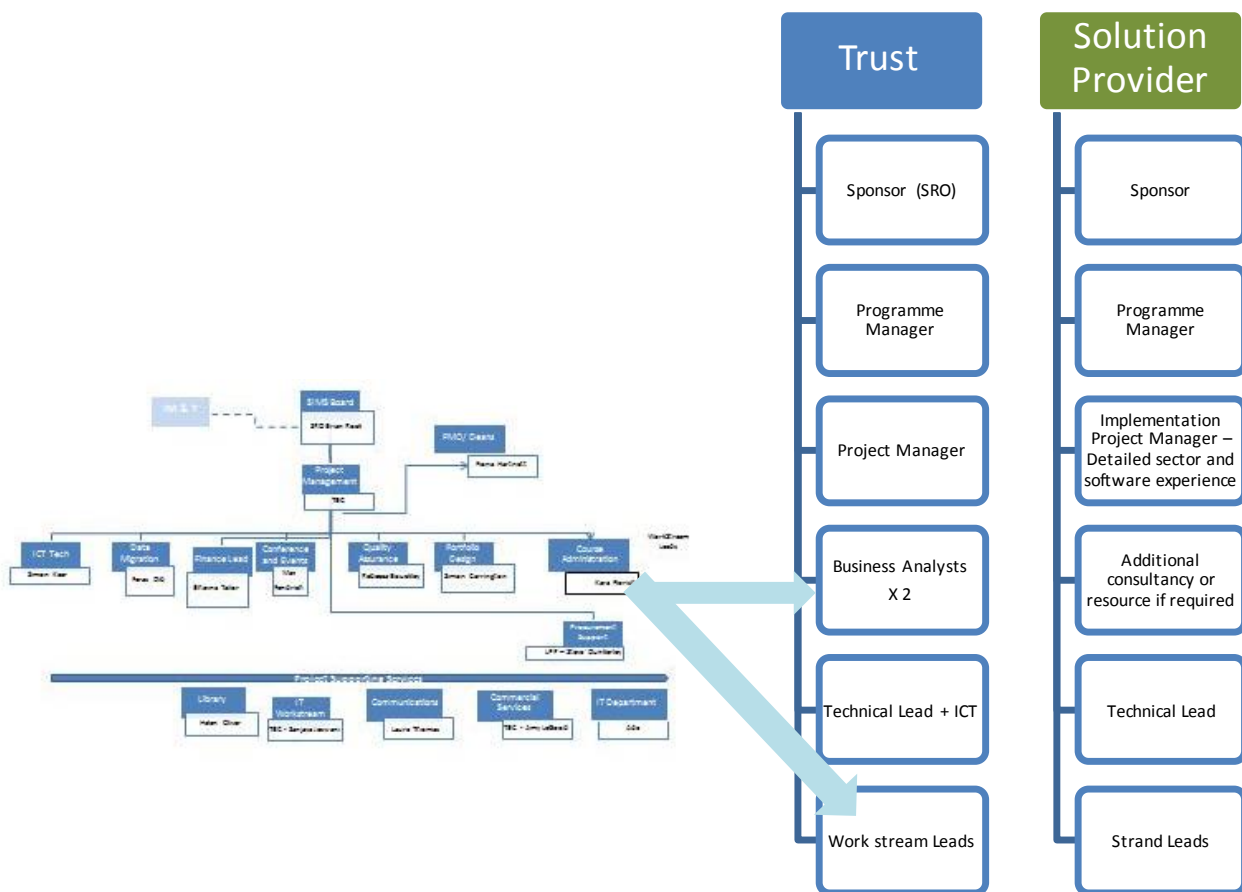
6.2.2   Management Structure

The structure of the project organisation illustrates how the project management team brings together the different interests to carry out the various project activities. In summary, the project organisation is structured as follows:

Role	Trust	DET ICT SIMS Supplier
Sponsor Takes the investment decision.	Trust Board of Directors	-
Direction Provides guidance and leadership.	Senior Responsible Owner / Project Champion and sponsor Project Board	Programme and Account Manager (Education and Training HE) – Project Board Member
Management Accountable for a successful project.	Project Lead / Project Manager	Deployment Manager
Activity Creates change by deploying the improvements created by SIM system.	Work Stream Leads Work Stream Teams Trust Representatives	Work Stream Leads and Specialists

6.2.3   Project Governance Structure

Part of the governance will be the following for the SIMS project control, reporting, and documentation.

To cater for comprehensive project reporting, the team will provide, in conjunction with the systems/solution delivery partner, regular progress reports and updates. Based on experience from the recent implementation of IDCR – Carenotes the new Electronic Patient Records system, for the purpose of this project we would recommend the following format:

- Monthly project progress reports
- Monthly project board meetings
- Monthly combined project team meetings
- Weekly conference/check-in calls
- Weekly internal project team meetings (both Tribal and client)
- Work stream meetings
- Exception reports as needed

For business critical and/or fast track deployments, the project will incorporate a more frequent and detailed reporting structure presented below.
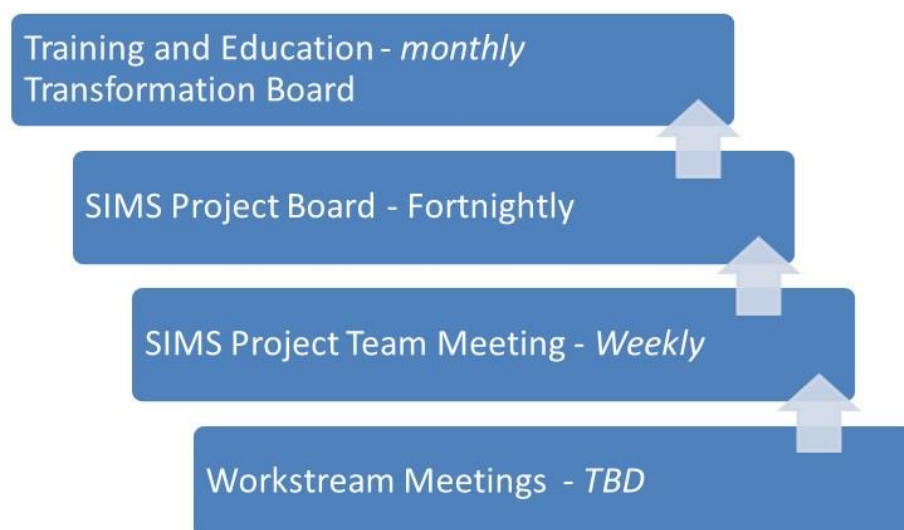
6.2.4   SIMS Project Board Membership

Project Board appointments Role	Name
Chief Executive Officer	Paul Jenkins
Senior Responsible Owner (Chair) (Responsible for the project)	Brian Rock (Director of DET and Dean of Postgraduate Studies)
Simon Kear	Project and Technical Design workstream lead
Dean's Office	Project Manager + Project Office
Feras Dib	Data Migration
Karen Tanner	Course lead
Senior Steering Group	Course Administrative lead Portfolio lead Finance processes lead
Senior Supplier (Responsible for solutions)	Tribal Account manager + Tribal Implementation Project Manager (SITS)

6.2.5   Senior User Group (SUG), key input to the Core Project Team

Assurance Role	Name
Senior User Group (Represents users of SIMS and are advisers and members of work streams that provide steer, assurance and sign-off on key deliverables supporting the core Project Team leads.	Peter Griffiths (Portfolio Manager) Paul Dugmore (Portfolio Manager) Yvonne Ayo (Portfolio Manager) Katie Argent (Portfolio Manager) Laure Thomas (Director of Marketing) Brian Rock (Dean and Director)

Education & Training Report

Assurance Role	Name
	Karen Tanner (Associate Dean)
	Elisa Reyes-Simpson (Associate Dean)

6.2.6   Project Management

A dedicated and experienced PRINCE2-qualified project manager is assigned to the project who will manage it in accordance with PRINCE2 methodologies and work with a supplier PRINCE2 qualified Manager. The project will be designed, considered and introduced in a controlled fashion to increase likelihood of delivery with innovation introduced by the supplier.

Lots of learning can be taken from the recent CareNotes Trust clinical electronic patient records system utilising consultancy, technologies and products to deploy solution in partnership with Supplier project teams, and is pivotal to shared understanding and deliverables. The project will provide post-implementation system reviews to ensure maximum value, efficiency and performance is achieved.

Training will be delivered by qualified and experienced trainers with extensive hands-on experience and an exceptional ability to relate courses to real life situations. Provision of training plans, hand outs and other training material and assistance with onward training plans, together with post-implementation support and follow-up included as standard.

6.2.7   Project activities to be designed, agreed and undertaken with supplier

- Benefits identification/creation of benefits register

- Stakeholder engagement/communications plan

- Governance structure, project board makeup and terms of reference guidance

- Current state/future state process mapping

- Designing a student centric system that enhances the experience across the user groups

- Organisation/facilitation of workshop sessions

- Formation of a transformation team and training to enable them to run their own process mapping and other transformation activities

- Current processes analysis, and production of a proposal to map this to system setup/design

- System setup advice to ensure paper-based or legacy systems aren't simply replicated in Tribal's SITS solution

- Process change identification to maximise the benefit from the system

- Assistance with training strategy/plans, training needs analysis and creation of lesson plans

- Go live planning/floor-walking support, including manual migration planning/execution.

6.2.8   The Milestone Chart in 6.3 presents the high-level view of the key blocks of activities and dependencies taking the project through selecting an application supplier through to end of Lot 1.

6.3   **High-level Project Milestones to end of Lot 1- shortlisting (2)**

DET SIMS Project : Oct v 0.1	2014			2015				2016			
	APR-JUN	JUL-SEP	OCT-DEC	Q1	JAN-MAR	APR-JUN	JUL-SEP	OCT-DEC	JAN	FEB	MAR	APR

time now

1. DET SIMS 2015

1. Consortia Framework
2. Internal Project mobilisation
3. Requirements gathering
4. Preparation for initiating mini competition

Interviewing and Requirements Gathering

Tender documents development

Statement of Requirements

Student Journey Review Complete - July 2015

DET Statement of Requirements Complete

Mini-Competition LOT 1 (invitations 1,2 & 3)

2. Mini Competition – LOT 1 Application Selection

Stage 1 – Written Evaluation (30%)
Stage 2 – Supplier Demonstrations (30%)
Stage 3 – Financial Evaluation and clarification (40%)

03

Evaluation

13   **Demos**

31

Solution
1. SITS
2. QURCUS

Supplier
1. TRIBAL
2. ELLUCIAN

Full Business Case Complete

Lot 1 Outcomes Finalised

Site visits

Supplier Interviews

Review and demo teams set up and Trust staff engaged and committed

LOT 1 Contract Awarded Supplier Announced

Contract Negotiation

Contract Awarded Supplier Announced

Preferred Bidder Confirmed for LOT 1

FBC to Trust Board Approved

Supplier Mobilisation and Engagement Starts - Plan TBC

3. Due Diligence

Project Management

◆ Milestone

Options Analysis complete

OBC to Mgmt Team agreed NOV

OBC to Trust Board approved

Project Team Structure approved

ICT Project reports into DET Transformation Training and Education Programme Board

Detailed analysis & Clarification questions

Recommendations paper to TEPMB

6.4 Deployment Sequence

A major aspect of planning the project is to decide how the system will be deployed in terms of key functional releases.

Planning the transformation will be developed in collaboration with the supplier during the Discovery and mobilisation phase immediately after contract signature. The Project team will require a significant amount of planning and resource availability to ensure a smooth transition. As part of the SIMS project lifecycle there will be rigorous phase of 'User Acceptance testing' (UAT)

This phase is critical for the go/no go criteria for a live system providing the assurance a system involving users work and is secure for the faculty and signed off by the SRO for the Trust.

6.4.1 ICT SIMS 2016 Road Map

The Chart on the next page presents the high-level blocks of activities and key dates of the roadmap of design, development/configuration, testing, training and go-live. The detail and actual go-live date to be worked through with the supplier.

6.4.2 Business analysis

- Early stage solution overview to aid change agents in making informed decisions when consulting users on business transformation and future ways of working.

- A 2-stage process including 'as is' process mapping and 'to be' process design, to understand the full SITS capabilities, support best working practices adoption and to optimise functionality. With business and user acceptance testing through each deployment phase and functionality.

6.4.3 Key deployments to be discussed with supplier during contract discussions and discovery phase:

- ❖ Curriculum set-up and testing should be completed and tested - end of June 2016

- ❖ System ready from July 2016 ready for new and re-registering accepted students to be entered on the system from July/August 2016 for start of academic term - September 2016

- ❖ To develop a detailed data migration plan including the level of data to migrate agreed with supplier and Student Data Group - end of April 2016

- ❖ System used for recruitment processes - CRM/student record functionality - Early November 2016

2016 — DET SIMS Project

Activities	Project Start-up / Initiation	Managing phase & project scope		Project Delivery				Partial system roll-out
	JAN - FEB	MAR - APR		MAY - JUN	JUN - JUL	AUG - SEP	Q4	

Business Planning & Documentation

- Receive DET Documentation Project scope
- Document assumptions and constraints
- *Board decision point*
- Construct active Risk and Issues registers to support project management

Discovery/ fact finding

- Discovery
- Product & process discovery
- Technical Integration Discovery

Business requirements and process

User acceptance testing

Analysis, design & delivery

- Develop Plan
- Establish governance and escalation routes and management reports
- Define Communication & stakeholder and partner Engagement plan
- Prepare Board papers and supportive documents

Mobilisation

- Technical Integration Discovery
- DET Programme Board
- SIMS Project Board
- Stakeholder management and communication plan

Data Migration & configuration

Registration Go-live

Configuration

1st year Enrolment Phase

Design & configuration

Applications functionality end of Nov - Go-live

We are here

New term Readiness

SIMS– Vision and Aspiration

SIMS access and use

Procurement Process steps: 1 2 3

1. Feb'15 The SIMS ICT Project went out to tender, RFP issued to market, unfortunately no responses from companies on the framework. We worked with LPP to extend the timeline for response following market engagement with suppliers about the Trust project

2. June '15 The Trust received two sets of bid documentation . The procurement process was unfortunately closed , in September, as the market responses were beyond the financial expectations for the Trust and did not allow the Trust to continue and complete the process

3. An amended Statement of Requirements was rapidly produced with a focus on a managed service for 5 years with a financial Cap was presented in the Trust's documentation. The Trust rapidly turned this around to issue a new RFP and two strong bids were received from the original two suppliers. The mini-competition and procurement process continued on to recommend a winning preferred supplier.

6.5 Constraints and Risks

6.5.1 The following bullet points below were identified as currently being the most significant factors that might constrain the project or at least cause difficulties:

- Other projects with other organisations delivered by the preferred supplier may gain greater priority than the Tavistock and Portman Foundation Trust's DET SIMS Project

- Difficulty of involving staff already involved in balancing priorities between the "day job" and the project. Monitored and managed through a dedicated core team

- Affordability of Solution exceeds budget, however to ensure vision and transformation is realised, a key enabler is the technology and information systems

- The Scope and resource requirements for the project increases going through the Project lifecycle resulting in costs increase

- Links between SIMS and legacy systems to avoid duplicate data entry and share relevant information on service users are not available at the moment.

- Managing expectations especially among those who imagine that the deployment of SIMS System will be smooth, problem free and meet all key information needs.

- Negative experience shared by colleagues from other Training and educational institutions.

6.6 Dependencies

6.6.1 The detail from Q1 2016 will be developed with the selected supplier, with key emphasis on change management and operations.

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

6.7 **Project Plan and Description**

6.7.1 The project is based on a generic framework that is intended to provide a consistent approach to managing the project whilst ensuring that proper "checks and balances" are applied at key decision points. The project is sub-divided into phases and stages. The deployments of the new system to meet particular business needs are to be determined once engagement with a supplier commences. The Trusts and project team may choose to deploy and go live with the solution with all areas or stage it as presented in the high level plan section 6.4.3. Work streams run throughout the project lifecycle from start to finish. The phases and stages provide a framework to direct the project and monitor progress. Work streams focus on the specific areas necessary to complete the deployment e.g. data migration and a testing function.

Appendix A Risk and Issue Log

D	Risk/Issue Description	C	L	R	Controls	Gaps	Action plan	Lead
1	Resourcing is not adequate.	2	2	4	Once supplier engagement begins with awarded supplier we can assess resource requirements to deliver this project successfully		Core project Team identified with work stream leads.	
2	End User engagement	4	1	4	Director of Communications and Marketing involved in developing plans, SRO regular update emails. Key super users of the system engaged. Quality, registry, Finance and conference unit inputting. Input to ensure enhanced student experience to sustain growth.	*Communications Plan not yet developed*	To develop and begin to implement communications and marketing plan. Specific events planned	LT
3	Business continuity. Ensuring reports can still be produced during transition from systems	5	3	15	Resources have been secured within DET		Working with IT and informatics to maintain current systems with key dedicated staff in DET. Senior lead systems analyst and newly appointed business systems analyst.	FD

D	Risk/Issue Description	C	L	R	Controls	Gaps	Action plan	Lead
4	Ownership / high-level support of change benefits	4	1	4	Project team working closely with Portfolio Managers		Working with supplier to establish benefits	KT
5	Slow response to issue resolution resulting in delay to project	4	2	8	Project Manager working closely with product manager. DET SIM Project Board currently meets fortnightly for decision making and issue resolution Project Team meets weekly once constituted to identify proposals and options to resolve issues identified.		Working with supplier to establish issue resolution process. Developed Governance routes identified.	SK
6	Staff project skills limited in the project team in delivery of large scale IT procurement and business change	3	2	6	Scoping of PMO function Currently receive support from LPP - London procurement partnership Ensuring through due diligence supplier input to business change activities and innovation.		Recruitment of project management coordinator capability dedicated to support the project	JM
7	Securing a high quality, committed project team, for the lifecycle of the project, who are able to dedicate sufficient time to the project?	4	2	8	Team has been set up as the ICT board has been set up since February 2015 and commitment is in place.		Project plan will be developed in collaboration with the selected supplier with resource allocation and commitment agreed.	SK/FD

D	Risk/Issue Description	C	L	R	Controls	Gaps	Action plan	Lead
8	Coordinated and consistent approach to the adoption and implementation of policies and working practices by all stakeholders.	4	3	12	DET Programme Director developing the strategic business processes. Training and Education Programme Board	Report in progress covering the Transformation.	DET Executive / Dean's Office, training supporting the design of a generic service delivery model/ operating model for trust services.	JM/ BR

Key:
LT – Laure Thomas
FD – Feras Dib
KT – Karen Tanner
JM – John Martin
BR – Brian Rock
SK – Simon Kear

Appendix B Notes from site visits

Ellucian

The Institute of Contemporary Music Performance (ICMP), Foundation House, 1A Dyne Road, London NW6 7XG

4th August 2015, platform implementation in 2014, 1200 students
David Howell (Registrar)

Tribal

Regent's University London, Inner Circle, Regent's Park, London, NW1 4NS

5th August 2015, platform implementation in 2008, 4000 students
Angela Postill, Head of MIS (team of 12)

Agenda

We spent just over two hours with the Ellucian user. This involved discussion with David while viewing the platform itself.

We spent two hours with the Tribal user in discussions with Angela and a member of her team. We did not see the platform but the discussion was immensely informative.

Questions to ICMP and Regents

What do you most like about the system?

ICMP (Ellucian) – Personal relationship with Ellucian
Regents (Tribal) – reporting from the data warehousing, Unity

What is lacking?

ICMP (Ellucian) – [not articulated]
Regents (Tribal) – Admissions was poorly thought out but now getting better e.g. email harvesting

De-briefing comments from the DET team

BH – Ellucian didn't seem to have the finance functionality e.g. for debt chasing.
MR – Ellucian out of the box (ICMP's experience) may not suit our purposes
SK - ICMP felt Tribal were too expensive and pushy at their presentations.
BJ – our work is more closely aligned to Regents. We didn't see great complexity with ICMP.
BH – we did see the Ellucian platform but not Tribal so could be biased
BJ – students and staff may be familiar with Tribal already
BH – Tribal user group and forums very useful – probably not as developed for Ellucian
FD – both systems allow external users
SK – it was noted that Regents academics responsible for marking and keeping the attendance register input both directly into the system
MR – there was one person running Ellucian but a team of 12 exploiting Tribal
FD – Tribal great if resourced through large MIS team; if we stay as we are then Ellucian is good

Appendix C List of evaluators

Written bids: functional requirements

	Name	Role	Department
1	Pravin Hirani	Finance and Registry	DET
2	Rebecca Bouckley	Quality Unit	DET
3	Jas Dahele	Course Administrator	DET
4	Kara Florish	Course Administrator	DET
5	Louie Oestreicher	TEL	DET
6	Bhavna Tailor	Finance Manager	DET
7	Gurjit Matharu	Conference Unit	DET
8	Helen Oliver	Systems Librarian	Library
9	Max Fendrich	Conference Unit	DET
10	Mwen Rukandema	Student Recruitment	DET
11	Roz Wood	Student Recruitment	DET
12	Simon Carrington	Learning Portfolio Officer	DET
13	Angela Douglas	Head of Library	Library
14	Feras Dib	Senior Lead Systems Analyst	DET
15	Simon Kear	Head of TEL	DET

Written bids: non-functional Requirements

	Name	Role	Department
1	Feras Dib	Senior Lead Systems Analyst	DET
2	Muhammed Akram	Head of Informatics	IM&T/ICDR
3	Ricky Kothari	Project Manager	IM&T/ICDR

Demonstrations 11 December 2015

	Name	Role	Department
1	Pravin Hirani	Finance and Registry	DET
2	Kate McWilliams	Project Manager	DET
3	Kara Florish	Course Administrator	DET
4	Max Fendrich	Conference Unit	DET
5	Rebecca Bouckley	Quality Unit	DET

Education & Training Report

6	Jas Dahele	Course Administrator	DET
7	Bhavna Tailor	Finance Manager	DET
8	Helen Oliver	Systems Librarian	Library
9	Feras Dib	Senior Lead Systems Analyst	DET
10	Simon Carrington	Portfolio Academic Developer	DET
11	Fiona Hartnett	Deans Office Manager	DET
12	John Martin	DET Programme Director	DET
13	Megan Hitchcock	Quality Unit	DET
14	Roz Wood	Student Recruitment	DET
15	Gurjit Matharu	Conference Unit	DET

Site Visits, 4-5 August 2015

	Name	Role	Department
1	Feras Dib	Senior Lead Systems Analyst	DET
2	Mwen Mrukandema	Quality Unit	DET
3	Simon Kear	Head of Technology Enhanced Learning	DET
4	Pravin Hirani	Registry and Finance	DET
5	Billie Josef	Course Administrator	DET

Supplier Interviews 11 December 2015

Ellucian, 14 August 2015			
	Name	**Role**	**Department**
1	Feras Dib	Senior Lead Systems Analyst	DET
2	Carl Doherty	Deputy Director of Finance	Finance
3	Simon Kear	Head of Technology Enhanced Learning	DET
4	Toby Avery	Director of IM&T	IM&T
5	John Martin	DET Programme Director	DET
6	Ricky Kothari	Project Manager	IM&T/ICDR
Tribal, 9 September 2015			
	Name	**Role**	**Department**
1	Feras Dib	Senior Lead Systems Analyst	DET

2	Pravin Hirani	Registry and Finance	DET
3	Simon Kear	Head of Technology Enhanced Learning	DET
4	Toby Avery	Director of IM&T	IM&T
5	John Martin	DET Programme Director	DET
6	Ricky Kothari	Project Manager	IM&T/ICDR

Education & Training Report

Appendix D Comments from demonstration evaluators

The second demonstrations of the two platforms were held in the Lecture Theatre on 11 December 2015. They provided the opportunity for us to drill down on the functionality of both systems by asking suppliers to address a number of DET procedures within six main areas. Most of the 15 evaluators were also present at the July 2015 demonstrations when the focus was on the student journey so were they were already quite familiar with the products.

These evaluators represented specific teams within DET. The six areas and multiple procedures reflected: a) what the current Agresso system was unable to do but which was needed by DET as a priority: b) enhancements to current business processes that the transformation programme underpins.

Key Area	Functionality to be demonstrated
1. Customer Relationship Management (CRM)	1.1 Record creation and log call against enquirer's name. 1.2 Avoidance of the creation of duplicate accounts. 1.3 Generate reports drawn from enquiries using course/data parameters 1.4 Export data into e-marketing tool such as Pure360
2. Management / data reporting	Produce the following reports: 2.1 Student progression 2.2 Age, gender, ethnicity, alumni 2.3 Hesa, Heses (Hefce) 2.4 Sponsor's 2.5 Current status (e.g. students due to graduate) 2.6 Incomplete applications 2.7 Course enrolments
3. Finance	3.1 Tracking debtors 3.2 Allocating costs to a course, including teachers 3.3 Credit control 3.4 Integration with payment systems 3.5 Integration with financial platform (Oracle)
4. Record Management	4.1 Former CPD participant applies for and enrols on a long course 4.2 Conversely, student enrols on CPD event while studying on long course 4.3 System supports on-going activity with graduated student for further CPD events
5. Assessment	5.1 Support for assessment boards 5.2 Migration of grades from VLE 5.3 Submission of work by students, including plagiarism detection
6. Document Management	6.1 Tracking and history versioning 6.2 Making multiple documents available to users

GENERAL

Ellucian

"Demo not that clear on the creation of records."

"[Finance] was not clearly demonstrated."

"[Finance] very limited cost build."

"[Record management] does what you want."

Tribal

"Really like the reporting interface"

"Tool appears to be versatile. Good identification of duplicate record."

"Good interaction with students/sponsors for fee setting/payment."

"I like the idea of a personalised prospectus."

"[Student] portal adapts to meet disability needs."

"[Management/data reporting] worked well to log all the various records."

Q: WHAT FUNCTIONALITY MOST IMPRESSED YOU?

Ellucian

"University partners capacity to log on to view data."

"Clean dashboard and ability to generate workflows."

"All in all a simple user friendly operating system."

"The student portal looked very functional and easy to use e.g. student deferring was good."

"I liked the ease and simplicity of use of the staff portal."

"Events – early booking system. Linked to long courses they are currently on."

Tribal

"All of it as demo – integration layout easiest I've seen."

"Flexibility – a lot of user configurability. Interfaces generally user friendly. Offers a good student experience."

"The CRM functions."

"Document management."

"CRM – good function to have / track applications etc."

Q: WHAT FUNCTIONALITY LEAST IMPRESSED YOU?

Ellucian

"Lack of configurability in some areas."

"CRM was probably not as impressive or maybe not explained well."

"Cannot harvest emails from Outlook as of yet."

"Record management. These look like a mass list of reports. Not organised that well."

Tribal

"Power user functions appeared quite complex. Financial abilities limited."

"Assessment."

"Generation of fees for new courses."

Board of Directors : January 2016

Item : 15

Title : Quarter 3 Governance statement

Purpose:

The Board of Directors is asked to approve three elements of the governance statement to be submitted to Monitor for quarter 3:

For Finance
The board anticipates that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.

The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.

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

Otherwise
The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, table 3) which have not already been reported.

At the Executive Management Team on 19 January, members supported all these statements and confirmed that we are not aware of any risk to compliance with any conditions of our licence.

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

For : Approval

From : Deputy Chief Executive and Director of Finance

Q3 Governance Report

Page 1

Quarter 3 Governance Statement

1. Introduction

1.1 Monitor oversees NHS foundation trusts through the terms of our provider licence and through the Risk Assessment Framework.

1.2 A key element of the Risk Assessment Framework is the requirement to submit a governance statement each quarter.

1.3 This quarter's statement is to be returned to Monitor by 31 January, on the template which also includes the quarterly financial return.

2. Finance declaration

2.1 In the revised Risk Assessment Framework implemented in August, Monitor has replaced the continuity of service risk rating (CoSRR) by the financial sustainability risk rating (FSRR), which has two additional metrics. Details were circulated to Board members at the time.

2.2 Based on the Trust's Operational Plan the results for the four metrics which comprise the FSRR would be:

- Our Capital Service Cover rating is projected to be 4 for all quarters of 2015/16.

- Our Liquidity rating is projected to be 2 for the last three quarters of 2015/16.

- Our I&E margin is projected to be between 0% and 1% of income, and is therefore be rated at 3 for all quarters of 2015/16.

- If we achieve or exceed the Plan I&E margin, we will be rated 4 on the final element.

2.3 The four elements are each given a 25% weighting; so based on the ratings predicted, our FSRR will be 3.25 which is rounded to 3, and which remains satisfactory.

2.4 The three ratings relating to surplus (the Capital Service Cover and I&E margin) are all calculated without including certain exceptional items such as restructuring costs. For these three ratings to fall to 3, 2 and 2 respectively (which would bring the overall rating down to 2),

the Trust's surplus/deficit would have to fall to around £400k (pro rata), or almost 1% of income. This is not expected to occur.

2.5   For the Liquidity rating to fall to 1 in quarter 4, the combination of the Trust's surplus and its capital expenditure would have to be some £500k worse than Plan. This is also not expected to occur.

2.6   The declaration this time includes the first nine months of 2016/17. We currently expect to be able to budget for a small surplus in 2016/17.   We are seeking to fund the capital expenditure on continuing preparatory work for the relocation project through a medium-term loan rather than from the Trust's cash balances. If confirmed, this will ensure that the liquidity ratio remains satisfactory.

2.7   Based on the above, we are able to affirm that we anticipate that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.

2.8   A revised forecast for 2015/16 capital expenditure for the year will be included in the Finance report, with supporting details; and the same figure will be provided to Monitor.   The Board should be able to confirm from this that the actual expenditure is not expected to differ materially from the amended forecast.

3.   <u>Governance Declaration</u>

3.1   <u>Declaration of risks against healthcare targets and indicators</u>

3.1.1 The Monitor template for our quarterly return sets out a list of targets and indicators, in line with the Risk Assessment Framework. The targets and indicators which apply to this Trust are given in the table on the next page.

3.1.2 All targets and indicators are being met; and plans are sufficient to ensure that they continue to be met. Further details are given below. The Trust should therefore continue to receive a green governance rating.

Target/Indicator	Weighting	Quarter 3 result	
Data completeness: 97% completeness on all 6 identifiers	1.0	Achieved (see 3.4 below)	0
Compliance with requirements regarding access to healthcare for people with a learning disability	1.0	Achieved (see 3.3. below)	0
Risk of, or actual, failure to deliver Commissioner Requested Services	Report by exception	No	0
CQC compliance action outstanding		No	0
CQC enforcement action within the last 12 months		No	0
CQC enforcement action (including notices) currently in effect		No	0
Moderate CQC concerns or impacts regarding the safety of healthcare provision		No	0
Major CQC concerns or impacts regarding the safety of healthcare provision		No	0
Unable to declare ongoing compliance with minimum standards of CQC registration		No	0
		Total score	0
		Indicative rating	

3.2   Care Quality Commission registration

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

3.2.2 The Trust remains compliant with the CQC registration requirements.

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

3.3.1 The Lifespan team manager is currently carrying out the Green Light audit, the self-assessment tool for our services for people with a learning disability; this will be completed this month. The previous review was in 2014, and confirmed that the Trust meets all the access requirements for this group.

3.3.2 The Trust has continued to develop its services for LD service users,

and actively involves users to further refine and tailor provision. The Lifespan team has introduced Photosymbols, a picture based system, to ensure that where necessary correspondence is written in ways that fit the communication needs of service users. They are also continuing to work on a phone App to act as an adjunct to therapeutic support; though this is initially being tested for people with autism spectrum conditions, it may later be applicable to a wider population.

3.4 Data Completeness

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

	Month 7, final	Month 8, provisional
Valid NHS number	99.75%	99.69%
Valid Postcode	99.96%	100.00%
Valid Date of Birth	100.00%	100.00%
Valid Organisation code of Commissioner	98.51%	98.46%
Valid Organisation code GP Practice	99.47%	99.55%
Valid Gender	99.89%	99.90%

4. Other matters

4.1 The Trust is required to report any "incidents, events or reports which may reasonably be regarded as raising potential concerns over compliance with [our] licence." The Risk Assessment Framework gives – on page 22 – a non-exhaustive list of examples where such a report would be required, including unplanned significant reduction in income or significant increase in costs; discussions with external auditors which may lead to a qualified audit report; loss of accreditation of a Commissioner Requested Service; adverse report from internal auditors; or patient safety issues which may impact compliance with our licence.

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

Simon Young
Deputy Chief Executive and Director of Finance
19 January 2016

Q3 Governance Report

Page 5

Board of Directors : January 2016

Item : 16

Title : Emergency Preparedness , Response and Recovery (EPRR) Assurance and Work plan for 2015-16

Summary:
All health provider organisations are obliged to undertake an annual EPRR assessment against NHS England core standards and to secure agreement from the Board to the submitted level of compliance and the workplan.

The Tavistock and Portman NHS FT EPRR Assurance was reviewed by the Trust Accountable Executive Officer for Emergency Planning, Dr Rob Senior, and submitted to NHS England in December 2015 with the Level of Compliance as 'Substantial' (green). All outstanding standards (amber rating) are addressed in the work plan and will be monitored by the Corporate Governance and Risk Workstream.

The Board of Directors is asked to confirm the Level of Compliance submitted and where not, whether the Board of Directors is satisfied with the action plan that has been put in place.

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

For : Approval

From : Medical Director , Dr Rob Senior

Emergency Planning

Page 1 of 11

Emergency Planning, Response and Recovery Assurance to NHS England

1.   Introduction

NHS England (London) uses an annual EPRR assurance process to assure themselves that NHS organisations in London are prepared to respond to an emergency, and have the resilience in place to continue to provide safe patient care during a major incident (MI) or business continuity (BC) event.

2.   Assessment compliance

To comply with the NHS England requirements and enable a national-level overview of EPRR, Trusts are required to undertake an annual self-assessment of the NHS England EPRR Core Standards.

This was undertaken in October and reviewed with members of the NHS England EPRR Team, Clinical Commissioners, external Trust peer reviewer and the Trust AEO in November. The Trust assessed itself as compliant with all relevant standards (48/58) which was confirmed with NHSE. This was required to be submitted to NHS England by 12th December 2015 following agreement by the Trust AEO.

Please see Appendix 1 for a summary of the *relevant* standards and the Trusts assessment and assurance.
Pandemic Flu and Haz Mat training are being updated within MI and BC Plans

3.   Board requirements

All organisations participating in EPRR assurance process are required to ensure their Boards (or equivalent) are sighted on the Level of Compliance achieved, the results of the assessment and the action/work plan for the forthcoming period.

Please see Appendix 2 for the Trust EPRR Workplan as of January 2016.

Lisa J Tucker
Health and Safety Manager, Emergency Planning Liaison Officer
January 2016

Appendix 1
NHS England EPRR Core standards
*RAG rated Assurance as submitted to NHS England in December 2015

Core standards Self-assessment RAG rating Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. *Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	RAG status
EPPR Governance	
Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)	
Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	
Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	
The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resource are made available to enable the organisation to meet the requirements of these core standards.	
Duty to assess risk	
Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	

Emergency Planning

There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.

There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.

Duty to maintain plans – emergency plans and business continuity plans

Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.

Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):

- Major Incident Plan
- Business Continuity
- HAZMAT/ CBRN
- Severe Weather
- Pandemic Influenza
- Infectious Disease Outbreak
- Evacuation
- Lockdown
- Utilities, IT and Telecommunications Failure

Ensure that plans are prepared in line with current guidance and good practice which includes: Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.

Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.

Arrangements explain how VIP and/or high profile patients will be managed.

Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content

Arrangements include a debrief process so as to identify learning and inform future arrangements

Command and Control (C2)

Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	
Those on-call must meet identified competencies and key knowledge and skills for staff.	
Documents identify where and how the emergency or business continuity incident will be managed from, i.e. the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist.	
Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.	
Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.	

Emergency Planning

Duty to communicate with the public

Arrangements ensure the ability to communicate internally and externally during communication equipment failures

Information Sharing – mandatory requirements

Arrangements contain information sharing protocols to ensure appropriate communication with partners.

Co-operation

Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)

Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA

Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.

Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties

Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level

Training And Exercising

Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents

Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.

Demonstrate organisation wide (including on call personnel) appropriate participation in multi-agency exercises

Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.

Pandemic Flu

Organisation have updated their pandemic influenza arrangements to reflect changes to the NHS and partner organisations, as well as lessons identified from the 2009/10 pandemic including through local debriefing

Organisations have developed and reviewed their plans with LHRP and LRF partners	
Organisations have undertaken a pandemic influenza exercise or have one planned in the next six months	
Organisations have taken their plans to Boards / Governing bodies for sign off	

Emergency Planning

Appendix 2

Emergency Preparedness Resilience and Response (EPRR)

2015-16 Work Plan

	Action to be taken	Lead	Timescale	Current position Dec 2015 – Actions	RAG
1	Pandemic Flu Plan to be updated	Medical Director	Feb 2016	The Trust has a current Pan Flu plan which needs to be updated	
2	Include a 'Decision Tree' on both BCP and MIP - including activation levels and Director 'on call' responsibilities	EPLO and Silver Command	January 2016	To update contact details and a flow chart of activation levels to be added to plans	
3	BCPs; 'Deep dive' of specific services; detailed service level BCPs to be drafted.	AEO and EPLO	August 2016	EPLO to assist services on BCPS and update Service Specific Risk Assessments	

#	Action	Lead	Date	Notes
4	'Strategic Leadership in a Crisis' Course to be attended	AEO , EPLO and Silver Command	Dec 2015	Deputy Chief Executive (Silver Command) *Attended in December 2015* AEO and H&S manager to attend, as outlined in EPRR Training Needs Analysis (TNA)
5	Contact details to be updated and extended to Commissioners and key personnel and include mutual aid and EPO contacts, for the Command and Control Rooms	EPLO	March 2016	SR4, Board room and Monroe team room, all need to be checked and updated for use as a major incident room. Check for analogue lines with IT.
6	Update Communications Card on MIP and BCP	EPLO and Comms	March 2016	Communication Strategy to include Social Media and how to access the website. Clarify how to send the Emails / texts to patients, staff and students in the case of a major incident.
7	To make formal arrangements with Royal Free Hospital & Camden and Islington MH for formal Mutual aid agreements	AEO and EPLO	August 2016	Formal contacts to be made and agreed on plans

8	AEO / Medical Director - attendance Local Health Resilience Partnership	AEO	December 2015	AEO called in for the December meeting and EPLO can attend future meetings on behalf of the AEO.
9A	Internal Communications exercise required.	EPLO	December 2015	Updated telephone contact list for Trust leads Revised the group email 'incidentcontrolroom@tavi-port.nhs.uk' Internal communication exercise completed.
9B	Ensure Table top exercise - annually	EPLO	August 2016	Book for MT before December 2016
9C	Live exercise at least every three years.	EPLO	August 2016	IT incident from Q1 2015/16 to be submitted as a report on a 'Live exercise'

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

10	"Demonstrate organisation wide (including on call personnel) appropriate participation in multi-agency exercises"	NHS England	August 2016	NHS E to invite EPLO / AEO to exercises

AEO: Accountable Emergency Officer, Dr Rob Senior, Medical Director "Gold Commander"
DCE: Deputy Chief Executive, Simon Young, "Silver Commander"
EPLO: Emergency Planning Liaison Officer, Lisa J Tucker Health and Safety (H&S) Manager
BCP: Business Continuity Plan
MIP: Major Incident Plan