

## Board of Directors Part One

### **Agenda and papers**

of a meeting to be held in public

2.00pm–4.00pm  
Tuesday 27<sup>th</sup> October 2015

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



## BOARD OF DIRECTORS (PART 1)

**Meeting in public**  
**Tuesday 27<sup>th</sup> October 2015, 14.00 – 16.00**  
**Board Room, Tavistock Centre, 120 Belsize Lane, London NW3 5BA**

### AGENDA

PRELIMINARIES				
1.	<b>Chair's Opening Remarks</b> Ms Angela Greatley, Trust Chair		Verbal	-
2.	<b>Apologies for absence and declarations of interest</b> Ms Angela Greatley, Trust Chair	To note	Verbal	-
3.	<b>Minutes of the previous meeting</b> Ms Angela Greatley, Trust Chair	To approve	Enc.	p.1
3a.	<b>Outstanding Actions</b> Ms Angela Greatley, Trust Chair	To note	Enc.	p.9
4.	<b>Matters arising</b> Ms Angela Greatley, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	<b>Trust Chair's and NEDs' Report</b> Non-Executive Directors as appropriate	To note	Verbal	-
6.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To note	Enc.	p.10
7.	<b>Finance &amp; Performance Report</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.13
8.	<b>Training and Education Report</b> Mr Brian Rock, Director of Education & Training; Dean	To note	Enc.	p.24
9.	<b>Quality Strategy</b> Ms Louise Lyon, Director of Quality & Patient Experience	To note	Enc.	p.27
10.	<b>Q2 Governance Statement</b> Mr Simon Young, Deputy Chief Executive	To approve	Enc.	p.42
11.	<b>Q2 Quality Report</b> Ms Marion Shipman, Associate Director of Quality	To discuss	Enc.	p.47
12.	<b>NHS Workforce Equality Standard</b> Ms Louise Lyon, Director of Quality and Patient Experience	To discuss	Enc.	p.76

13.	<b>NED, CEO and Chair Objectives</b> Ms Angela Greatley, Chair	To approve	Enc.	p.85
14.	<b>Service User Story</b> FNP Service Users	To note	Verbal	-
<b>CLOSE</b>				
16.	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"> <li>Tuesday 10<sup>th</sup> November 2015: Joint Boards' Meeting – Introductions, 11.30am- 2.00pm</li> <li>Tuesday 24<sup>th</sup> November 2015: Board of Directors' Meeting, 2.00-4.00pm, Board Room</li> <li>Thursday 3<sup>rd</sup> December 2015: Council of Governors' Meeting, 2.00-4.00pm, Lecture Theatre</li> <li>Tuesday 15<sup>th</sup> December 2015: Leadership Group Away Day Conference, 10.00-5.00pm, Danubius Hotel.</li> </ul>		Verbal	-

## Board of Directors

### Meeting Minutes (Part One) Tuesday 29<sup>th</sup> September 2015, 2.00 – 3.50pm

<b>Present:</b>			
Ms Angela Greatley Trust Chair	Ms Jane Gizbert NED	Dr Rita Harris CYAF Director	Ms Louise Lyon Director of Q&PE and A&FS
Mr David Holt NED	Mr Paul Jenkins Chief Executive	Ms Lis Jones Nurse Director	Mr Simon Young Deputy CEO & Director of Finance
Ms Edna Murphy NED	Dr Rob Senior Medical Director		
<b>Attendees:</b>			
Mr Gervase Campbell Trust Secretary (minutes)	Ms Elisa Reyes Simpson, Associate Dean (item 9)	Ms Karen Tanner, Associate Dean (item 9)	Ms Shilpi Sahai, HR Manager (item 11)
Ms Sally Hodges, PPI Lead (item 13)			
<b>Apologies:</b>			
Dr Ian McPherson NED & Vice Chair of Trust	Mr Brian Rock Director of E&T/ Dean	Prof. Dinesh Bhugra NED	

#### Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to be made to the minutes	GC	Immd.
2	14	See if it would be possible to circulate a written Student Story	GC	Sept.

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

Ms Greatley opened the meeting.

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

Apologies as above. There were no declarations of interest specific to this meeting.

Mr Campbell reported that Mr Holt had updated his declaration of interests for the register: Mr Holt was no longer a director of Urban Patch Ltd, and he was appointed to the board of Hanover Housing Association on the 23<sup>rd</sup> September as a Non-Executive and chair of their Audit Committee.

#### 3. Minutes of the Previous Meeting

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

#### 4. Matters Arising

Action points from previous meetings:

AP1 – (minutes) – completed

AP2 – (changes to Board Objectives) – completed

AP3 – (circulate correct Quality Report) - completed

Outstanding action points:

OAP3 (Arrange broad Equalities Event) – event has been arranged for 2<sup>nd</sup> December, with Roger Kline speaking and Frank Lowe facilitating discussion on race equality in employment within the Trust.

OAP4 (service summary sheets) – these have been superseded by team descriptions, which will be circulated once updated.

## **5. Trust Chair and NEDs' Report**

Ms Greatley reported that she had visited GIDS in Leeds, and met the manager and team. The offices are small, as the board knows, but the lease for new accommodation has been signed. The internet connection continues to be a challenge. They currently have 379 patients on their books, and 8 staff, but are coping well.

Mr Campbell read out a report from Prof. Bhugra on his visit to South Camden Camhs, where he noted the team was enthusiastic with an impressive skill-mix, but commented that the team meeting happens in the reception area, which suggests issues for confidentiality. Ms Harris explained that use of the reception area for the weekly team meetings is deliberate, designed to be an efficient use of space, with no patients scheduled during the meeting period, and a procedure in place should someone arrive unexpectedly, so that confidentiality was ensured.

Ms Murphy reported that she had met with Ms Hodges, to discuss the KLOE she led on, and to think out how the NED role in being a critical friend.

Ms Gizbert reported that she had met the web development team, who were doing good work, but needed more representatives from outside the communications team to contribute.

The Board **noted** the reports.

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

Mr Jenkins summarised his report, highlighting the excellent, sympathetic and helpful coverage the 'Mending Broken Minds' documentary had provided, and noted the hard work behind the scenes from both clinical and communications teams in making it possible.

He reported that the Council had approved the recommendation of the appointment panel and Mr Paul Burstow would start as Chair of the Trust in November. Mr Burstow had already begun meetings to pick up the business of the Trust, and would be focussing on external audiences once in post.

He gave updates on the strategy document, which would come to the October meeting, and on Care Notes, where there were some reporting issues that were being addressed, and on the Surrey Camhs bid, where Dr

Hodges and Dr Wiener had given an excellent presentation to commissioners, with very positive involvement from a service user.

Mr Young gave further details of the reporting issue with CareNotes, noting that it affected both reports for internal management and those for commissioners, and whilst they had taken on an additional staff member to focus on reports they were partly dependent on the supplier over data migration issues. Mr Holt asked if there were any patient safety implications. Mr Young explained that he did not think there were: all records had been transferred over successfully and were fully accessible, and it was only in the performance reporting, on waiting times etc., where there were issues.

The Board **noted** the report.

## 7. Finance & Performance Report

Mr Young noted that the report did not give sufficient explanation of the vacancies it referred to, and a comprehensive description of the various reasons behind them would be provided in October, along with clarification of expected underspends. He noted that the cash forecast for the end of year was £2.8M, but this did not allow for additional work on the relocation project if the OBC were to be approved.

Mr Young noted that the current Working Capital Facility would expire at the end of October, and although they had not needed to use it in the past 9 years, he felt it was an important safety net that currently cost approximately £3k pa for a £1M facility. He proposed that he should negotiate to renew it at the current level for a further year, and the Board **approved** this.

Ms Murphy noted in section 2.2.4.2 there was an indication that GIDU would be using agency staff later in the year, noted the costs associated with this and queried why agencies were needed with a planned situation. Mr Young explained that this was a mistake, they would not be using agency staff, but were planning to give current staff additional sessions, or employ them on short term contracts to address the work.

The Board **noted** the report and approved renewal of the working capital facility.

## 8. Training and Education Report

Mr Jenkins noted that Mr Rock was recovering from an operation today, and the Board expressed their best wishes for his recovery.

Mr Jenkins introduced the report, noting that it was in a different format as there had not been a programme board meeting, so it was a more general update. He highlighted some of the milestones over the summer, including the successful appointment to all the Portfolio Manager roles, and noting that in a change of structure Ms Tanner had taken on the role of deputy to Mr Rock. He noted that they were planning significant changes to the support functions to better align them to the requirements of the recruitment cycle, and that negotiations with Essex had been agreed and communicated to students.

Ms Murphy commented that it was clear enormous work had been done, with hugely critical work on the structure, and it would be good to see more of the outcomes in the next report.

*[After the meeting it was noted that the figures given in the report were commercially confidential, and so the report should have been in part 2 of the meeting. It was agreed that the paper would be taken off the website, but the minutes of the discussion left in part 1.]*

The Board **noted** the report.

## **9. Service Line Report – Education and Training Portfolios Overview**

Ms Reyes Simpson summarised the main points of the report, noting that the appointments and their transitions from their existing roles had been a helpful opportunity to identify new talent and look at the use of resources. The benefits of the Portfolio Managers had been seen in recruitment, with more capacity to be hands on with the process and mobilise resources to where they were needed. They were also proving valuable in course development and leading cultural change.

Ms Tanner noted they were moving to a more managed system of training, and were seeing the benefits of that already. She commented on the portfolio recruitment figures, and how valuable it was to be able to do comparisons across courses of these and staff costs. They would not meet the full target on student numbers, and were looking at ways to disaggregate some of the courses to make them suitable for CPD, which would also benefit the regional expansion.

Ms Murphy praised the systematic approach, and the numbers, which allowed the Trust to ask strategic questions. She asked how resources could be optimised given the numbers, for example with mid-year enrolment, and asked about the external element and competition. Ms Reyes Simpson commented that the Portfolio Managers met as a group and could work



flexibly to address resources, and consider changes, including late entry to CPD courses, and the benefits of a modular system. Ms Tanner noted that competition was a key issue, and fees needed to be considered as some of the courses were relatively expensive, and the Course Approval team were meeting weekly and considering these issues.

Mr Holt noted that two courses, D10d and M10 were losing £60k between them, and had only accepted one student each this year. He asked whether they would be considered before the start of the term, and whether there were minimum viable student numbers. Ms Reyes Simpson explained that minimum numbers had been discussed, but they did not yet have the definitive break-even point to allow them to make the decisions. In addition it was necessary to consider the need for a cohort, and the impact on the learning experience, as well as the possibility of attrition over the years of a course. Mr Jenkins commented that it was crucial to look at the income and costs, and where costs could not be taken they would need to discuss what was sustainable going forward. Moreover, they needed to develop a new agenda for HEE and there were opportunity costs to consider.

Ms Murphy asked about the distance learning capability, which was likely to be important for the national contract. Ms Reyes Simpson commented that they had made big strides in the technology, and in familiarity and comfort in using it. Ms Tanner added that they had won over key people on its value, and they had some concerns about capacity in the unit now that people were coming through.

The Board **noted** the report.

## 10 CQSG Quarter 1 report

Dr Senior noted that the date on p2 of the report should be September rather than May.

Dr Senior flagged that a new NED would need to join the committee when Ms Greatley stepped down, noting that the scrutiny the governors provided was important, but the assurance provided by having a NED on the committee was critical. Ms Greatley commented that NED roles would be revisited more widely in November, but Mr Burstow was willing to step into the role from his start and it would be valuable experience for him – the Board **approved** the appointment.

Concerning the content of the report, Dr Senior noted that the Information Governance stream was amber not because there were any failures, but to reflect that much of its work was done later in the year.

The Board **noted** the report, and **approved** Mr Burstow joining the CQSG committee from the 1<sup>st</sup> November.

## **11 Workforce Statistics Report**

Ms Sahai introduced the report, commenting that there were no major areas of concern, but noting that the disappointing situation with recruitment of BME candidates had remained unchanged since last year, despite the action plan HR had put in place in an attempt to improve matters. Ms Greatley noted that much of the problem came from pipeline of students in training, and asked how they were addressing this in their own training programmes. Ms Lyon commented that they had done work in Education & Training, and continued to scrutinise it in the Equalities Committee.

Dr Senior appreciated the workload involved, but asked if more could be done to investigate the issue or address it. Ms Sahai commented that they were doing a piece of work on bands 8a and above, and the Race Equality Statement would be coming out in October. Mr Holt asked if the broad comparison to the ethnic makeup of London was the correct measure, and whether a comparison to that of professional bodies might give a more realistic picture of how well they were doing. Mr Young noted that not all staff groups were related to professional bodies, and we were not that far off the London population as a whole, but the larger concern was the number of BME candidates who were shortlisted but not appointed, and work had been done to look at this in detail and had found that there were valid reasons in each case. The Board agreed it was an important issue that required further work, and should be incorporated into the Race Equality Strategy work, and Ms Lyon commented that statistics would only get them so far, and they needed to accept the Roger Kline challenge and really talk to BME colleagues to see what could be done, and the December event would be a way to begin this. Mr Jenkins commented that it was disheartening to see the problem recurring year after year despite the efforts put in, but they needed to remember that there were no easy fixes and the Trust needed to be in for the long haul, and have a long term strategy. Actions should be refreshed, given a rethink, but also given time to make an impact. And the changes made in training, where making an impact was perhaps easier, should act as a reminder that a difference can be made.

The Board **noted** the report.

## **12 Responsible Officer's Revalidation Report**

Dr Senior clarified the two different uses of 'deferred' in the report, and noted that none of his recommendations for revalidation had been refused or deferred. He commented that all the doctors were complying with the requirements, and doing so with good effects on the quality of appraisals. He explained that at some point in the coming year they could expect an inspection on a peer basis, but they had already been reviewed by internal audit and found robust.

Dr Harris commended the report. She noted on p76 the suggestion that CPD funding needed to be increased, and suggested this would be true for other disciplines as well. Dr Senior agreed, noting that the Local Negotiating Committee had made the same point, and whilst there were some statutory requirements specific to doctors there were requirements for all clinicians, and nurse revalidation was coming soon too. Ms Jones added that nurse revalidation would be introduced in April 2016, with a similar process to doctors expected. The full details were expected by the end of November and then they would be able to put plans in place by January, and report to the board on them then.

The Board **noted** the report.

## **13 PPI Annual Report**

Dr Hodges commented that it was a long document, and they would be moving to quarterly updates in the next year as the work being done was growing so rapidly. This also marked a significant change to having the work held locally by teams, and adapted to local needs, with PPI providing central support. She noted that they had struggled to engage with some groups, and would aim to develop events and activities better aimed at them, with a model of facilitating recovery and resilience and to build on strength. This included working with PALS on issues that had been raised with them, such as support with applying for jobs.

The board commended the excellent look of the report, and the quality of work done over the year. Mr Jenkins commented that it was uplifting to so much good work gathered together, and they should be proud of the progress over the last year. Dr Senior relayed feedback praising the excellent presentation at the Clinical Induction, which had shown that the work we were doing was substantially different from that of other Trusts.

The Board **noted** the report.

## **14 Update on Governor Elections**

Mr Campbell tabled a list of the Governors who would be in post from

November, and called attention to the joint boards meeting on the 10<sup>th</sup> November which would be an opportunity to welcome them to the Trust in person.

Ms Greatley noted that they were fortunate in having Mr Levy and Ms Baron elected for a second term, but it was a shame that Mr Pearce and Ms Alcock had not been successful. They had both done such excellent work on the Council, and she would be writing to them to thank them.

The Board **noted** the report.

## **15 Student Story**

Ms Greatley noted that the student who had been going to speak to the board had been called away at the last minute with by a clinical situation he needed to address. Whilst it was a great shame they would not be able to hear from him today, it did speak volumes of the special nature of the training the Trust provided. Mr Campbell would explore whether the student would be willing to jot down some details of what he had wanted to say, to circulate to the directors.

**AP2**

The Board noted the report.

## **16 Any other business**

The Board noted its future meetings.

Part one of the meeting closed at 3.50pm.

## Outstanding Action Part 1

Action Point No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
3	Mar-15	10. Annual Equalities Report	Arrange a broad equalities/ Time to Change event	Louise Lyon	Sep-15	Event organised for 2nd December. Complete.
4	Apr-15	11. Draft Annual QR	Produce summary sheets for each service	Louise Lyon	Jul-15	Superseeded by Team Descriptions, which will be circulated to board once complete.



## Board of Directors: October 2015

**Item :** 6

**Title :** Chief Executive's Report (Part 1)

**Summary:**

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

**For :** Discussion

**From :** Chief Executive

## Chief Executive's Report

### **1. AGM**

- 1.1 We held the Trust's AGM at Coram on October 7<sup>th</sup> with a focus on the work of our FDAC service. The presentation from the service, including contributions from parents who had used the service, was excellent.
- 1.2 In total 90 people attended the AGM, 25% more than last year and the feedback on the event was excellent. While we will probably want to return to the Tavistock Clinic for next year's AGM it gave a good message to hold AGM in an external venue.

### **2. TADS study**

- 2.1 On 2nd October the TADS (Tavistock Adult Depression Study) was featured on the Today Programme with an interview with Dr David Taylor. The study, which was published in World Psychiatry, demonstrates positive benefits of long term psychotherapy for people affected by treatment resistant depression.

### **3. Nice Conference**

- 3.1 I spoke at the annual NICE Conference in Liverpool on the subject of new models of care.

### **4. CQC**

- 4.1 We have made our first submission of data for CQC on 2<sup>nd</sup> October with a further submission required on 21<sup>st</sup> October.

### **5. Rita Harris**

- 5.1 This will be Rita Harris' last Board meeting as she retires as Director of the Children, Young Adult and Families Directorate on 1<sup>st</sup> November. I would like to put on record my appreciation of the



enormous contribution which Rita has made to the work of the Trust.

## **6. Angela Greatley**

- 6.1 This will also be Angela Greatley's last meeting as Trust Chair. I would also like to note the very special contribution which Angela has made to the Trust in her 6 years as Chair.

Paul Jenkins  
Chief Executive  
19<sup>th</sup> October 2015



## Board of Directors : October 2015

**Item :** 7

**Title :** Finance and Performance Report

**Summary:**

After the six months a surplus of £1,141k before restructuring is reported, £1,044k above the planned surplus of £97k. The main reason for the surplus is the number of vacancies across the organisation, partly offset by shortfalls on income.

The current forecast for the year is a surplus of £527k before restructuring. The cash balance at 30 September was £2,360k.

This report was reviewed at the Management Team, 20th October 2015.

**For :** Information.

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

## 1. External Assessments

### 1.1 Monitor

- 1.1.1 Monitor's assessment on Quarter 1 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 September submission the FSRR remained 4.

## 2. Finance

### 2.1 Income and Expenditure 2015/16

- 2.1.1 After September the trust is reporting a surplus of £1,141k before restructuring costs, £1,044k above budget. Income is £306k below budget, and expenditure £1,321k below budget.
- 2.1.2 The income shortfall at September of £306k is due to shortfalls on Training £159k, Consultancy £90k and Clinical £80k.
- 2.1.2.1 Training is £159k below plan due to Portfolio income being £94k below plan and a £49k shortfall on FNP project income.
- 2.1.2.2 Consultancy is £90k below budget, £68k of which is due to TC.
- 2.1.2.3 Clinical Income was £90k below budget at the end of September which was mainly due to a provision for the Hackney element of 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 £1,321k below budget was due mainly to the following areas.
- 2.1.3.1 Family Nurse Partnership (FNP) has a cumulative under spend of £244k due to £88k vacancies and lower than expected non pay costs of £156k. They are forecasting this to reduce to an £18k under spend by the end of the financial year.
- 2.1.3.2 GIDU are under spent £205k. Pay is £214k below budget due to a number of vacancies which will be covered by temporary staff which commenced in October. The under spend is expected to reduce to £60k by the end of the financial year.
- 2.1.3.3 Education and Training is under spent by £105k on pay which includes £66k from E-learning; this under spend is anticipated to reduce to £50k by year end. The Portfolios are also £116k under spent on pay and this is expected to be utilised before the end of the year.

- 2.1.3.4 Complex Needs is under spent £68k on pay due vacancies as staff transferred to Camden TAP and One Hackney project is £81k under spent on pay .
- 2.1.3.5 Portman is £109k under budget on pay this is due to a vacant consultants post plus additional budget due to the increased Probation Service income.
- 2.1.3.6 The remainder of the under spend was mostly vacancies spread across the organisation.
- 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 after restructuring of £171k is £121k above budget.
- 2.2.2 Clinical income is currently predicted to be £25k above budget due to £200k of old year funding for GIDU over performance offsetting the provision for under performance of £146k on the FDAC Service.
- 2.2.3 Training Portfolio income is forecast to be £394k below plan for this financial year due to student numbers being below target. Further detail is in 3.1.3
- 2.2.4 Visiting Lecturer costs are forecast to be £85k below budget.
- 2.2.5 TC expect their income to be £750k which is £163k below target. To offset this loss they forecast their expenditure will be £149k under spent.
- 2.2.6 The Portman Clinic are currently £116k below their expenditure budget and expect this increase to £177k by the end of the year.
- 2.2.7 Commercial Directorate are currently £52k over budget and this is expected to increase to £113k over spent by the end of the financial year due to temporary staffing requirements.
- 2.2.8 The forecast assumes that £100k of the contingency remains unutilised.

## 2.3 Cash Flow

- 2.3.1 The actual cash balance at 30 September £2,360k this is a decrease of £434k in month but is £572k above Plan. The balance was above Plan mainly due to the size of the surplus although this has been offset by delays in payment from Local Boroughs for a number of small contracts which are being pursued. Capital expenditure is £163k below Plan.
- 2.3.2 The Trust is arranging to renew our £1.0m working capital facility for 12 months from 1 November. As previously, this facility is not expected to be used, but would provide a back-up in the event of major delays in receiving payments from commissioners.

		Cash Flow year-to-date		
		Actual	Plan	Variance
		£000	£000	£000
Opening cash balance		2,761	2,761	0
Operational income received				
	NHS (excl HEE)	10,283	10,306	(23)
	General debtors (incl LAs)	5,100	5,692	(592)
	HEE for Training	5,555	5,359	196
	Students and sponsors	1,027	925	102
	Other	0	0	0
		21,965	22,282	(317)
Operational expenditure payments				
	Salaries (net)	(9,043)	(9,397)	354
	Tax, NI and Pension	(6,495)	(6,631)	136
	Suppliers	(5,077)	(5,294)	217
		(20,615)	(21,322)	706
Capital Expenditure		(1,562)	(1,725)	163
Interest Income		5	3	2
Payments from provisions		0	0	0
PDC Dividend Payments		(194)	(211)	17
Closing cash balance		2,360	1,788	572

## 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 September we achieved 85% (by number) for all invoices. The cumulative total for the year was 89%.

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

2.5.1 Appendix E reports the SoFP at 30 September, compared to the Plan figures.

2.5.2 Cash is above plan as mentioned in 2.3.1.

2.5.3 Trade Debtors are £1.5m above plan due to outstanding Local Authority payments for a number of contracts and NHS debtors being higher than expected. However, as of 19 October £500k of this has been received and the Local Authorities have agreed to pay the outstanding amounts. All outstanding debtors are regularly followed up by our shared services and where appropriate by our own finance team.

## 2.6 Capital Expenditure

2.6.1 Up to 30 September, expenditure on capital projects was £1,562k. This included £898k on the Modular Building and £263k on the IDCR project.

2.6.2 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 £2,892k.

Capital Projects 2015/16	Budget 2015/16	Actual YTD September 2015	Forecast 2015/16	Spend 2013/14	Spend 2014/15	Total Project	
						Spend to date	Budget to date
	£'000	£'000					
Toilets	100	15	100			115	100
Fire door	40	1	40			41	40
Boiler at the Portman Clinic	-	23	23			46	25
Relocation Project up to OBC	200	200	200	12	420	832	600
Relocation Project up to FBC	500		500				
Modular Building	825	898	898		14	1,810	925
DET refurbishment	63	16	63			79	63
Building Management system ext	10	-	10			10	10
Car Park Extraction Unit	70	-	70			70	70
<b>Total Estates</b>	<b>1,808</b>	<b>1,153</b>	<b>1,904</b>	<b>12</b>	<b>434</b>	<b>3,003</b>	<b>1,833</b>
IT Infrastructure	350	146	350			146	350
IDCR	400	263	263	-	389	548	789
Student record system	375		375				375
<b>Total IT</b>	<b>1,125</b>	<b>409</b>	<b>988</b>	<b>-</b>	<b>389</b>	<b>694</b>	<b>1,514</b>
<b>Total Capital Programme</b>	<b>2,933</b>	<b>1,562</b>	<b>2,892</b>	<b>12</b>	<b>823</b>	<b>3,698</b>	<b>3,347</b>

### 3. **Training**

#### 3.1 **Income**

3.1.1 Training income is £159k below budget in total after six months.

3.1.2 FNP income is currently being reported as £49k below budget and is expected to be £97k 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 517 year 1 students to date, compared to the target of 630. Across all years, student numbers on long courses are 74 short of plan. Currently, the academic year fee income for 2015-16 is forecast at £642k below Plan; £375k (7/12ths) of this shortfall is in this financial year. HEFCE income is expected to be in line with plan for the year: a gain in the first half may be fully offset by a shortfall in the remainder of the year.

3.1.4 The Education and Training expenditure is currently £317k lower than budget in all areas of the service line. The Department of Education and Training has current pay underspend due to a number of key posts being vacant to date. Some short-term posts have been and are being recruited to.

## 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 September actual income is £65k 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 £8k below target after September.

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	7,995	7,973	-0.3%	-42	126	Over performed on GIDU relating to 2014/15
NPAs	74	139	88.0%	131	55	Over performed on GIDU
Projects and other	582	537		-		Income matched to costs, so variance is largely offset.
Day Unit	410	402	-1.9%	-16	-10	
FDAC	1,210	1,138	-6.0%	-145	-146	
Total	10,270	10,189		-72	25	



## 5. Consultancy

5.1 TC are £67k behind budgeted target after six months. This consists of expenditure £2k underspent and consultancy £69k below budget. TC have currently reviewed their forecast income and expenditure for the rest of the year and estimate income to be £163k below target and expenditure to be £149k under spent.

5.2 Departmental consultancy is £22k below budget after September; £21k of the shortfall is within Children's, Young Adults and Families Services.

Carl Doherty  
Deputy Director of Finance  
19 October 2015

[illegible]

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST  
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2015-16

APPENDIX B

All figures £000

	Sep-15			CUMULATIVE			FORECAST FOR FULL YEAR			
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	OPENING BUDGET	REVISED BUDGET	FORECAST	VARIANCE FROM REV BUDGET
<b>INCOME</b>										
CENTRAL CLINICAL INCOME	623	614	(9)	3,702	3,728	26	7,035	7,404	7,390	(14)
CYAF CLINICAL INCOME	525	409	(116)	3,027	2,936	(91)	6,868	5,705	5,500	(204)
AFS CLINICAL INCOME	492	490	(3)	2,165	2,086	(79)	2,865	4,370	4,531	161
GENDER IDENTITY	229	229	0	1,375	1,440	64	2,648	2,751	2,833	82
NHS LONDON TRAINING CONTRACT	605	605	0	3,627	3,627	0	7,254	7,254	7,254	0
CHILD PSYCHOTHERAPY TRAINEES	179	191	12	1,074	1,071	(3)	2,148	2,148	2,142	(7)
JUNIOR MEDICAL STAFF	40	69	29	426	440	14	900	852	880	28
POSTGRADUATE MED & DENT'L EDUC	7	3	(4)	42	31	(11)	111	84	79	(5)
PORTFOLIO FEE INCOME	479	338	(141)	2,549	2,455	(94)	5,422	5,298	4,904	(394)
DET TRAINING FEES & ACADEMIC INCOME	224	250	26	746	730	(17)	1,373	976	1,065	89
FAMILY NURSE PARTNERSHIP	298	288	(10)	1,787	1,738	(49)	3,574	3,574	3,477	(97)
TC INCOME	76	77	1	466	389	(68)	925	913	750	(163)
CONSULTANCY INCOME CYAF	6	0	(6)	38	17	(21)	91	77	29	(48)
CONSULTANCY INCOME AFS	(6)	13	19	149	148	(1)	624	248	255	7
R&D	7	5	(3)	43	27	(15)	123	83	61	(21)
OTHER INCOME	57	41	(17)	255	292	38	819	457	486	29
<b>TOTAL INCOME</b>	<b>3,843</b>	<b>3,621</b>	<b>(221)</b>	<b>21,462</b>	<b>21,156</b>	<b>(306)</b>	<b>42,781</b>	<b>42,193</b>	<b>41,636</b>	<b>(558)</b>
<b>EXPENDITURE</b>										
COMPLEX NEEDS	311	266	45	1,682	1,505	177	2,662	3,483	3,279	205
PORTMAN CLINIC	156	107	49	797	681	116	1,421	1,605	1,428	177
GENDER IDENTITY	183	157	26	1,095	890	205	2,079	2,191	2,133	58
DEV PSYCHOTHERAPY UNIT	8	(7)	14	60	54	7	106	106	88	18
NON CAMDEN CAMHS	508	483	25	3,184	3,100	84	7,222	6,107	6,022	84
CAMDEN CAMHS	363	336	27	2,244	2,204	40	4,639	4,471	4,409	62
CHILD & FAMILY GENERAL	37	57	(19)	315	313	2	762	691	666	24
FAMILY NURSE PARTNERSHIP	259	255	4	1,556	1,312	244	3,112	3,112	3,094	18
JUNIOR MEDICAL STAFF	83	81	1	497	431	66	993	993	902	91
NHS LONDON FUNDED CP TRAINEES	179	187	(8)	1,074	1,067	7	2,148	2,148	2,134	15
TAVISTOCK SESSIONAL CP TRAINEES	2	1	0	9	7	2	19	19	15	4
FLEXIBLE TRAINEE DOCTORS & PGMC	(12)	14	(25)	117	95	22	309	234	207	28
EDUCATION & TRAINING	444	421	23	1,994	1,833	161	3,906	3,604	3,554	50
VISITING LECTURER FEES	111	72	39	663	582	82	1,332	1,332	1,247	85
CYAF EDUCATION & TRAINING	42	42	(0)	205	256	(51)	1,503	429	429	0
ADULT EDUCATION & TRAINING	39	29	10	162	163	(1)	1,015	334	334	0
PORTFOLIOS	143	111	32	857	730	127	0	1,714	1,714	0
TC EDUCATION & TRAINING	0	0	0	0	1	(1)	0	0	0	0
TC	64	51	12	382	381	2	787	765	616	149
R&D	17	15	2	101	47	53	238	201	159	42
ESTATES DEPT	159	172	(13)	1,005	1,127	(122)	2,090	1,960	2,038	(78)
FINANCE, ICT & INFORMATICS	172	170	2	1,078	1,105	(26)	2,295	2,113	2,171	(59)
TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	93	95	(2)	552	551	1	981	1,103	1,109	(6)
COMMERCIAL DIRECTORATE	37	61	(24)	230	281	(52)	454	449	563	(113)
HUMAN RESOURCES	48	47	2	307	339	(32)	652	614	654	(39)
CLINICAL GOVERNANCE	91	68	23	404	368	36	824	808	718	90
CEA CONTRIBUTION	6	6	0	35	60	(25)	0	70	95	(25)
DEPRECIATION & AMORTISATION	65	62	2	387	354	34	775	775	775	0
VACANCY FACTOR	0	0	0	0	0	0	(134)	0	0	0
PRODUCTIVITY SAVINGS	0	0	0	0	0	0	(80)	0	0	0
INVESTMENT RESERVE	0	0	0	0	0	0	0	0	0	0
CENTRAL RESERVES	108	0	108	164	0	164	205	296	196	100
<b>TOTAL EXPENDITURE</b>	<b>3,715</b>	<b>3,359</b>	<b>356</b>	<b>21,157</b>	<b>19,836</b>	<b>1,321</b>	<b>42,314</b>	<b>41,727</b>	<b>40,748</b>	<b>979</b>
<b>OPERATING SURPLUS/(DEFICIT)</b>	<b>128</b>	<b>262</b>	<b>134</b>	<b>305</b>	<b>1,320</b>	<b>1,015</b>	<b>466</b>	<b>466</b>	<b>888</b>	<b>422</b>
INTEREST RECEIVABLE	0	1	1	2	5	2	5	5	8	3
DIVIDEND ON PDC	(35)	(9)	26	(210)	(184)	26	(421)	(421)	(368)	53
<b>SURPLUS/(DEFICIT)</b>	<b>93</b>	<b>255</b>	<b>162</b>	<b>97</b>	<b>1,141</b>	<b>1,044</b>	<b>50</b>	<b>50</b>	<b>527</b>	<b>477</b>
<b>RESTRUCTURING COSTS</b>	<b>0</b>	<b>42</b>	<b>(42)</b>	<b>0</b>	<b>110</b>	<b>(110)</b>	<b>0</b>	<b>0</b>	<b>357</b>	<b>(357)</b>
<b>SURPLUS/(DEFICIT) AFTER RESTRUCTURING</b>	<b>93</b>	<b>213</b>	<b>120</b>	<b>97</b>	<b>1,030</b>	<b>934</b>	<b>50</b>	<b>50</b>	<b>171</b>	<b>121</b>

APPENDIX D											
2015/16 Plan	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Total £000
Operating cash balance	2,761	5,420	4,596	4,150	4,621	3,087	1,788	4,108	3,170	1,794	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	17,397
General debtors (incl LAs)	1,171	894	1,000	857	985	785	1,470	1,049	923	1,520	13,063
HEE for Training	2,457	142	79	2,457	143	79	2,457	142	79	2,457	10,717
Students and sponsors	325	150	150	100	0	200	800	250	100	750	3,025
Other	0	0	0	0	0	0	0	0	0	0	0
Operational expenditure payments	6,453	3,101	3,152	4,802	2,433	2,339	5,893	2,645	2,277	5,893	44,202
Salaries (net)	(1,622)	(1,422)	(1,433)	(1,833)	(1,633)	(1,454)	(1,485)	(1,471)	(1,468)	(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)	(13,435)
Suppliers	(1,072)	(838)	(865)	(1,090)	(865)	(565)	(865)	(865)	(865)	(865)	(10,481)
Capital Expenditure	(3,794)	(3,361)	(3,399)	(4,032)	(3,608)	(3,129)	(3,474)	(3,483)	(3,470)	(3,462)	(42,123)
Loan	0	(565)	(200)	(300)	(360)	(300)	(100)	(100)	(185)	(100)	(2,370)
Interest Income	0	1	0	1	0	1	0	0	1	0	5
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	0	0	0	0	0	(211)	0	0	0	0	(421)
Closing cash balance	5,420	4,596	4,150	4,621	3,087	1,788	4,108	3,170	1,794	4,126	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	Total £000
Operating cash balance	2,761	3,793	2,340	1,592	4,403	2,794	2,360	4,679	3,642	2,215	2,761
Operational income received											
NHS (excl HEE)	1,274	2,238	1,379	2,829	1,254	1,309	1,166	1,204	1,175	1,166	17,374
General debtors (incl LAs)	1,120	125	828	1,104	495	1,428	1,470	1,049	923	1,520	12,471
HEE for Training	2,471	118	202	2,597	60	107	2,457	142	79	2,457	10,914
Students and sponsors	356	87	95	87	121	281	800	250	100	750	3,127
Other	0	0	0	0	0	0	0	0	0	0	0
Operational expenditure payments	5,221	2,568	2,504	6,617	1,930	3,125	5,893	2,645	2,277	5,893	43,886
Salaries (net)	(1,541)	(1,455)	(1,499)	(1,527)	(1,641)	(1,381)	(1,485)	(1,471)	(1,468)	(1,462)	(17,853)
Tax, NI and Pension	(1,068)	(1,127)	(1,062)	(1,086)	(1,110)	(1,110)	(1,124)	(1,147)	(1,137)	(1,135)	(13,299)
Suppliers	(1,317)	(882)	(241)	(1,138)	(752)	(747)	(865)	(865)	(865)	(865)	(10,264)
Capital Expenditure	(3,925)	(3,463)	(2,802)	(3,751)	(3,436)	(3,238)	(3,474)	(3,483)	(3,470)	(3,462)	(41,416)
Loan	(264)	(559)	(451)	(56)	(104)	(128)	(100)	(200)	(236)	(200)	(2,658)
Interest Income	0	0	0	0	0	0	0	0	0	0	0
Payments from provisions	0	1	1	1	1	1	0	0	1	0	7
PDC Dividend Payments	0	0	0	0	0	0	0	0	0	0	0
Closing cash balance	3,793	2,340	1,592	4,403	2,794	2,360	4,679	3,642	2,215	4,446	2,175

STATEMENT OF FINANCIAL POSITION	Plan	Actual	Variance	Appendix E
	30 September 2015 £000	30 September 2015 £000	30 September 2015 £000	31 March 2015 £000
<b>Non-current assets</b>				
Intangible assets	52	26	(26)	52
Property, plant and equipment	16,113	16,009	(104)	14,776
<b>Total non-current assets</b>	<b>16,165</b>	<b>16,035</b>	<b>(130)</b>	<b>14,828</b>
<b>Current assets</b>				
Inventories				
Trade and other receivables	4,121	5,640	1,519	5,479
Cash and cash equivalents	1,792	2,360	568	2,761
<b>Total current assets</b>	<b>5,913</b>	<b>8,000</b>	<b>2,087</b>	<b>8,240</b>
<b>Current liabilities</b>				
Trade and other payables	(3,500)	(4,062)	(562)	(5,085)
Provisions	0	(6)	(6)	(6)
Tax payable	(650)	(608)	42	(651)
Other liabilities	(2,750)	(3,055)	(305)	(2,123)
<b>Total current liabilities</b>	<b>(6,900)</b>	<b>(7,731)</b>	<b>(831)</b>	<b>(7,865)</b>
<b>Total assets less current liabilities</b>	<b>15,178</b>	<b>16,304</b>	<b>1,126</b>	<b>15,203</b>
<b>Non-current liabilities</b>				
Loans	0	0	0	0
Provisions	(65)	(114)	(49)	(117)
<b>Total non-current liabilities</b>	<b>(65)</b>	<b>(114)</b>	<b>(49)</b>	<b>(117)</b>
<b>Total assets employed</b>	<b>15,113</b>	<b>16,190</b>	<b>1,077</b>	<b>15,086</b>
<b>Financed by (taxpayers' equity)</b>				
Public Dividend Capital	3,474	3,474	0	3,474
Revaluation reserve	8,763	8,764	1	8,763
Income and expenditure reserve	2,876	3,952	1,076	2,849
<b>Total taxpayers' equity</b>	<b>15,113</b>	<b>16,190</b>	<b>1,077</b>	<b>15,086</b>



## Board of Directors : October 2015

**Item :** 8

**Title:** Training & Education 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 5<sup>th</sup> October 2015.

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

- Quality
- Risk
- Finance
- Productivity

**For :** Noting

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

# Training & Education Board Report

## 1. Introduction

- 1.1 The Training and Education Programme Management Board met on Monday 5<sup>th</sup> October 2015 and discussed the following areas.

## 2 Office Reconfiguration

- 2.1 Brian Rock informed the programme board that phase 1 of the office reconfiguration was complete with staff returning to the new offices in mid-September.
- 2.2 The response to the change has been positive with staff commenting on the look and feel of the office as well as appreciating the level of transparency it has provided.
- 2.3 Plans for the development of the proposal for Phase 2 are underway. This is scheduled for discussion at the November TEPMB and for approval to be sought from the Board in November. Proposed works would likely to take place over Easter 2016 with some minor works occurring over Christmas this year.
- 2.4 Brian thanked Fiona Hartnett, Dean's Office Manager, for her work in coordinating the project.

## 3 Visiting Lecturers

- 3.1 Karen Tanner updated the programme board on the work of the Visiting Lecturer review.
- 3.2 Herself, Susan Thomas and Fiona Hartnett have been meeting to scope out the work of the project. They are looking to recruit a temporary member of staff to assist in data collection.
- 3.3 She confirmed that the VL's that have raised these issues have been communicated with as to the Trust's decision and we are awaiting their response.

## 4 Restructuring

- 4.1 A proposal on a restructure of staffing in education and training was brought to the programme board for its consideration and endorsement.
- 4.2 The proposal was written with the aim of further aligning roles in the department within structural changes that have already occurred such as the recruitment of portfolio managers.



- 4.3 The programme board discussed the importance of bringing these changes alongside process change to improve practices. It was emphasised that these structural changes were necessary to bring about process change.
- 4.4 It was requested that consideration was given to the possibility of making cost savings through this restructuring.
- 4.5 The programme board gave its support to the proposal

## **5 Regional Strategy**

- 5.1 Karen Tanner presented an update on this item to the programme board.
- 5.2 She has continued to meet with the various centres around the country. Brian Rock & Karen Tanner are working closely with NSCAP to develop the partnership further, which would enable us to deliver more trainings in the North West.
- 5.3 She visited Penn Green on 14<sup>th</sup> October to discuss the possibilities of becoming an associate centre.

## **6 National Contract**

- 6.1 Paul Jenkins explained to the programme board that Liz Hughes, Regional Director of Education & Quality, was leading on the HEE review into the national contract
- 6.2 He provided a paper that outlined the scope of the Trust's plans for taking it forward. He highlighted the lack of support from education directors outside London.
- 6.3 A further update will be brought when he has a response from HEE as to the next steps.

**Brian Rock**

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



## Board of Directors : October 2015

**Item : 9**

**Title :** Draft Clinical Quality Strategy

**Purpose:**

This draft Clinical Quality Strategy sets out our approach to the maintenance and improvement of the quality of healthcare we deliver.

**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

# Clinical Quality Strategy 2015-2017

## 1. Introduction

- 1.2 The Tavistock and Portman NHS Foundation Trust aims to deliver high quality healthcare to our patients. This Quality Strategy supports the ambitions and objectives of the Trust to innovate, to grow and to improve healthcare and outcomes.
- 1.2 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. Post Francis, the Berwick report identified organisational culture and leadership as additional significant elements of quality. See Appendix 1 for an overview of national drivers of the quality agenda.



## 2. Local Drivers of Quality

- 2.1 Securing and improving quality cannot be achieved in isolation. To this end, there are a number of key local drivers which will support the overarching direction of travel and delivery of the Trust's strategic objectives. Our two-year objectives and 5-year ambitions are integral to our clinical quality 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. Our Approach

- 4.1 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.
- 4.2 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.

- 4.3 In 2014, the Trust appointed a Director of Quality and Patient Experience to lead the Trust's work on embedding and evaluating the quality of clinical services, placing patient experience and participation as central to the effective delivery of high quality services.
- 4.4 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.
- 4.5 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.
- 4.6 We work closely with our many stakeholders to ensure that they have every opportunity to contribute to our plans, and to monitor our progress. The Clinical Quality Review Group (comprising Clinical Commissioning Group and Commissioning Support Unit representatives) is central to these iterative processes.
- 4.7 Our Council of Governors is fully committed to our quality agenda.
- 4.8 The influence of the Council of Governors is interwoven in all the key decision-making processes and they via attendance at key committee meetings and fora including:
  - Patient and Public Involvement (PPI) Meeting
  - Clinical Quality, Safety, and Governance Committee (CQSG)
  - Equalities Committee
  - Quality Stakeholders Meeting
  - Governors Clinical Quality Meeting

## 5. Key Outcomes

- 5.1 The key outcome expected as result of our Clinical Quality Strategy is to be able to qualitatively and quantitatively demonstrate year on year continuous quality improvements within services and improved outcomes for patients.
- 5.2 Ten key areas for quality maintenance and improvement
  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 and comfortable settings affording patients privacy and dignity at all times.
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, 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.
7. To communicate our learning across the Trust ensuring that everyone from the frontline staff to the Board of Directors are aware of the areas we have identified as needing improvement and the quality improvement plans we have developed in response.
8. To support 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 care

## 6. Quality Domain Summaries

6.1 A summary of the aims for each of the key quality domains at the heart of our strategy can be found below:

### 6.2 Caring

- We want all our service users 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 our services through providing information on our services in a range of formats so that can make informed choices.
- We ensure patients do not have lengthy waits for an initial appointment and keep them informed and supported if they wait for 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.

### 6.3 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 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 propose 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 supervised. We also 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.

### 6.4 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.



## 6.5 Responsive

- To run our services based primarily on the needs of the user, involving users 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.

## 6.6 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 team, service line and Trust Board levels of leadership and ensure that there are good systems in place for gathering and using feedback from people.
- We promote an open culture where staff are encouraged to report incidents or propose improvements.
- 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. **Clinical Quality Priorities for 2015-16**

7.1 We are fully committed to improving quality across every aspect of the Trust's work, building further on what we have achieved in previous years. Clinical quality priorities are determined through consultation with stakeholders including Clinical Commissioners, service users, staff and Healthwatch.

7.2 Our Quality Priorities for 2015/16 will focus on:

- Continuing to demonstrate further positive changes for patients, as a consequence of the psychological intervention/treatment they receive from the Trust.
- Increasing the involvement of service users across our work including increasing representation on interview panels and working to ensure that this is a positive and valuable experience for the service users who volunteer to do this.
- Developing a quarterly PPI newsletter for Trust staff and service users to include updates on patient stories.
- For the PPI team to improve its presence on the Trust website.

Action plans for each of these areas have been developed and are monitored on a quarterly basis by our Management Team and our Trust Board.

## 8. Supporting Groups

- 8.1 Relevant, valid and accessible data is essential to the demonstration of 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.
- 8.2 The implementation of the new CareNotes clinical record system will in due course improve our capacity. Further developments of the system will include a patient portal .The planned appointment of a Clinical Information Development Lead within the year will allow the development of the use of information to support innovative health care and self -care for service users.
- 8.3 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.

### 8.4 Clinical Quality Task Force

In order to drive forward progress on achieving our clinical quality objectives, we have set up a quality taskforce, chaired by the Director of Quality and Patient Experience and working to a programme that is in line with the Care Quality Commission Key Lines of Enquiry. Five work stream leads covering the domains of Caring, Leadership, Effectiveness, Patient Responsiveness and Safety report fortnightly to the taskforce. Membership of the taskforce includes the Directors of CYAF and AFS, the Medical Director, a service user representative and a Non-Executive Director

- 8.5 Three new groups have been established. See Appendices 2, 3 and 4 for terms of reference:
  1. Data Analysis and Reporting Committee: This is a strategic objective setting group and will direct activity and commission solutions to problems.
  2. Clinical Quality and Patient Experience work stream: This provides the assurance that the above and related activity is effective.
  3. Quality Group: This is the operational data management group.

## **9. Promoting quality and learning from experience**

- 9.1 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.

## **10. Staff training**

- 10.1 A well-trained and up to date work force is essential to the delivery of high quality services.
- 10.2 A programme of 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.

## **11. Communications**

- 11.1 Over 2015-16 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, etc.
- 11.2 Quality News was established in 2014-15 and we plan to produce 4 issues a year each with a specific focus. Quality News is a vehicle for disseminating learning from clinical incidents, complaints and service user feedback across the Trust.

## **12. Ensuring Learning across the Trust**

New 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, e.g. 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.

## **13. Service Redesign, Quality Improvement Projects and Clinical Research**

- 13.1 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.
- 13.2 We do this through developing and implementing new systems of service delivery and new models of clinical practice.

**13.3 Examples of development and implementation in 2015-16 include:**

- THRIVE
- MBT for ASPD
- Camden Team Around the Practice

13.3 In line with our Operational Plan, some services will be redesigned. We are piloting Quality Impact Risk Assessment tool for service redesign projects. This will be rolled out to all service developments once it has been fine-tuned.

**14. Clinical Research**

14.1 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.

**14.2 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

**15. Allied Strategies and Plans**

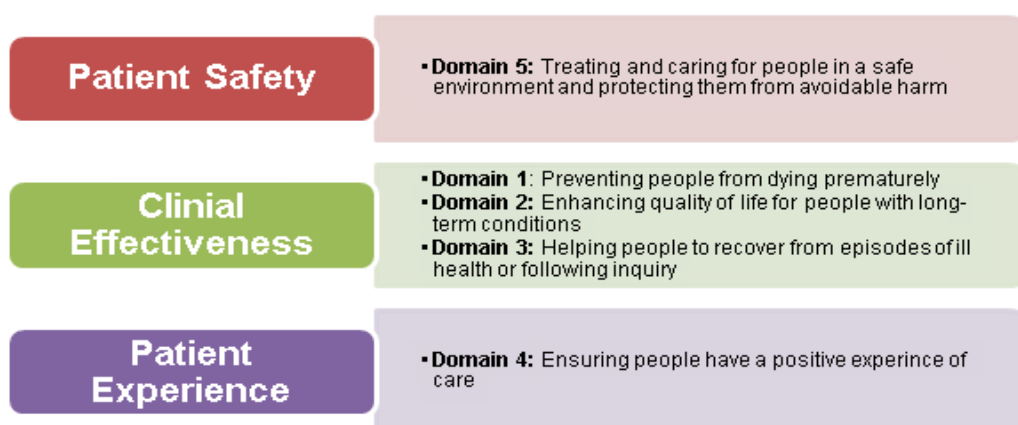
- Patient and Public Involvement Strategy
- Equalities annual plan and priorities

## 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.

## APPENDIX 2

# Terms of Reference

## Data Analysis and Reporting Committee

1. Set data collection strategy that incorporate the Board's strategic plan, NICE guidelines, commissioner requirements, and regulatory expectations.
2. Review the work of the Quality Group to ensure that data management is aligned with these objectives at service line level
3. Ensure that the quality of data is of a high standard so that strategic decisions can be based on best possible information
4. Review evidence that data analysis is influencing clinical practice
5. Review evidence that data analysis is influencing service development
6. Ensure that data can be benchmarked against other providers' data for similar services
7. Direct how the Trust's data is presented in reports to external bodies

### Typical Annual Work Plan

The first meeting will follow the Board at which the annual strategic plan is set, the second needs to be in time to inform the annual planning process. So a DARC meeting would explore:-

QUARTER 1	QUARTER 3/4
<p>In the context of the Trust's strategic aims and mission:-</p> <ul style="list-style-type: none"> <li>• Note CQUINs and KPIs etc. for the current year</li> <li>• Discuss any essential issues which might affect the delivery of the agreed targets.</li> <li>• Task the Quality Group to ensure plans are in place to deliver the agreed targets across all relevant Trust service lines and are monitored on a monthly basis and reported to Service Line Management.</li> </ul>	<ul style="list-style-type: none"> <li>• Review metadata to measure outcomes against DARC TOR</li> <li>• Agree themes for narrative in Quality Report</li> <li>• Identify areas that need to be addressed in the following year's strategy</li> <li>• Review progress against previous action plans</li> </ul>

### Assurance

Clinical Data Assurance will be provided by the Clinical Quality and Patient Experience work stream of the CQSG as agreed at the Board.

## APPENDIX 3

### Terms of Reference

#### Clinical Quality and Patient Experience Workstream

1. Directors of clinical services have plans in place to improve the culture and practice of data collection, management and quality.
2. Reports provide assurance that outcome data demonstrates improved outcomes at individual and patient group levels and that the results, where they can be benchmarked, compare favourably against those of other providers.
3. Outcome monitoring methodology best suits the Trust's patient population.
4. Data to be collected have been agreed by commissioners and other appropriate external parties.
5. The annual audit programme is aligned with organisational priorities as set out in the annual organisational plan.
6. The implementation of outcomes of the recommendations of clinical audits leads to improvements in patient care.
7. 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.
8. The feedback from the Experience of Service Questionnaire is dealt with effectively, both individually and by analysing trends and common issues.
9. Members contribute to strategic discussions to aid planning based on data from all available sources.
10. The Trust has prepared for inspections from the regulator of clinical services.
11. The group needs to provide assurance so that the Trust knows.
  - What are we doing?
  - How are we going to do it?
  - Were we any good?
  - Are we getting better?
  - How can we tell the story?

The Clinical Quality and Patient Experience covers the following areas of enquiry:

Process	Assurance task
<b>Discharging CQPETOR</b>	That CQRG expectations, regulatory expectations, annual plan objectives are being addressed.
<b>Quality assurance activity</b>	That there are effective procedures, audit exercises, data collection, benchmarking exercises, surveys scheduled and carried out.
<b>Outcomes reporting last quarter</b>	That quarterly results, or results reporting in the quarter that are half-yearly or annual, are being collected and considered in a timely manner and inform quality management and development.
<b>Trends</b>	That data, e.g. graphs over time of the outcomes, is being analysed from a long-term perspective in relation to the long term cyclical nature of mental health episodes.
<b>Reports</b>	That quality reports, including the respective section in the annual report, are being developed and produced to high quality which supports quality development.

It is proposed that the clinical quality sections of every service line report are reviewed periodically, probably one to three per quarter; the report would provide assurance that performance reporting is based on robust data and is making a difference to patients. A *pro forma* report needs to be developed based on the above.

This group will develop its methodology and approach over 2015-6 and will put in place a new integrated reporting and assurance framework for 2016-17



## APPENDIX 4

### Quality Group

1. The Quality Group, with the support provided by the manager in collaboration with the patient experience team, will be the engine of the system.
2. Its purpose is:
  - To provide monthly reporting dashboards to service line management in relation to both internal and external reporting targets including CQUIN, KPIs etc.



## Board of Directors : October 2015

**Item :** 10

**Title :** Quarter 2 Governance statement

### **Purpose:**

The Board of Directors is asked to approve three elements of the governance statement to be submitted to Monitor for quarter 2:

#### 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 Management Team on 13 October, 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

## Quarter 2 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 October, 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, 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, and there could be scope to avoid it through delaying capital expenditure if necessary.
- 2.6 We are now required to make a declaration covering the 12 months to September 2016, and so including the first half of 2016/17. Financial projections for the medium-term strategy set out the Trust's plans and targets to remain in a satisfactory financial position next year; though the necessary growth and savings have not yet been secured.
- 2.7 Based on the above, we are able to affirm that we anticipate that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.
- 2.8 The statement about capital expenditure (see cover sheet of this paper) is a new requirement. A revised forecast for 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. Governance Declaration**

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

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

Target/Indicator	Weighting	Quarter 2 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 Trust Lead for Vulnerable Adults reviewed the Self certification against compliance with requirements regarding access to healthcare for people with a learning disability in December 2012.

3.3.2 The Trust has continued to develop its services for LD service users, and actively involves users to further refine and tailor provision. As reported last quarter, for example, the LD team is currently working

with service users on an App to act as an adjunct to therapeutic support.

### 3.4 Data Completeness

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

	Month 4, final	Month 5, provisional
Valid NHS number	99.43%	99.56%
Valid Postcode	99.81%	99.72%
Valid Date of Birth	100.00%	100.00%
Valid Organisation code of Commissioner	98.06%	98.40%
Valid Organisation code GP Practice	99.39%	99.00%
Valid Gender	99.89%	99.88%

## 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  
13 October 2015





# Board of Directors : October 2015

**Item : 11**

**Title : Quarterly Quality Report 2015-16 , Quarter 2**

## **Summary:**

The report provides an update of the Key Performance Indicators (KPIs), CQUIN and Quality Indicator targets for Quarter 2, 2015-16. It has been updated to incorporate the new KPI and CQUIN targets for 2015-16 agreed with commissioners and the Quality Indicator targets selected by the Trust. The report combines the performance data reported to the Board and commissioners (CQRG) into a single report.

This report has been reviewed by the following Committee:

- **Management Team, 20<sup>th</sup> October 2015**

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

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

- Quality
- Patient / User Experience
- Safety

**For : Noting**

**From : Associate Director of Quality**



# Tavistock and Portman NHS Foundation Trust Quarterly Quality Report for Board of Directors & CQRG

Quarter 2: September, 2015/16

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## Section One: KPIs for TPFT

Quality Key Performance Indicators – KPIs rolled over from last financial year														
Target	Monitoring	Target%	Progress						% Progress for 2015/16					
			Q1		Q2		Q3		Q1	Q2	Q3	Q4		
			N	%	N	%	N	%						
<b>Waiting Times*</b> 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	2	0.5%	5	1.3%								
<b>DNA</b> Adult DNA rates: Yearly average no larger than 10%.	Quarterly	10%	7%		6%									
<b>Patient Satisfaction</b> Patient Satisfaction: Target 92% or more report satisfied with the service.	Quarterly	92%	N	%	N	%	N	%	N	%				
			210	92%	102	94%								
<b>Personal Development Plan</b> Quality and Development of staff: Target 80% of staff to have a PDP.	Quarterly	80%	99%		99%									
<b>Sickness and Absence</b> Sickness and absence rates. Target: <2% green (2-6% amber, >6% red)	6 monthly	<2%	n/a this quarter		0.7									
<b>Trust Service cancellation rates</b> Target: <5% green (5-9% amber, >10% red)	Quarterly	<5%	2.4%		2.3%									
<b>Staff Training</b> % of staff with up-to-date mandatory training for infection control. Target >95% green. 80-95% is amber < or = 80% red.	Annually	>95%	n/a this quarter											
<b>DBS Checks</b> 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 Quarter 2, there were 9 waiting time breaches, where patients were required to wait eleven weeks or longer for their first appointment. However, only 5 of these breaches related to factors internal to the Trust and represented 1.3 % of the total number of patients who were offered a first appointment in Quarter 2. These related to Adults, Portman and Camden CAMHS services. Waiting times ranged between 11 weeks (and 1 day) to 21 weeks.

# KPIs for TPFT

Quality Key Performance Indicators												
Target	Monitoring	Target %	Progress				% Progress for 2015/16					
			Q1		Q2		Q3		Q4		Q1	Q2
			N	%	N	%	N	%	N	%		
<b>Explanation of Service</b> Number and % of children who answer certainly agree that they received a clear explanation of service (ESQ)	Quarterly	75%	41	77%	34	97%						
<b>Care Plans</b> A - % of care plans evidencing co-production with service users*	6 monthly	n/a	n/a this quarter		See narrative below							
			n/a this quarter		See narrative below							
B - % of care plans evidencing input from primary care (Baseline for 15/16)**												

\*Care plan information is completed for each patient following assessment. This is co-produced with the service user and a copy is 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. It would be possible to add another field for the clinician to confirm if they had co-produced the plan with the user.  
 \*\*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.

Quality Key Performance Indicators									
Target	Monitoring	Target%	Progress		% Progress for 2015/16				
			Q1	Q2	Q3	Q4	Q1	Q2	
% Response to Complaints									
A - 90% of complaints acknowledged within 3 working days.*			100%	88%					
B - 80% of complaints responded to within 25 working days.			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 this quarter	n/a					
D - 100% of upheld complaints identify learning and improvements as a result.			100%	100%					
E - Trends and themes of PALS concerns and complaints identified and published on a quarterly basis.			n/a this quarter	Annual PPI report published this quarter					
F - Implementation of actions plan			n/a	n/a					
<b>Complaints and Claims</b>									
A - Provide quarterly complaints and claims update to include:									
i) no. of complaints where response is outstanding at 3 months and reasons why			0	0					
ii) Number of complaints reported to CQC			0	0					
iii) Numbers of complaints partially and fully upheld by Parliamentary Ombudsman			0	0					
iv) Number of re-opened complaints.			0	0					
v) all legal claims acknowledged within 14 days			0	1					

\* In Q2 there were 9 complaints received by the Trust.. 1 was not acknowledged within 3 working days. Please see CGR Report for further details.

Quality Key Performance Indicators										
Target	Monitoring	Target %	Progress				% Progress for 2015/16			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>B - Provide bi-annual complaints and claims lessons learnt report with:</b> i) Themes of lessons learnt including breakdown of clinical policy/clinical pathway areas where complaints are made ii) Detail of actions undertaken as a result of complaints	Quarterly	n/a	n/a this quarter	Achieved*						
			n/a this quarter	Achieved*						
<b>Serious Incidents</b>			<b>July 15</b>	<b>August 15</b>	<b>Sept 15</b>					
<b>Improvement trajectory agreed for the following:</b> A - % of Serious Incidents (SI) submitted within the designated timescale	Monthly		0	0	1					
B - Where SI reports are returned incomplete, % returned complete within 10 working days.	Quarterly	n/a	0	n/a						
C - Evidence of implementation of action plans	6 Monthly Audit		n/a this quarter	n/a this quarter						
D - Organisational learning identified and actions embedded as a result in 100% of SIs.	Q4		n/a	n/a						
<b>Safeguarding</b> Completion and submission of the NCL Safeguarding Children and Adult Metrics Return	Quarterly	n/a	Achieved	Agreed submission date: 17 <sup>th</sup> October 2015						
<b>Female Genital Mutilation**</b> A - To include FGM as part of mandatory safeguarding training levels 1, 2 & 3, 80% of staff will be trained in safeguarding B - Safeguarding alerts raised and number counted within service in accordance with NICE guidance	Quarterly	80%	L1: n/a	L1: n/a	L1: n/a	L1: n/a				
			L2: 98%	L2: 98%	L2:	L2:				
			L3: 94%	L3: 93%	L3:	L3:				
			0	1						

\* Results published in Q2 Corporate Governance and Patient Safety and Risk Compliance Report

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



## KPIs NCL Trusts

Quality Key Performance Indicators										
Target	Monitoring	Target %	Progress				% Progress for 2015/16			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>Compliance</b> Compliance with relevant standards of the Mental Capacity Act are completed and DOL applications and outcomes.*	Quarterly	n/a	Yes	Yes						
<b>Audit of Trust Consent Policy standards</b> To perform an audit on 20 patient notes in Q2.	Q2 Audit	n/a	n/a this quarter	Audit delayed due to Carenotes migration. To be completed in Q3.						
<b>Assessment Reports</b> 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.						
<b>Clinical Audit</b> A - Provide CCGs with copy of Trust wide audit program in Q1.	Q1 Audit		Provided in Q4 14/15	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 this quarter	Updated schedule will be provided with CCG papers this quarter						
C - Provide CCGs with copies of Clinical Audit Annual report to include learning the lessons from audit, demonstrating achievement of outcomes	6 Monthly Audit		n/a this quarter	n/a						
<b>Reporting on Guidelines</b> Report on compliance with new relevant NICE Clinical Guidelines, Quality Standards and Technology appraisals within 3 months of publication date.	6 Monthly	n/a	n/a this quarter	NICE compliance report to be reviewed by the Trust Clinical Effectiveness lead by Oct 2015						
<b>Mandatory Training**</b> % of eligible staff are currently compliant on all of their mandatory training	Quarterly	80%	93%	94%						
<b>Enhanced DBS checks</b> Enhanced DBS checks for 100% of all relevant staff including renewals every 3 years for all staff in direct contact with Adult at risk, children and patient data. To include locums, temporary staff and sub-contractors.	Quarterly	100%	98%	96%***						

\*The Trust to provide 11 MCA training dates to staff over the course of 2015/16. However, the DOL applications and outcomes is not applicable to the TPFT.

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

\*\*\*The Trust failed to reach 100% due to 20 outstanding DBS checks. Reasons being: 2 career break, 8 secondment, 5 maternity leave and 5 Risk Assessment form

# KPIs NCL Trusts

Quality Key Performance Indicators									
Target	Monitoring	Target %	Progress		% Progress for 2015/16				
			Q1	Q2	Q3	Q4	Q1	Q2	Q3 Q4
<b>Staff FFT and Annual Staff Survey</b> 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*					
<b>Friends and Family Test</b> % of positive responses on the FFT	Quarterly	90%	94%	93%					
<b>Staff Appraisals</b> Number of Staff Appraisals completed	Quarterly	80%	99%	99%					
<b>Staff Absence</b> % Sickness Absence rate less than 2% for all staff groups	Quarterly	<2%	0.8%	0.8%					
<b>Duty of Candour</b> 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					
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.					

\* Compared to Q2 2014/15, 102 more responses were received for Q2 2015/16 (an increase of 18%).

Quality Key Performance Indicators										
Target	Monitoring	Target%	Progress				% Progress for 2015/16			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>GP satisfaction with communication received from Trusts</b> > above 60% of GPs who respond to be satisfied with communication from MH Trust Services	Annual	>60%	Survey confirmed and to be sent out in Q3. Q4				Survey results to be published Q4			
<b>Local participation in Suicide Prevention</b> Trust will comply with requirements on Mental Health Trusts outlined in the National Suicide Prevention Strategy (2012)	Quarterly	n/a	Achieved	Achieved						
<b>Physical Health Care</b> Evidence of physical health addressed across all mental health services	Annual	n/a	n/a this quarter	Achieved: Physical health form now implemented on Carenotes. From Q3, all staff now have access.						
<b>Clinical Risk Assessments</b> Annual Audit presented to CQRG	Annual Audit	n/a	n/a this quarter	Audit to be undertaken Q4						
<b>Adherence to Crisis Concordat standards</b> Baseline in 2015/16	Annual	n/a	n/a this quarter	Results due in Q4						
<b>Crisis Concordat standards - Crisis plan</b> Bi-annual Percentage of patients who have been offered a crisis plan for emergency mental health situation	6 monthly	95%	n/a this quarter	100%						
<b>Equality and Diversity - BME access to 'talking therapies'</b> Percentage BME access to 'talking therapies' (Baseline in 2015/16)	Quarterly	n/a	July 15 36% (5174)	August 15 32% (2330)	Sept 15 34% (4123)					
<b>NICE guidance - Bipolar Disorder (CG185, Sept 2014) - CBT/psychological treatment</b> Baseline in 2015/16, Proportion of patients with a diagnosis of bipolar disorder offered CBT/psychological treatment	Quarterly	n/a	0.62% (13 patients)	0.64% (15 patients)						

\* This KPI is looking at reporting the number of BME patients who attend appointments Trustwide in all services (Generic & Portman) on a monthly basis. Those attending more than once in a month are only counted once. A total of 11627 patients were seen over the quarter, 4021 were BME, resulting in 36% BME for the entire quarter.

\*\* Total of 2340 unique patients seen in Q2 (excluding GIDS service)

## Section Two: Generic Service CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q2	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Children Young Adult and Families (CYAF) (Outcome monitoring)	For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at the Pre-assessment stage (known as Time 1) and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	Q1-Q4	Informatics working on this	80%	Informatics working on this				
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	Informatics working on this	75%	Informatics working on this				
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	Achieved: 71%	50%	Achieved target: Improvement rate for period April 2015 - September 2015: Adult and Adolescent (combined) % = 71%  Improvement by individual services: Adolescents = 70% Adults % = 73%.	64%	71%		

## Physical Health CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q2	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	Not achieved: 5.5%	95%	Q2 poor performance is due to: Rio to Carenotes data migration complications and lack of clinical staff knowledge of the Physical Health Form. Staff training is now underway.				
	Very brief advice for 95% of patients recorded as current smoker	Q1-Q4	Not achieved	95%	No data recorded				
	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	Not achieved	n/a	Physical Health Nurse to start on 16th October 2015. No data to currently report due to this.*				
	Quit attempts, initiation of treatment and referral of patients by Physical Health Practitioner to community stop smoking centres for on-going support.	Q1-Q4	Not achieved	n/a	Physical Health Nurse to start on 16th October 2015. No data to currently report due to this.*				
	Offer Nicotine Replacement Therapy (NRT) for patients wishing to stop smoking (Prescribing to be a pass through cost to the Trust)	Q1-Q4	Not achieved	n/a	Physical Health Nurse to start on 16th October 2015. No data to currently report due to this.*				
	Appointment of a BTS clinical champion to promote smoking cessation for patients and staff	Q1-Q4	Not achieved	n/a	Julian Stern and Caroline McKenna have been appointed Trust Physical Health Leads.				
	Pro-active promotion of stop smoking to staff through in-house or local stop smoking service	Q1-Q4	Not achieved	n/a	Physical Health Nurse to start on 16th October 2015. No data to currently report due to this.*				
	*Please note that those patients who have expressed an interest in meeting with the physical health nurse have been put on a Waiting List pending the appointment of the physical health nurse.	Q1-Q4	Not achieved	n/a					

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

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## Physical Health CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q2	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	Achieved: 16 newly referred patients screened	n/a	2.4% (16 patients out of 676 Trustwide newly referred patients in Q2) screened for Alcohol misuse. 25% patients scored >=3, so eligible for help to quit. Of the 4, 3 refused help to quit.				
	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	Not achieved: 25% of the 16 newly referred patients screened positive	95%	25%. A total of 4 patients screened positive. Out of the 4: 1 patient has been referred to the Physical Health Nurse, and 3 to be followed up.				
	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%	Physical Health Nurse to start on 16th October 2015. No data to currently report due to this				
	Referrals made to local alcohol services when identified as appropriate by the Physical Health Nurse.	Q2-Q4	Not achieved	n/a	Physical Health Nurse to start on 16th October 2015. No data to currently report due to this				
	Trust to implement system of recording instances where patients disclose either:	Q2-Q4	Not achieved	n/a	We have now set up a DV sub-committee and we are recording DV on Carenotes				
	A) Being the victim of violence in relation to alcohol or								
	B) Perpetrating violence in relation to alcohol		Not achieved		We have now set up a DV sub-committee and we are recording DV on Carenotes				

## Domestic Violence CQUIN Targets

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

## Safe and Timely Discharge CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q2	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
SAFE AND TIMELY DISCHARGE	Discharge letters for GPs to be sent within 2 weeks of final appointment for planned discharges	Reported in Q3 after completion of audit	n/a this quarter	85%	n/a				
	85% Patients discharged from Carenotes within 2 weeks of letter to GP	Reported in Q3 after completion of audit	n/a this quarter	85%	n/a				
	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.				



	Detail of indicator	Reported	Performance at Q2	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	50%	75%	50% of patients with a PROM for Time 1 and Time 2 shown an improvement.				

GIDS CQUIN

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

## Section Three: Quality Priorities

Quality Priorities								
Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achieve-ment Date	Progress	% Progress for 2015/16
								Q1 Q2 Q3 Q4
(1)Outcome Monitoring	For 80% of patients (attending CYAF who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at the Pre-assessment stage (known as Time 1) and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	Caroline McKenna	Carenotes  Monitoring of progress by the OM Lead  Quarterly progress report  Quarterly basis, providing reports to the Patient Experience and Care Quality Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs.	<ul style="list-style-type: none"> <li>OM analysis of the % return rate for Time 1 and Time 2.</li> </ul>	1 July 2015	n/a	Informatics working on this	x
	For 75% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).							
				<ul style="list-style-type: none"> <li>OM analysis of the % of patients who achieve an improvement in their score for at least two GBM targets.</li> </ul>	1 July 2015	n/a	Informatics working on this	x

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.	<ul style="list-style-type: none"><li>OM analysis of the % of service users who achieve an improvement in their score from pre assessment to End of Treatment.</li></ul>	1 July 2015	30 Sept 2015	Achieved target	64%	71%		
(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		<ul style="list-style-type: none"><li>The PPI team will develop and launch a quarterly PPI newsletter for Trust staff and service users to include updates on patient stories.</li></ul>			An adult and a CAMHS bulletin flyer has been finalised with the Communications department. These bulletins contain Trustwide updates on current and upcoming PPI activities.				
	2. PPI Newsletters to be available on the Trust website			<ul style="list-style-type: none"><li>PPI newsletters will be posted on the website.</li></ul>			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.	<ul style="list-style-type: none"><li>A question on the Visual Straw Poll will be used to evaluate awareness and knowledge of the PPI quarterly newsletter.</li></ul>			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).				

Quality Priorities											
Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2015/16			
								Q1	Q2	Q3	Q4
(3) Patient and Public Involvement	1. To provide a service user for every clinical interview panel that requests a service user panel member.	Sally Hodges	<ul style="list-style-type: none"><li>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.</li></ul>	<ul style="list-style-type: none"><li>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.</li></ul>	1 July 2015	30 Sept 2015	16 separate interview panels requested an individual service user or service users for their panels. From these requests, 19 service users were involved in these panels.				
	2. To gain feedback from the service users who participate in interview panels. Feedback will be gained regarding three areas: preparation for the panel, participating in the panel and the debrief process. The PPI team will contact every service user who participates on an interview panel.		<ul style="list-style-type: none"><li>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.</li></ul>	<ul style="list-style-type: none"><li>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.</li></ul>			Feedback is currently being gained via email, phone and in person. 56% of the 19 service users that were on interview panels have responded with feedback.				

## Appendix: Quality Indicator Performance Supporting Evidence

### 1. Waiting Times

QUARTER 2						
Service	AYAS	Adult	Camden CAMHS	Other CAMHS	Portman	TOTAL
Breaches Cause internal to Tavi	0	1	2	1	1	5
Breaches: Cause external to Tavi	0	3	0	1	0	4
<b>Total number of breaches</b>	<b>0</b>	<b>4</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>9</b>
Number of 'breaches' shown after data validation shown to be 'no breach'	1	3	4	9	2	19
Total number of patients offered a first appointment in the quarter	31	53	199	59	39	381
The percentage of patients that are breached in the quarter	0.0%	7.5%	1.0%	3.4%	2.6%	2.4%
% of internal breaches	0.0%	1.9%	1.0%	1.7%	2.56%	1.3%
% of external breaches	0.0%	5.7%	0.0%	1.7%	0.00%	1.0%

# Waiting Time Breaches 11+ weeks (Quarter 2)

Client ID	Service	Team	Purchaser	Referral Date	First Attended Apt	Wait Weeks	Internal / External	Reason for breach
21721	Adults	Lyndhurst	NHS CENTRAL LONDON (Westminster) CCG	02-Jun-2015	10-Sept-2015	13.29	Internal	Clinical delay in providing a specialist clinician for this patient.
21478	Adults	Fitzjohns	NHS BARNET CCG	19-May-2015	01-Sep-2015	13.86	External	Single Point of Entry referral complications confirming funding.
21831	Adults	Lyndhurst	NHS HAMMERSMITH AND FULHAM CCG	16-Jun-2015	29-Sep-2015	13.86	External	Patient had problems attending scheduled appointments due to existing conflicting hospital appointments.
11055	Adults	Lyndhurst	NHS CAMDEN CCG	26-May-2015	24-Sep-2015	16.14	External	Clinical delay in providing an appointment for patient due to availability issues and contacting patient.

## Waiting Time Breaches 11+ weeks (Quarter 2)

Client ID	Service	Team	Purchaser	Referral Date	First Attended Apt	Wait Weeks	Internal / External	Reason for breach
21954	Portman	Portman Limentani	NHS Herts Valley	13-Jul-15	30th September 2015	11 Weeks + 2 Days	Internal	Clinical Delay: The clinician and patient were unable to find a mutually convenient date within 11 weeks.
13475	Camden CAMHS	SOUTH Primary Care	NHS CAMDEN CCG	06-May-2015	23-Jul-2015	11 Weeks + 1 day	Internal	During this period there was an increase in referrals with no increase in resources, so that a waiting list for new assessments built up. This case was seen 1 day after the breach date.
21087	Camden CAMHS	NORTH Secondary School	NHS CAMDEN CCG	10-Feb-2015	09-Jul-2015	21.14	Internal	Clinical Delay in allocating a clinician to the patient.
21416	Other CAMHS	Developmental - Autism	NHS HARINGEY CCG	10-Apr-2015	13-Jul-2015	11.29	Internal	Clinical Delay in providing an available appointment for this patient.
21519	Other CAMHS	Developmental - Autism	NHS EAST AND NORTH HERTFORDSHIRE CCG	12-May-2015	23-Sep-2015	19.	External	Patient dropped out of contact and only got back in touch as we were about to close the case.

Trust-wide Waiting Times for Q2 - including Mean and Median data

Service	Total Seen Patients Q2	Median (Weeks)	Average (Weeks)
Adolescent and Young Adult	31	3.86	4.6
Adults	53	6.4	6.9
Camden CAMHS	199	4.6	8.5
Other CAMHS	58	6.9	8.0
Portman	39	7.0	9.9
<b>Total</b>	<b>380</b>	<b>6.4</b>	<b>7.6</b>

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.



## 2. DNA Rates

Total DNA Rates			
QUARTER 2			
Target <11%	2013/14	2014/15	2015/16
Total 1st appointments attended	294	290	263
Total first appointments DNA's	50	34	27
Total first appointments	344	324	290
% 1st appointments DNA'd	15%	10.5%	9.3%
Total subsequent appointments attended	7151	7574	6959
Total sub. appointments DNA'd	903	721	786
Total subsequent appointments	8054	8295	7745
% DNA subsequent Appointments	11%	8.7%	10.1%
<b>Total % DNA</b>	<b>11.3%</b>	<b>8.8%</b>	<b>10%</b>

Adolescent and Young Adult DNA Rates			
QUARTER 2			
Target <11%	2013/14	2014/15	2015/16
Total 1st appointments attended	28	30	30
Total first appointments DNA's	2	2	10
Total first appointments	30	32	40
% 1st appointments DNA'd	6.7%	6.3%	25.0%
Total subsequent appointments attended	642	820	858
Total sub. appointments DNA'd	148	149	190
Total subsequent appointments	790	969	1048
% DNA subsequent Appointments	18.7	15.4%	18.1%
<b>Total % DNA</b>	<b>18.3%</b>	<b>15.1%</b>	<b>18%</b>

## DNA Rates

Adult DNA Rates				
QUARTER 2				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	56	51	50	
Total first appointments DNA's	6	9	3	
Total first appointments	62	60	53	
% 1st appointments DNA'd	9.7%	15.0%	5.7%	
Total subsequent appointments attended	1820	1863	1863	
Total sub. appointments DNA'd	272	172	170	
Total subsequent appointments	2092	2035	2033	
% DNA subsequent Appointments	13.0%	8.5%	8.4%	
<b>Total % DNA</b>	<b>12.9%</b>	<b>8.6%</b>	<b>8%</b>	

Camden CAMHS DNA Rates				
QUARTER 2				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	112	137	97	
Total first appointments DNA's	32	20	12	
Total first appointments	144	157	109	
% 1st appointments DNA'd	22.2%	12.7%	11.0%	
Total subsequent appointments attended	2063	2543	2067	
Total sub. appointments DNA'd	267	245	262	
Total subsequent appointments	2330	2788	2329	
% DNA subsequent Appointments	11.5%	8.8%	11.2%	
<b>Total % DNA</b>	<b>12.1%</b>	<b>9.0%</b>	<b>11%</b>	

## DNA Rates

Other CAMHS DNA Rates				
QUARTER 2				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	78	60	47	
Total first appointments DNA's	5	2	0	
Total first appointments	83	62	47	
% 1st appointments DNA'd	6.0%	3.2%	0.0%	
Total subsequent appointments attended	1607	1394	1233	
Total sub. appointments DNA'd	128	76	84	
Total subsequent appointments	1735	1470	1317	
% DNA subsequent Appointments	7.4%	5.2%	7.5%	
<b>Total % DNA</b>	7.3%	5.1%	6%	

Portman DNA Rates				
QUARTER 2				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	20	12	39	
Total first appointments DNA's	5	1	2	
Total first appointments	25	13	41	
% 1st appointments DNA'd	20%	7.7%	4.9%	
Total subsequent appointments attended	1019	954	938	
Total sub. appointments DNA'd	88	79	80	
Total subsequent appointments	1107	1033	1018	
% DNA subsequent Appointments	8%	7.6%	7.9%	
<b>Total % DNA</b>	8.2%	7.6%	8%	

3. **Patient Satisfaction** – See ESQ Report 2015-2016 Q2. 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 Q2 in table below.

Quality and Development of Staff - PDPs:		
Number of staff who require a PDP at 30 <sup>th</sup> September 2015.	Number of staff with a PDP	% of staff with a PDP
482	481	99%

## 7. Safety (Children Safeguarding)

Level 1 Safeguarding Training/Adults Risk Training (Which provided at Trust INSET day)				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	93 %	94 %		
Narrative	Quarter 2 results			
Total numbers requiring training:	533			
Number of staff trained:	506			
Number of staff NOT trained:	27			
%:	94 %			
Rationale (Reason for non-attendance):	18 staff exempted by their Directors to attend INSET day held in May and will be attending November INSET day. 9 new starters staff to attend the next induction in December 2015.			
Level 2 Safeguarding Training				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	98 %	98 %		
Narrative	Quarter 2 results			
Total numbers requiring training:	44			
Number of staff trained:	43			
Number of staff NOT trained:	1			
%:	98 %			
Rationale (Reason for non-attendance):	The one staff member due to attend is leaving October 2015			
Level 3 Safeguarding Training				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	94 %	93 %		
Narrative	Quarter 2 results			
Total numbers requiring training:	305			
Number of staff trained:	284			
Number of staff NOT trained:	21			
%:	93 %			
Rationale (Reason for non-attendance):	1 staff member was on long term sick leave, 2 staff members are based elsewhere (1 arrived late and the other had postponed due to team day event both rebooked for Dec 15), 1 staff member had pre-booked conferences as a speaker (now booked for Nov 2015), 1 staff member on annual leave (have now rebooked), 16 staff members are just due or they are new starters and they are all booked for Nov or Dec 2015.			

## 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

**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

**VSP:** Visual Straw Poll

Marion Shipman  
Associate Director Quality & Governance  
October 2015

## Board of Directors : October 2015

**Item :** 12

**Title :** Workforce Race Equality Standard

### **Summary:**

The NHS Equality and Diversity Council announced on July 31 2014 that it had agreed action to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The Council pledged its commitment, subject to consultation with the NHS, to implement two measures to improve equality across the NHS, which would start in April 2015. The first is a **Workforce Race Equality Standard (WRES)** that would, for the first time, require organisations to demonstrate progress against a number of indicators of workforce equality.

This report has been reviewed by the following Committees:  
Management Team, 20<sup>th</sup> October.

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

- Equality

**For :** Discussion

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





# Workforce Race Equality Standard REPORTING TEMPLATE

Name of Provider Organisation	Date of Report
Tavistock and Portman NHS Foundation Trust	
Name and title of Board lead for the Workforce Race Equality Standard	
Louise Lyon, Director of Quality and Patient Experience/Director of Adult and Forensic Services/Chair of the Equalities Committee	
Name and contact details of manager responsible for compiling this report	
Louise Lyon: llyon@tavi-port.nhs.uk	
Name of Commissioners to whom this report has been sent	
To be sent to the CQRG once approved by the Board.	
Name and contact details of coordination Commissioner to whom this report has been sent	
URL Link to this report	
TBA	
Report signed off by (on behalf of the Board)	
Date	
Louise Lyon	

# Report on the WRES Indicators

## 1. Background Narrative

### a. Issues relating to completeness of data

This report is mainly based on the workforce statistics report reflecting the data held on ESR as of 31<sup>st</sup> March 2015.

### b. Issues relating to reliability of comparisons

There are no issues to report.

## 2. Staff Numbers

### a. Total number of staff employed within the organisation at the date of the report

578

### b. Proportion of BME staff employed within the organisation at the date of the report

21.4%

## Report on the WRES Indicators continued

### 3. Self-reporting

- a. The proportion of total staff who have self-reported their ethnicity

97.9 %.

- b. Steps taken in the last reporting period to improve the level of self-reporting by ethnicity

Staff are encouraged to provide this data at the commencement of employment.

- c. Steps planned during the current reporting period to improve the level of self-reporting by ethnicity

We intend to send out a request to staff who have not provided this data emphasizing its importance in ensuring that we have inclusive representation.

### 4. Workforce Data

- a. Period to which the organisation's workforce data refers

2014/15

## Report on the WRES Indicators continued

### 5. Workforce Race Equality Indicators

Indicator	Data for the reporting year 2014-15	Data for the previous year 2013-14	Narrative: The implications of the data and any additional background explanatory narrative	Action taken and planned, including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality objective
For each of these four workforce indicators, the Standard compares the metrics for White and BME staff				
1 Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce	White: 82.7% BME: 15.2%	White: 82.6% BME: 16.3%	BME staff are well represented in Band 8. However, the Trust recognises the lack of representation at Band 9 and will consider steps for positive action.	Recruitment adverts for senior posts will include a statement inviting applications from BME candidates.  The option of having trained observers sit on recruitment panels during interviews for Band 8 and above will be explored.  Roger Kline, author of <i>The Snowy White Peaks of the NHS</i> and creator of the WRES, will attend our Leadership Group Conference on 15 <sup>th</sup> December for a discussion with the Board and senior management.
2 Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.	White: 70.1% BME: 27%	White: 73.9% BME: 22.6%	In 2014, the Board requested further scrutiny of these figures. The resulting enquiry indicated no areas for concern with regard to fairness of the selection process.	We will review the data for 2014/15 and take positive action to increase the number of shortlisted applicants from BME communities. This will include consultation with BME staff members to obtain suggestions for further action to improve in this area.

## Report on the WRES Indicators continued

Indicator	Data for the reporting year 2014-15	Data for the previous year 2013-14	Narrative: The implications of the data and any additional background explanatory narrative	Action taken and planned, including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality objective								
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* <i>*Note: This indicator will be based on data from a two year rolling average of the current year and the previous year.</i>	0	As a small organization, with highly professional staff, we have very few disciplinary cases.	We will continue to review this metric and, in partnership with staff side, ensure that our policies and processes are fair and equitable. However, the Trust does recognise that unfair or biased disciplinary action can disproportionately impact BME staff. Therefore, in the event that a disciplinary process were to find that there was no case to answer, this fact would be publicly acknowledged in writing to all staff by a Director.								
4	Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff	0	All applications for CPD and bursaries are agreed against the funds available.	More accurate data recording is planned for next year, through Online Learning Manager (ESR).								
For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff												
5	KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	<table><tr><td>White</td><td>16%</td></tr><tr><td>BME</td><td>12%</td></tr></table>	White	16%	BME	12%	<table><tr><td>White</td><td>15%</td></tr><tr><td>BME</td><td>11%</td></tr></table>	White	15%	BME	11%	Following the National Survey and a report to the Board raising concerns, the Trust has set up an independent Raising Concerns helpline and re-launched the Staff Advice and Consultation Service.
White	16%											
BME	12%											
White	15%											
BME	11%											

## Report on the WRES Indicators continued

Indicator	Data for the reporting year 2014-15	Data for the previous year 2013-14	Narrative: The implications of the data and any additional background explanatory narrative	Action taken and planned, including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality objective								
				A campaign will be run to make it clear to patients that harassment of staff will not be tolerated.								
6	KF19. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	<table><tr><td>White</td><td>19%</td><td>White</td><td>17%</td></tr><tr><td>BME</td><td>15%</td><td>BME</td><td>11%</td></tr></table>	White	19%	White	17%	BME	15%	BME	11%	A further survey on this matter was commissioned by the Board and reported in 2014.	The Trust does not wish to see any member of staff bullied or harassed and therefore encourages staff to raise concerns, including bullying and harassment issues, via the Freedom to Speak Up initiative.
White	19%	White	17%									
BME	15%	BME	11%									
7	KF27. Percentage believing that the trust provides equal opportunities for career progression or promotion	<table><tr><td>White</td><td>88%</td><td>White</td><td>92%</td></tr><tr><td>BME</td><td>70%</td><td>BME</td><td>96%</td></tr></table>	White	88%	White	92%	BME	70%	BME	96%	Note that a significant number of staff who replied "Don't know" to this question have been excluded when calculating these percentages, in both years.	<p>The Inclusion in the Workplace Sub-group has been tasked with reviewing the data on staff promotion and progression to ascertain whether there are any disparities in relation to career progression and access to qualifying training.</p> <p>If issues are identified, the IWP Sub-group will devise an action plan, which (if approved by the Board), would include targeted career development programmes, mentoring, and a BME network. However, if no disparities exist, then Trust data on promotions and appointments will be shared regularly with staff to address this perception.</p>
White	88%	White	92%									
BME	70%	BME	96%									

## Report on the WRES Indicators continued

Indicator	Data for the reporting year 2014-15	Data for the previous year 2013-14	Narrative: The implications of the data and any additional background explanatory narrative	Action taken and planned, including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality objective
8	<p>Q23. In the last 12 months have you personally experienced discrimination at work from any of the following: manager/ team leader or other colleague?</p> <p>White 7% BME 12%</p>	<p>White 6% BME 9%</p>	<p>Narrative: The implications of the data and any additional background explanatory narrative</p> <p>Trust score in 2014 was 15% compared to 12% in 2013.</p>	<p>Questions have been added to our Staff Survey to provide a clearer picture of staff views on the following;</p> <ul style="list-style-type: none"> <li>• equal opportunities regarding non-mandatory training and CPD;</li> <li>• equal treatment in relation to bullying and harassment, and disciplinary and grievance issues;</li> <li>• equal treatment in relation to consideration for senior posts with the Trust.</li> </ul> <p>We will engage in consultation with BME staff members with a view to understanding the ways in which they feel they are discriminated against.</p> <p>Roger Kline will attend two events in December 2015, which will help us to:</p> <ol style="list-style-type: none"> <li>1) discuss race equality within the Trust and find out the issues facing BME staff, and</li> <li>2) acquire learning from Roger's nationwide work on race equality within the NHS and seek suggestions for positive change.</li> </ol>

## Report on the WRES Indicators continued

Does the Board meet the requirement on Board membership in No. 9?

9	Boards are expected to be broadly representative of the population they serve	Yes	Yes	The recent appointment of a Non-Executive Director has changed the BME profile of the Board to more accurately reflect the population.	We will continue to review this metric through future recruitment.
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6. Are there any factors or data which should be taken into consideration in assessing progress?  
Please bear in mind any such information, action taken and planned may be subject to scrutiny by the Coordinating Commissioner or by regulators when inspecting against the 'Well Led' domain.

None known.

7. If the organisation has a more detailed plan agreed by its Board for addressing these and related issues, you are asked to attach it or provide a link. Such a plan would normally elaborate on the steps summarised in section 5 above, setting out the next steps with milestones for expected progress against metrics. It may also identify the links with other work streams agreed at Board level, such as EDS2.

The Equalities Annual Report, agreed by the Board in 2015, is attached.



## Board of Directors : October 2015

**Item :** 13

**Title :** NED, Chair and CEO Objectives

**Summary:**

The objectives of the Chair, NEDs and CEO are agreed each year following agreement of the Board Objectives, and brought to the Board for approval.

This report details the CEO's objectives. The NED objectives are in progress and will be confirmed with the new Chair once he takes up his post in November, and similarly the objectives of the new Chair will be agreed once he is in post.

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

- Risk

**For :** Approval

**From :** Gervase Campbell, Trust Secretary

## Chair, NED and CEO Objectives, 2015

### **1. Chair Objectives**

- 1.1 Objectives for the new Chair, Mr Paul Burstow, will be agreed once he has taken up post on the 1<sup>st</sup> November, and then brought to the Board for approval.

### **2. NED Objectives**

- 2.1 The Non-Executive directors are working on their personal objectives, following on from the Board Objectives, and will agree these with Paul Burstow in November. They will then be brought to the Board for approval.

### **3. CEO Objectives**

- 3.1 The Chief Executive has agreed his objectives with the Chair, Angela Greatley, and discussed them with Paul Burstow. They are presented here for approval.

Gervase Campbell

Trust Secretary  
October 2015

## Appendix 1

### Tavistock and Portman NHS Foundation Trust Chief Executive Objectives September 2015- August 2016

Area	Aim	Objective	Review Date
Strategy	Complete and launch the Trust's 2 year strategy	Secure Board agreement to the strategy.  Establish an effective system for monitoring progress against the strategy working through the Strategic and Commercial Programme Board.  Ensure alignment between strategy and BAF.	January 2016
Strategy	Strengthen the voice of lived experience in the Trust's decision making and activities	Oversee introduction of new strategy for involvement in the Trust	April 2016
Training and Education	Make tangible progress in delivering the transformation agenda for training and education work	Secure successful outcome for negotiations with HEE on the future of the National Contract	Ongoing

Area	Aim	Objective	Review Date
		Ensure effective strategy in place to deliver recruitment targets for AY 2016/7	December 2015
		Support delivery of actions to transform our internal capability to support education and training work.	Ongoing
		Support delivery of strategy to extend geographical reach of training and education work.	Ongoing
		Support delivery of strategy to broaden diversification of our training and education portfolio.	Ongoing

Area	Aim		Review Date
Operational and financial performance	Ensure Trust maintains strong operational and financial performance	Ensure the Trust maintains a Monitor green rating for Governance	Ongoing
		Ensure the Trust maintains a Continuity of Service risk rating of 3 or above	Ongoing
		Deliver a balanced budget for 2016/7	March 2016
		Put in place structures that will deliver a longer term sustainable financial position for the Trust.	Ongoing
Business Development	Ensure the Trust has vigorous business development strategy which is capable of delivering growth targets set out in the Trust's 2 year strategy	Support the delivery of growth objectives set out in the Trust's Medium Term strategy including securing at least one new CAMHS service	Ongoing
		Establish and chair Adult Services Development Group to put together a clear strategy for the development of adult services.	April 2016

Area	Aim	Objective	Review Date
<b>Relocation</b>	Hold oversight of relocation project.	Oversee progress in developing FBC for relocation. Keep oversight on internal and external communications on the project.	August 2016
<b>Clinical quality and safety</b>	Ensure the delivery of clinical quality, safety and governance	Ensure Trust is fully prepared for CQC Inspection	January 2016
		Deal with any emerging quality issues identified through CQSG and other channels.	Ongoing
		Promote a culture of openness in the Trust with commitment to gather and review concerns. Appoint a Freedom to Speak Up Guardian	Ongoing
<b>Research</b>	Ensure progress in taking forward the ambitions of the Trust in relation to the Trust	Establish Research Committee	December 2015
		Support work to secure a further major research grant	Ongoing
<b>Leadership</b>	Ensure I am visible as a leader and that I communicate clearly with stakeholders including members, Governors and staff	Carry out a regular programme of visits to clinical services and training programmes	Ongoing

		Develop leadership group across the Trust	Ongoing
		Carry out a regular programme of communications to staff and other stakeholders	Ongoing
		Make successful appointments to key management team vacancies and develop team.	December 2015
		Ensure development of effective workforce strategy for the Trust with focus on staff well-being and development .	April 2016
<b>External Profile</b>	Ensure a robust strategy for raising the profile of the Tavistock and Portman	Work with Director of Marketing and Communications and new Chair to exploit external opportunities to raise the profile of the Trust including successful delivery of Century Films project	Ongoing
		Take advantage of personal opportunities to raise the profile of the Trust through membership of external bodies including One Hackney, i-Thrive Partnership, HEE Mental Health Advisory Group.	Ongoing

<b>Governance</b>	Ensure Board of Directors develops plans to support the roles of NEDs and Chair	Supporting the new Trust Chair in talking up his duties.	Ongoing
		Oversee the implementation of the recommendations of the Governance Review agreed in July 2015 by the Board of Directors.	April 2016
		Support appointment of new NED in Spring 2016	April 2016
		Support work of Council of Governors including successful induction of new Governors.	Ongoing





