

Board of Directors Part One

Agenda and papers

of a meeting to be held in public

2.00pm–4.20pm
Tuesday 26th April 2016

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

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 26th April 2016, 14.00 – 16.20
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES				
1.	Chair's Opening Remarks Mr Paul Burstow, Trust Chair		Verbal	-
2.	Apologies for absence and declarations of interest Mr Paul Burstow, Trust Chair	To note	Verbal	-
3.	Minutes of the previous meeting Mr Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	Outstanding Actions Mr Paul Burstow, Trust Chair	To note	Enc.	p.9
4.	Matters arising Mr Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	Service Line Report – Portman Clinic Mr Stan Ruszczyński, Director	To discuss	Enc.	p.10
6.	Trust Chair's and NEDs' Reports Mr Paul Burstow, Trust Chair	To note	Verbal	-
7.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To note	Enc.	p.29
8.	Finance and Performance Report Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Late	-
9.	Training and Education Report Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.32
10.	Q4 Review of Strategic Objectives Mr David Holt, Chair of the Strategic and Commercial Committee	To note	Enc.	p.38
11.	Q4 Quality Report Ms Marion Shipman, Associate Director of Quality & Governance	To discuss	Enc.	p.40
12.	Performance Indicator Dashboards Ms Julia Smith, Commercial Director	To discuss	Enc.	p.76

13.	Q4 Governance Statement Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.86
14.	Nurse Revalidation Update Ms Lis Jones	To note	Enc.	p.91
15.	a. Clinical Complaints and Whistleblowing Report Ms Amanda Hawke, Complaints Manager b. Education and Training Complaints Report Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.96 p. 105
16.	Q4 HR Annual Report and Staff Survey Action Plan Mr Craig DeSousa, HR Director	To note	Enc.	p.109
CLOSE				
16.	Notice of Future Meetings <ul style="list-style-type: none"> Tuesday 24th May 2016: Board of Directors' Meeting, 1.00pm – 5.00pm, Lecture Theatre Tuesday 7th June 2016: Directors' Conference, 12.00-5.00pm, Lecture Theatre Tuesday 28th June 2016: Board of Directors' Meeting, 1.00pm – 5.00pm, Lecture Theatre Thursday 30th June 2016: Council of Governors' Meeting, 2.00 – 5.00pm, Lecture Theatre 		Verbal	-

Board of Directors

Meeting Minutes (Part One) Tuesday 29th March 2016, 2.00 – 4.30pm

Present:			
Mr Paul Burstow Trust Chair	Prof. Dinesh Bhugra NED	Ms Jane Gizbert NED	Dr Sally Hodges CYAF Director
Mr Simon Young Deputy CEO & Director of Finance	Mr Paul Jenkins Chief Executive	Ms Lis Jones Nurse Director	Ms Louise Lyon Director of Q&PE and A&FS
Dr Ian McPherson NED & Vice Chair of Trust	Ms Edna Murphy NED		Dr Rob Senior Medical Director
Attendees:			
Mr Gervase Campbell Trust Secretary (minutes)	Mr Paul Dugmore, Portfolio Manager (item 6)	Mr Craig DeSousa, HR Director (item 9)	
Apologies:			
Mr Brian Rock Director of E&T/ Dean	Mr David Holt NED		

Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to be made to the minutes	GC	Immd.
2	6	Update on revalidation of M55 to be given	BR	April
3	11	3 to 5 year financial view to be drawn up	SY	July.

1. Trust Chair's Opening Remarks

Mr Burstow opened the meeting.

2. Apologies for Absence and declarations of interest

Apologies as above. No interests specific to the meeting.

3. Minutes of the Previous Meeting

AP1 The minutes were approved subject to minor amendments

4. Matters Arising

Action points from previous meetings:

AP1 – (Minutes) – completed.

Outstanding Actions:

OAP3 – (Board to discuss support for carers) – scheduled for April Board lunch.

5. Service User Story

The board heard from two students, Ms I who had been both a student on D60 (Social Work and emotional wellbeing doctorate) and later a visiting lecturer, and Mr J, who had attended both D10 (Consulting and Leading in Organisations: psychodynamic and systemic approaches) and D10d (Consultation and the Organisation)They explained their backgrounds and the value they had found in studying at the Trust. They had both found that the connections they had made

to their fellow students and their outstanding teachers, the community of practice, combined with the academic study and theory, had made their experience with us especially rich and rewarding. We had provided something that had been missing in their professional lives, and which gave them both resilience and insight that had helped them at work. They agreed it could sometimes be difficult to explain the value of our courses to their colleagues, and thought there was more the Trust could do in communicating the benefits clearly to social workers and workers in social care. They discussed how the Trust might better keep in touch with students, and what would be looked for from an alumni association, noting that there had been groups for individual courses in the past.

Mr J commented that he had some concerns over the support available for dyslexia within the directorate.

Mr Burstow thanked them both for coming, commenting on the value of hearing about how the training was perceived in the wider world, and of the gaps that needed to be addressed.

6. Service Line Report - E&T Portfolio: Social Care, Management, Leadership

Mr Dugmore explained that it had been a challenging time for the team since last summer, with the implementation of the new structure, the CQC and now the QAA visits, but he was very pleased with how the team were working hard to achieve the directorate objectives. The challenge outside the Trust was the fragility of public sector funding, which was affecting how able people were to attend longer courses, and so they were working on adapting to provide more CPD and flexible offers. A third challenge was the uncertainty over the National Training Contract; some of the portfolio aligns well with their priorities, but the social care aspect less well, prompting them to actively look to develop relationships with new organisations.

Mr Dugmore commented that the University of Essex had very recently refused validation of one course, M55. The feedback contained some valid and helpful points which they would address, and some that were being considered by the quality team. He hoped that they would be able to revise the course and be able to get it reconsidered in time for the next round of recruitment. The Board discussed whether some of the difficulties might be with wider concerns over observation and research. Mr Jenkins commented that Essex were good at responding to issues and he would work with Mr Rock to ensure the team were supported. Mr Burstow asked that an update on the progress should come to the next Board meeting.

AP3

On a positive note the work with Liden University on Video-feedback Intervention to Promote Positive Parenting (VIPP) was going well, and they were mentioned in the NICE guidelines on attachment. A grant from the Department for Education meant that they would be able to expand and become, in partnership, the UK training centre. Ms Gizbert suggested that they should sign up as a registered stakeholder with NICE so that they could comment on coming guidelines, and try to get onto the committees, as this would be mutually beneficial relationship.

Ms Hodges commended the report, the first from an E&T portfolio, and asked about the dyslexia issue that had been raised earlier. Mr Dugmore commented that he had found preparing the report helpful in assessing where they were in the team, but one of the big challenges was in getting accurate data, and the new SIMS would be a very welcome help with this. He explained that with the changes in university partner some aspects of dyslexia support had been lost at the interface between the organisations, but they were aware of it and would address it.

Ms Murphy asked whether they were engaging in market research. Mr Dugmore commented that they had done work with employers of social workers, and in a limited way with employers in social care, which included holding events and round table discussions, to varying success. Mr Burstow suggested attending the BASWA conference, and Mr Dugmore commented that with the new marketing team in place they were in a position to attend events of this sort that they hadn't traditionally, and were working out a strategic approach to get their brand out to new and existing customers, which might include hosting free events to entice in new people including those from traditionally underfunded social care organisations.

Mr Burstow asked for more details of the FastTrack social work training that had fallen through (page16). Mr Dugmore explained that the original partnership had not discussed costs frankly enough at the outset, and as Think Ahead made more explicit what the costs would be it became clear that the risks were too great for the Trust to proceed. This was a shame, as it was a good opportunity, but the door was not closed and if they applied again they would do so with a clearer partnership agreement.

The Board **noted** the report.

7. Trust Chair and NEDs' Reports

Dr McPherson reported that he had attended a recent Thinking Space event, and suggested it could be the model for low cost events designed to bring people into the Trust and to raise policy issues.

Ms Murphy reported she had met with our Freedom to Speak Up Guardian, Gill Rusbridger, for an update on the role. Gill had been making contacts in the Trust and people had been speaking to her, and were glad that she was in post, but no serious issues had been raised.

Mr Burstow reported that he had attended the London Mental Health Chairs meeting, and there was concern about how little NEDs and Chairs were being involved in the sustainability and transformation plans process. He and Paul Jenkins had met with a number of governors to discuss the relocation project, and would be following up on this at the joint boards meeting. Appraisals of the NEDs were underway.

The Board **noted** the reports.

8. Chief Executive's Report

Mr Jenkins highlighted the good news that the Trust had been successful in securing a string of funding bids on the i-Thrive partnership. Knitting these small projects together, whilst not the ideal way to proceed, would provide the platform needed to go forward. A second community of practice event had been held for the ten sites currently involved, and it was encouraging how they were taking the model and applying it to their local circumstances.

Mr Jenkins noted the Trust was well engaged with the mental health programme of the Sustainability and Transformation Plan, where the next step was to narrow down the options to the 3 or 4 with that would have the most impact, and hopefully also be in areas to which the Trust could most contribute.

Mr Jenkins reported that he had, with the medical director, met the junior doctors to discuss the issues they were currently facing. These included concerns about the responsibilities they faced in out-of-hours work, and the general increase in complexity of cases, and we would look at how we could support them with our partners in NCL. Dr Senior added that the strike scheduled for the 26th and 27th of April should have only a minimal effect on our services, C&A consultants would be covering the rota, and safety would not be compromised.

The Board **noted** the report.

9. Chair in Clinical Ethics

Mr Jenkins introduced the paper, noting that they had been successful in the bid for funding. The Board discussed locating the post within Education and Training, where they would aim to develop a programme around clinical ethics that could sustain the role beyond the five years of funding agreed. They also discussed the possibility of an honorary chair at the University of Essex, and the good match with their strong law presence. Regarding the role, Ms Murphy questioned whether the policy focus was public policy or practice policy. Mr Jenkins commented that Professor Bowman was already involved in public debate which linked to regulation and law on occasion, and it was intended that this would continue to be the case, but bringing in the mental health field.

The Board **approved** the establishment of the post.

10 Finance and Performance Report

Mr Young noted that the surplus had reduced due to moving some of the costs of Care Notes and the Relocation Project from capital to revenue. This had been done at the suggestions of the auditors. The cash projection of £3m shown in appendix C had now reduced to £2.7m, which was still a healthy position. This change was largely due to a delay in payment from Public Health England whilst negotiations over FNP were in progress.

The board **noted** the report.

11 Budget, Capital Budget, Operational Plan

Budget

Mr Young introduced the budget, noting that some areas had firmed up since they had seen the draft, but, in common with many other Trusts, a number of contracts remained uncertain. He highlighted that despite the work done they had not quite managed to bridge the gap between income and expenditure, but that the management team was putting in place plans now to achieve the savings needed. Details of how progress will be reported was covered in section 3: a report on progress will come back in July or sooner with details of the actions taken or further actions required. Mr Jenkins commented that in reaching this position they had wanted to avoid putting any more pressure on clinical services, and wanted to accept a degree of risk now in order to reduce the chance of finding an unplanned surplus later in the year when it was too late to use it effectively.

Ms Murphy asked about the vacancy factor rate being used, and whether it was possible to increase it above the current 1% without impinging on activity. Mr Young agreed that 1% might be cautious, and represented only the practical delays that exist in recruiting to fill any vacancy, but in avoiding all impacts they were probably limited to 1.5% at most. He added that impact of a vacancy factor was limited when there was low turnover, as was the case with the Trust.

Dr McPherson noted the underspend the Trust had seen this year, and asked if it might contribute to savings in the following year. Mr Young explained that the bulk of the underspend had been due to specific factors in two services which were not expected to continue.

Mr Burstow noted that there was no provision for additional IMT staff in the budget, and asked if this might be a cost pressure that hadn't been factored in. Mr Young explained that the capital budget included project management costs, but as the IMT staff had increased significantly in the recent past they were not anticipating the need for major increases in the coming year.

AP3

Mr Burstow commented that a longer term look at finances, a 3 to 5 year view, would be a helpful complement to the one year budget, and it was agreed that this would be completed once the National Training Contract was settled.

Capital Budget

Mr Young tabled a corrected version of the capital budget, noting the original version had double counted some of the IMT spending, and the total was now lower at £2,390k. The paper also included details of cash flow and liquidity; the cash position was satisfactory and the liquidity would reduce by approximately

two days of operating expenses and both remained satisfactory according to Monitor's formulas. Ms Murphy asked what the liquidity position now was, with the reduction and Mr Young explained that it was now around zero, which was satisfactory. Prof. Bhugra noted the estates spending, and asked how it fitted with the relocation plans. Mr Young explained that as they would not be moving into new premises for 3 to 4 years there was still a requirement to keep the premises in a satisfactory state, and these projects were judged to be the minimum required for that. Mr Burstow commented that as the date of the move got closer these decisions would get harder and would need more stringent consideration.

Operational Plan

Mr Young noted that the plan had been updated, but since being written they had received feedback from Monitor, which had been circulated, that would need to be accommodated. Mr Young detailed the points Monitor had raised:

- The loan and its effect – the loan had now been approved so they would include the details.
- The CQC report – the CQC report would not be completed until late April, but they were meeting with us on Friday, and if anything came out of that meeting which had implications for the plan it would be included.
- Cross referencing – this was straightforward and would be included.
- Agency template – they would identify agency costs and could incorporate the new limit without difficulty.

The Board **approved** the 2016-17 budget, the 2016-17 capital budget, and the 2016-17 operational plan, subject to ongoing monitoring of the budget and the textual changes to the operational plan discussed at the meeting.

12 PPI Garden Room

Ms Lyon explained that the idea of having a dedicated space for PPI work that did not feel embedded in our clinical spaces had been around for some time, and the Camden Clinical Commissioning Group had offered the funding following a discussion of the projects that it would enable. The plan was to develop a building within the Portman garden that was sufficiently large to accommodate suitable groups, but basic enough that it could quickly be installed, ideally without requiring planning permission. Ms Gizbert noted that it was proposed that it should be shared with other providers in Camden, and asked if the Trust would charge for this. Ms Lyon suggested that there might be a charge to cover costs, but no more. Dr Senior noted that the funding for the building had been provided to encourage community involvement in Camden.

The Board **approved** the proposal in principle.

13 Training and Education Board Report

Mr Jenkins presented the report, noting that more work on alumni engagement was needed before they could bring those details to the Board, especially as the implications went beyond the training and education directorate.

The Board **noted** the report.

14 NHS Staff Survey

Mr DeSousa explained that they had begun work to dig beneath the results, with managers looking at areas with hot spots and developing local action plans. These would be built up into a corporate action plan which would be presented to the board in April. Engagement from managers was very encouraging, with some conducting local surveys to look deeper into the results, and they were working on finding ways to build more granularity into the next annual survey.

Mr Burstow commented that the RAG rating was helpful, and certain areas stood out, such as the bullying and harassment result, and the equal opportunities for career progression, which underscored why the work being done now with Roger Kline was so important.

Dr McPherson noted the dis-satisfaction with opportunities for flexible working, and asked if that was new this year. Mr DeSousa confirmed that it was, and that they needed to do more work to understand the cause, but one possibility was that it could be because a part-time workforce made flexibility harder.

Mr Burstow commented that additional granularity would be helpful in subsequent years. They would await the detailed report in April, but in the meantime there were many encouraging results to celebrate.

The Board **noted** the report.

15 Annual Equalities Report and Four Year Objectives

Ms Lyon introduced the report, noting that the four year objectives were a broad brush framework for the organisation's direction, and the committee also selected priorities to focus on each year. She reminded the board that the work crossed all domains: staff, student and patients. Dr McPherson noted that as a long-time member of the committee he had seen a lot of progress made in areas such as addressing long held opinions on sexuality, but also in developing a real programme of actions that the Trust could be measured on.

Mr Burstow asked about the plans for extending Mental Health First Aider training. Ms Lyon explained that they had looked at the costs of training, and begun to broach it with staff at Inset days, but wanted to be careful to introduce it in a positive way so that it was understood as a support mechanism. She noted that it was recognised that support for mental health of staff was generally harder within mental health organisations, despite their clinical expertise.

Ms Hodges noted that the objectives were very clear, and suggested they might be added to the Performance Dashboard that is being developed. Dr McPherson noted that NHS England had announced that resources were available to promote staff wellbeing where there was evidence of initiatives being undertaken, and suggested that the objectives might help in accessing the funding.

The Board **noted** the report, and **approved** the objectives.

16 IMT Project Update

Mr Young introduced the report, noting it was an update from the February paper and included an action plan for priorities in appendix A, the ToR for the steering committee, and the Care Notes optimisation update. Mr Burstow asked when the board would receive details of the deadlines for the actions. Mr Jenkins explained that there would be regular updates to the board through templates attached to the monthly CEO reports.

Ms Gizbert noted that she had agreed to join the committee as the NED member, and the Board approved this. Mr Burstow added that under the responsibilities of the committee, the ToR should show that the IM&T Strategy and Annual Programme Plan were being developed for Board approval.

The Board **noted** the report, and **approved** the Terms of Reference with the amendments included.

17 Corporate Governance – Charitable Funds ToR and Minutes

Mr Burstow introduced the paper, noting there had been no changes to the terms of reference.

The Board **noted** the minutes, and **approved** the Terms of Reference.

18 Any Other Business

The Board noted its future meetings.

Part one of the meeting closed at 4.54pm.

Action Point No.	Originating Meeting	Action Required	Director / Manager	Due Date	Progress Update / Comment
3	Jan-16	Board to discuss support for carers	Paul Jenkins	Spring 2016	Support for carers to be discussed at April Board Lunch. Completed
2	Mar-16	Update on revalidation of M55 to be given	Brian Rock	April 2016	Covered in April T&E Report. Completed.
2	Feb-16	Monthly Optimisation Updates, and Quarterly IMT reports, to come to the Board	Toby Avery	April 2016	
3	Mar-16	3 to 5 year financial view to be drawn up	Simon Young	July 2016	

Board of Directors : April 2016

Item : 5

Title : Portman Clinic Service Line Report

Purpose:

The purpose of this report is

- to provide an overview of the work of the Portman Clinic.
- to ask the Board of Directors to confirm whether this paper is accepted as adequate assurance, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place.

This report has been reviewed by the following Committees:

- Management Committee, 14th April 2016

This report focuses on the following areas:

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

For : Noting

From : Stanley Ruszczynski, Portman Clinic Director

Service Line Report – Portman Clinic

Executive Summary

1. Introduction

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

The Clinic has two major areas of professional activity and associated funding. The first is the National Clinical Contract funded by NHS England, and the second is an overlapping range of consultation and service development activities, and teaching, training and CPD programmes, funded variously through the National Offender Management Service (NOMS) and from a variety of commissioning institutions (see below). The financial split between these two areas of activities is approximately 3:2 with growth in the second area.

2. Areas of Risk and/or Concern

- 2.1 The main area of concern in the Clinic results from the continuing reductions in the funding available to mental health, forensic, social care and criminal justice services, and the resultant need to adapt or restructure the nature of the Portman Clinic, its staff group and its range of service and activities. The future of the current National Clinical Contract remains uncertain, but the contract for 2016-17 has been verbally agreed and includes a clause requiring a full 12 month period of notice of termination. There are also uncertainties about the future funding available for the commissioning of teaching, training, consultation and service development activities. This has very recently been illustrated by the decommissioning of two major contracts for teaching, supervision and consultancy with the probation service.
- 2.2 The other area of concern is in relation to staff morale which is constantly undermined by these constant external threats and organisational uncertainties. Over the last few years, these have resulted in a reduction in the size of the staff group, but has now begun to be addressed (see below). The concern is always about how best to maintain high quality practice across the range of the Clinic's various activities.

3. Proposed Action Plan

- 3.1 The concern in relation to the financial concerns is being managed in a number of ways:
 - maintaining good relations with current commissioners, including a new senior commissioner
 - developing presentations of Portman activities to showcase and publicise if/when necessary with local CCGs and other clinical commissioners
 - developing new areas of clinical activity and funding

- maintaining good relations with current commissioners of consultancy and service development activities, and developing new contacts
- pursuing and developing contacts with independent/voluntary/charitable providers of services for patients/clients similar to those of the Portman Clinic
- developing, through the Trust Forensic Portfolio Lead and DET new Portman and Trust wide teaching and training activities
- establishing a research function to demonstrate the efficacy of Portman clinical and consultancy/teaching/training activities

3.2 The concerns in relation to staff morale are managed through:

- protecting the containment and support provided by a strong team ethic and Clinic-specific organisational structures, by ensuring transparency and staff involvement whenever possible when responding to and implementing changes in work activities and professional practices.
- recognising that the nature of Portman patients (i.e. they enact their disturbances in anti-social ways), that treatment is offered rather than only management or institutional care, and that dissemination of Portman clinical experience and knowledge is mostly through consultative and service development activities rather than didactic teaching, all require a critical mass of more senior clinical staff. These factors contribute to the Clinic having a particular place in the mental health, criminal justice and social care domains with the brand name of 'Portman Clinic'. This identity, in itself, functioning to sustain and contain the clinic and its staff.
- the appointment over the last six months of new staff to both add to the size of the clinical group and to bring in new expertise and experience.

Main Report

4 Overview of the Service

4.1 Core identity and purpose

The range of work of the Portman Clinic, all rooted in a developmental and psychoanalytic perspective is:

- a psychotherapeutic assessment and treatment service, offered to
- children and adolescents (including their parent(s)/carers) and adults
- (individuals and couples)
- teaching, training and CPD programmes, in part in association with the DET
- institutional and clinical consultancy
- service development
- risk assessment
- research and publications

The core activity of the Portman Clinic is the assessment and psychoanalytically oriented treatment of patients who are disturbed and distressed by the enactment of

their delinquent, criminal and violent behaviours or who, as a result of their sexual activities, cause hurt and damage to others and/or to themselves. By acting out their conflicts and difficulties, these patients and offenders have a disturbing emotional impact on those around them, including their clinicians and the services charged with their care. This psycho-social impact is inevitably disturbing and has to be taken very seriously in the delivery of clinical services to these patients, and in the understanding and perspective offered in the teaching, consultancy and service developments activities with colleagues working with similar patients/offenders.

The treatments offered are individual, couple and group treatment, and family/carer intervention in relation to children and adolescents patients. Frequency of sessions is mostly once weekly and tends to be medium to long term. Possible new clinical services currently being discussed, planned and piloted are innovative for the Clinic in that they are short term.

Rooted in this in-depth clinical experience, the Portman Clinic provides a range of teaching, training and CPD activities, and organisational and clinical consultancy to colleagues in community or institutional settings working with similar patients and

offenders, and in the development and delivery of new services. This includes supervisors, service leads and managers, as well as front line practitioners

The Clinic's third area of activity is research and publication. Though essential, these activities have been limited because staff have had to focus on income generating activities. (However, see below.) The Portman Clinic's last book publication was in 2014 when it published "*Forensic Group Psychotherapy: the Portman Clinic Approach*". A number of journal papers and book chapters have been published since that time and a book on suicide, co-written by two recently retired Portman clinicians will be published later this year. Another book is currently being written (on management of risk), and two others are being developed.

4.2 Overall vision and strategy

Through its clinical activity, the Portman Clinic is committed to continuing to develop an in-depth conceptual and technical understanding of, and the capacity to intervene psychotherapeutically with, its particular patient/offender population.

Through its teaching, consultancy and service development activities, and its research and publications, the Portman Clinic is committed to adapting, applying and disseminating its clinical experience and practice-based knowledge to colleagues working with similar patients/clients in social care, mental health and criminal justice services, in the community, in residential or in institutional settings.

4.3 Progress to date and current position

The increasing growth in its dissemination activities shows that the Portman Clinic is successfully adapting and disseminating knowledge obtained through its core clinical activities. The Clinic's staff experience and knowledge is valued in community, residential

and institutional services working with similar patients and offenders. The recent appointment of a Forensic Portfolio Lead in DET is already contributing to this development and growth of teaching programmes.

The maintenance of the Portman Clinic's clinical work is essential to grounding these dissemination activities, and plans are in place to engage with local CCGs should there be any threat to the National Clinical Contract. In addition two new clinical services are being developed and piloted, both involving the seeking of funding outside of the current Clinical Contract.

In addition, the Clinic has had funding from the Trust's under-spend to develop, together with independent providers, two new clinical interventions. One is aimed at adolescents, designing a group programme based on therapeutic understandings from mindfulness, mentalisation and psychodynamic principles. The other new is aimed at developing a therapeutic intervention for male gang-members, both those serving prison sentences and those known to services in the community.

5. Clinical Services and Activity Data

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

The Clinic receives approximately 300 referrals per year, split 4:1 between adults and children / adolescents. Adult referrals come from secondary care (50%) and primary care (25%). The vast majority have had a number of previous interventions from mental health services and the criminal justice system. Referrals of children and adolescents come from CAMHS and other mental health providers (34%), from social services (30%) and from Youth Offending services (13%).

The Clinic sees approximately 120 patients at any one time, of which 85% come from within London. About half are seen individually and half in groups, either symptom specific groups or in generic groups.

5.1 Performance against contracts – current and for next financial year

The National Clinical Contract has been frozen for the last four years to just over and activity output has been increased by a reduction in the tariff for each patient. Over the two years, 2012-14 the Clinic over-performed on its clinical contract to the (planned) level of 6-8%. In 2014-15 it under performed by 2% and in 2015-16 it has again over-performed by 7.5%. The contract for 2016-17 is currently being finalised with, at this point in time, a financial envelope very similar to that of the last four years.

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

The number of referrals and the levels of overperformance show a consistent demand on Portman clinical services. Meeting this demand is actively managed to stay within the financial envelope (plus a small overperformance). The annual reduction in the tariff per patient each year, results in more patients needing to be seen for the same funding. This

may explain the 2014-15 unusual small under performance of 2%. For 2015-16, the clinic is (again) overperforming to approximately the planned level of 7.5%.

5.3 Waiting times as evidenced by reports and any plans

Using information provided by Informatics for the recent CQC visit, the Clinic waiting times are:

- **referral to assessment:** a mean average of 8 weeks with a range of 6.3 to 9.9 weeks, within the Trust 11 week target period, with only extremely rare breaches (2 in the last year, one of only a one day). Other services in the Trust show a range of 3.9 - 9.9 weeks.
- **assessment to treatment:** a mean average of 5 weeks with a range of 4 to 6.1 weeks. There is no national target but other services in the Trust show a range of 2.3 - 8.4 weeks

5.4 DNA rate as evidenced by reports and any plans

Using information provided by Informatics for the recent CQC visit, the Clinic is shown to continue to have low DNA rates: in Q2 there were 88 DNAs from a total of 1026 appointments offered, a rate of 8.6%. This figure is lower than most generic services (approx 10-11%), and significantly lower than in other forensic and PD services. Figures for comparison purposes are extremely difficult to find because DNA rates are affected by many factors, including severity of patient pathology, seniority/experience of clinician, type of setting, nature of treatment being offered etc. Research reports/papers show a range of DNA rates of between 7.8% and 34%.

5.5 Ethnicity as compared to local population and national figures.

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

5.6 Supervision / reflection

See below – section 14.6

6 Financial Situation

6.1 Year-to-date financial situation

Please see in the attachment the Service Line Report at Month 10 for 2015-16

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

The 2015-16 Month 10 Service Line Report shows the Portman Clinic is on target for its 2015-16 income. The figures also show a salary underspend of just under £200,000. This figure is understood as being partly:

1. the result of having carried 2 clinical vacancies, which have now been filled (autumn, 2015, and January, 2016). The reduction in the banding for these posts resulted in disappointingly few applicants of the standard required.
2. the product of additional new income coming into the Portman during the course of the year resulting in an addition to the salary budget of 80% of that income. If the income is fixed term and short term, as it almost always is, it is very difficult to use it to increase staff posts, given that most patients require medium/longer term treatment. For example, we have had income in relation to the Mentalisation Based Treatment (MBT) for anti-social (ASPD) patients project, but were anxious not to employ new staff using that income until, in the late autumn of 2015, it was confirmed that the income would continue until 2019 (see below).

These results will contribute to a retained surplus at year end. This surplus will continue the positive financial changes in the Portman Clinic's annual year-end figures which have moved from deficits of £119k in 2009-10, £302k in 2010-11, £106k in 2011-12, £12k in 2012-13, £11k in 2013-14, to a surplus of £149,000 in 2014-15 and one of approximately £170,000 for 2015-16.

In addition to the continuation of the National Clinical Contract, 2015-16 has seen the continuation of good contracts with the probation service, with NOMS in relation to the MBT service development, with consultancy, and with the Personality Disorder Knowledge and Understanding Framework (PDKUF) contract. However, the probation contract has now been decommissioned (it ended on 31 March 2016) and NOMS have confirmed that their financial support for PDKUF service development training will be reducing and will cease altogether in 2018. On the other hand, the MBT for ASPD service development has been successful in its bid to become an RCT trial, with full funding guaranteed until 2018 and acknowledgement that to complete the research, it requires funding for at least one further year.

6.3 Plans for future developments / changes.

The demanding and disturbing nature of the patient population being treated and the complexity and toxicity of the institutions being worked with in dissemination activities, requires in the Clinic staff team a level of training, experience and expertise which is signalled by appropriate salary levels offered to new staff. With downward pressure on salaries, recruitment of new staff and succession planning has been difficult. However, in the last six months the Clinic has actively and successfully appointed a number of new staff (see below).

6.4 Plans for productivity / service redesign.

The Portman Clinic has been reasonably successful in its drive to improve productivity. It has done so by both diversifying its range of activities, especially in relation to growing its consultation, service development and its teaching activities (together with DET) , and by managing to recruit new staff at a lower salary banding.

7 Clinical Quality and Outcome Data

7.1 Description of what has been used

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

Experience of Service

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

Outcome monitoring

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

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

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

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

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

Patients in the Mentalisation Based Treatment for Anti Social Personality Disorder (MBT-ASPD) service receive, with informed consent, a comprehensive battery of measures as this service has been and will now continue to be part of a research project. Service user involvement has been integral to the evaluation of this service, and we have modified elements of the service and its evaluation in response to patient feedback.

8. Feedback

Given the complex nature of the patient population served by the Clinic, remarkably few complaints received and even fewer become formal matters.

No formal complaints were received by the Portman in 15-16 and only one complaint in 2014-15. This unfortunately developed into an Serious Untoward Incident, a process that continued into 2015-16 (see below).

The Clinic continues to develop service user involvement as appropriate. For some years, service users have been involved in planning and being part of various courses and programmes. In addition, a service user (from the MBT project) has presented at the Trust Board meeting. Two current service users were prepared to talk anonymously to CQC inspectors during their recent visit. And finally we have run three CPD events involving past and current (not Portman) service users, focusing on violence, gang culture and sexual exploitation of young people.

9. Serious Untoward Incidents and Safety Issues

There have been two SDUIs in the last year:

1. One occurred when a staff member was briefly confronted by an ex patient who approached him on Finchley Road and threw water at him from a small bottle of water. This patient was in the process of a formal complaint, but that was brought to an end by this incident when the matter was taken up with the police who have dealt with it as a criminal matter.

The main learning point from this incident was in relation to the assessment for treatment of prospective Portman Clinic patients. The issue of forensic/anti-social personality disordered patients' capacity to make use of and be contained by treatment in the Clinic, and not enact their difficulties (and past enactment is one of the 'passports' into the Clinic) was reviewed and found to be robust.

2. The second SUI was in relation a group therapy patient who took an overdose in the waiting room in front of another patient waiting to start the same group. A Root Cause Analysis Investigation Report was conducted and the investigator found that this patient had been carefully and thoroughly assessed for suitability for psychotherapy, evidenced by notes and reports in the file. The investigator found no evidence to support the proposal that the overdose could have been predicted or prevented and concluded that the case was well handled with no significant lessons to be learned.

10. Clinical Governance and Audit

10.1 To include projects / activities to date

Recent audits carried out have included

- referral sources
- presenting problems at referral
- engagement by patients treated via the Portman Clinic's MBT for ASPD service
- nature of violence in the referral or histories of patients referred to the Clinic

Part of the purpose of these audits was to provide clinical information regarding the nature of patients currently referred to the Clinic and how they are managed, as information which might be of value and interest to CCGs should we need to approach them when the current National Clinical Contract comes to an end.

In the second half of 2015-16 the Clinic was working on developing its Assistant Psychologist post, someone who would often be central to audit projects, into a Research Assistant post (which finally led to an appointment in mid-January 2016).

11. Education and Training

11.1 Description of range and direction of travel

Most Portman teaching and training activity is delivered through clinical and organisational consultancy within the criminal justice, forensic mental health and Personality Disorder services, rather than through didactic teaching. This involves Portman staff going out to host institutions and leading clinical and organisational discussions and programmes with the teams about their work with forensic patients and offenders. These reflective practice seminars are designed to assist individuals, teams and managers to contain, process and understand the disturbing and often toxic dynamics which inevitably exist in these settings. The milieu of the setting, the team and the culture of reflection, are understood to be primary therapeutic agents.

Increasingly the Clinic is engaged in didactic teaching activities and in developing new programmes. The most significant course is D59F, currently in its second academic year, linked with the Trust's D58 programme. This is a BPC accredited forensic psychotherapy training aimed at colleagues who already have some psychodynamic and forensic training and experience and want to further develop their knowledge and expertise.

There is ongoing activity in relation to organisational, administrative and teaching activities related to the national delivery of the PDKUF. The PDKUF is a range of national learning and teaching programmes addressing the development of services specifically for people designated as suffering from Personality Disorder. One 0.6 wte Portman clinician dedicates all her time to leading on this area of work, based in the Institute of Mental Health, University of Nottingham, which leads on the delivery of the programmes. This NOMS funded programme is now being phased out to end in 2018.

The Portman Clinic has had a contract, originally commissioned in early 2013, with the 'old' London Probation Trust (LPT), then re-commissioned by the newly 'transformed' Probation Service (split into the Community Rehabilitation Companies [CRC] and the National Probation Service [NPS]). This offered clinical supervision (individual and team) to all probation staff across London. This contract came to an end on 31 March 2016.

Predating the 11.13 above, and continuing in parallel, the Portman has run a number of teaching seminars/practice supervision seminars for probation staff from local probation offices using local training funds. The future of this programme is not yet clear.

Portman Clinic staff participates in a number of Trust wide courses and trainings as well as offering supervision and consultancy to Tavistock Clinic colleagues. In addition to D59f referred to above, the Portman Clinic runs a number of short courses, CPD lecture series and seminars, including courses on Risk Assessment and Management, a seminar/clinical discussion series at NSCAP in Leeds and various CPD programmes and events.

Jointly with the West London Mental Health Trust, the Clinic runs a medical training in forensic psychotherapy, a 'dual' training in forensic psychiatry and medical psychotherapy.

The Portman Clinic has one child and adolescent psychotherapy trainee undertaking the Trust's Child Psychotherapy programme and we are in the process of recruiting a second trainee for 2016-17.

11.2 Activity and financial performance against targets

All financial targets for institutional and clinical consultancy, teaching and supervisory activity with the probation service, for the PDKUF programmes and the Mentalisation Based Treatment programmes have been met for 2015-16, but as referred to above the contract with the probation services(s) has now been decommissioned and the PDKUF programme is beginning to be wind down.

To date, targets for Portman Clinic more didactic teaching activity have been modest, so the recent developments in this area are to be welcomed, as is the recent appointment of a DET Forensic Portfolio lead whose responsibility includes the development and growth of additional dissemination opportunities and teaching from Portman Clinic staff. This is an area for future development and growth.

11.4 Issues relating to trainees – management, satisfaction etc.

The D59f training programme has been very exciting in the speed of its establishment, and has required a lot of active management. Being a specialist forensic course, almost all the teaching and clinical supervision is carried out by Portman staff and this, together with the trainees seeing carefully assessed Portman patients under supervision, is making substantial new demands on staff resources.

Conferences

The Clinic has organised a small number of half day and evening conferences including on female sexuality and on gangs. Film, theatre and a play reading have been employed to deliver the learning opportunities and have been delivered with actively collaboration and participation with service users.

12. Research

12.1 Description of current activity and aspirations

The Portman Clinic employs one staff member in a post specifically designated as a consultant adult psychotherapist/researcher post. Together with other colleagues and an Assistant Psychologists there has been some development in the research mindedness of the clinic resulting, for example, in regular audits.

To try to develop more research, the Clinic has restructured the Assistant Psychologist post which we have had for a number of years, and have now appointed a Research Psychologist. We have been very fortunate to be able to employ the colleague who was centrally involved in the very important and recently reported on, with universal acclaim, Tavistock Depression

Study. This appointment of a dedicated researcher, is a very significant development in the potential output from Portman Clinic.

12.2 Regular audits are carried out of both child and adolescent and adult referrals as described above..

12.13 Projects

There are currently two major research projects. These are:

- evaluation of a Mentalisation Based Treatment group for men with ASPD, in Partnership with Anthony Bateman, Peter Fonagy and colleagues on 14 sites across the UK.
- in partnership with Cardiff University and Grendon Prison, using the Implicit Association Test to test psychoanalytic assumptions about different types of violence enacted by offenders.

Funding has been secured for the MBT project to become an RCT project, a major project in collaboration with Peter Fonagy and University College London and Anthony Bateman and the Anna Freud Centre.

13 Consultancy

13.1 Description of current activity and aspirations

Many forensic/personality disordered patients and offenders are cared for in secure institutional settings, or, if managed in the community, are often known to a multidisciplinary team. It therefore follows that the 'training of choice' is often that of clinical consultancy delivered in the setting and involving the entire multi-disciplinary team. In addition, consulting to the managers and service leads can protect the institution and managerial functions from being affected by the inevitable emotional impact of managing and offering treatment to forensic patients/offenders.

In the last year, the following organisational and clinical consultancy has taken place:

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

- to independent/private/charitable providers of social care provision, mostly to young people in danger of falling into criminal gang related activity

As referred to above, the MBT service for ASPD groups has now secured the funding for a national RCT research project. Securing this commission and funding for this national service development is a very significant achievement for the Clinic.

13.2 Financial reporting

See above in relation to the funding for the MBT for ASPD patients research/consultancy/service development.

14 Staffing and HR issues

14.1 Information about members, grades, and disciplines.

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

14.2 Planned staffing structure

The Clinic is managed by a Clinic Director and organised as one team made up of 10.15 wte permanent clinical staff, made up by 16 people. Of these, 2 are on 3 sessions per week, 1 is on 4 sessions per week and all others are on 5 sessions per week more. The number of staff on less than 0.5 has been actively reduced in the last few years.

In addition, the Clinic has 1 full time medical SpR trainee, 1 full time child and adolescent psychotherapy trainee, 1 full time Research Psychologist, plus 2 one day a week honorary staff. This clinical group is supported by an admin group of 1.7 wte and a receptionist, managed by an Administrative Manager.

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

As a result of ongoing significant cost reductions in annual budgets, the Portman's clinical staff group had fallen in number in the last 5 years, but is now growing again. New clinical staff posts are two 0.6 wte, one 0.3 wte, and a current staff member increasing her sessions from 0.8 wte to 1.0wte.

Table 1 below gives staffing over the last 5 years.

	Whole Time Equivalents (WTE)
Consultant Adult Psychotherapists	6.20 (2010) 5.20 (2014) 4.20 (2015) 5.7* (2016)
Consultant Child and Adolescent	2.60 (2010) 1.75 (2014) 1.75 (2015) 1.75**
Consultant Psychiatrists in Psychotherapy	3.45 (2010) 2.50 (2014) 2.60 (2015)
Total Clinical Staff	12.25 (2010) 9.45 (2014) 8.55 (2015) 10.15 (2016)

Some detail regarding these figures for 2016-17 are:

* the 5.7 adult figure will drop to 5.1 wte, at the end of July when two current staff members (between them) reduce their sessions by 0.6wte.

** there is no actual increase in the 1.75 wte of the child psychotherapy group (3 people) but one of the new adult staff members has experience and expertise in child/adolescent work, as has another adult staff member whose sessions have been increased by 0.2wte, and both will contribute approximately 2 sessions to working with child/adolescent patients.

*** the addition 0.1 wte to the 2.7 medical group (4 people) is for one of them to take on responsibility, in-house, for Clinical Governance.

The Clinic has long employed one full time Assistant Psychologist and we have successfully developed this into a more substantive Research Assistant post, with a view to actively developing our research function.

One Portman clinical staff member also holds a post of 0.2 wte at Broadmoor Hospital, another also holds a post in a local CMHT, and two also holds post in other parts of the Trust.

14.2 Planned staffing structures

As mentioned above reducing the banding for clinical staff posts made it very difficult to recruit to staff vacancies which existed in the Portman Clinic but this has now been achieved.

14.3 Succession planning

Succession planning has been in place for the last two or three years with a number of senior staff leaving or retiring and being replaced by younger colleagues, on a lower pay banding. A senior staff member, who retired, returned to work on specific projects, continues to reduce her time towards full retirement. A further change will take place when at the end of July 2016, the current Clinic Director steps down from this full time post, but will remain on the staff group for 6 sessions.

Planning for the management of these changes over the last few years has been taking place as described above. In addition a clinical training has started which involves students who are undertaking the training, seeing Portman patients under supervision. By this means we offer substantial training for colleagues working in sister organisations and have our patients treated, under supervision, without additional staff costs.

14.6 Supervision / support / reflective practice and how this is achieved

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

As described above all clinical staff are trained and experienced in one of the core NHS disciplines, and all have further specialist psychoanalytic trainings.

The clinical work is supported by two mandatory clinical meetings, one supporting individual treatment and the other supporting group treatment; and by a fortnightly meeting where assessments and appropriate disposal of patients following assessment is discussed.

The whole Portman staff group meets at least once a term to discuss and decide on policy matters and has an annual whole day Away Day to more fully consider and debate policy issues and the establishment of new projects.

The administrative staff have meetings to discuss details of their own structures and work, and to process the impact of the often very disturbing material they are reading and typing.

Staff Statements

Administrator

I first joined the Tavistock& Portman NHS Foundation Trust in 1999, working in the Adolescent Department of the Tavistock Clinic as Personal Assistant to two clinical leads before moving on to become the administrative coordinator for a number of different therapeutic services. During this time I learnt a lot about the specialist nature of administration in mental health research, training and patient services, as well as the basic principles of psychoanalytic and psychodynamic psychotherapy.

Last year I joined the administrative team at the Portman Clinic where my prior experience has been invaluable. My initial apprehension about moving from more generic to forensic services was soon dispelled when I was welcomed by the Clinic's caring, warm, friendly and professional team.

My current role focuses on patient referral through to clinical assessment stage work; whilst quite different from referrals I used to process for young people, students, their parents and families, my work at the Portman Clinic has been equally if not more, challenging, interesting and rewarding. The challenges presented are by calls or visits by distressed or difficult patients, external demands resulting from ongoing reorganisation and cuts to services leading to increased pressure and demands e.g. to accept less than appropriate referrals and provide more data more quickly. The interest and rewards are in learning about the

difficult human stories and the processes used by professional colleagues to bring about positive outcomes for their patients.

Above all, what stands out to me (and was something that was evident in my previous position also), is the camaraderie and strengths of the small specialist team, as well as the exceptional level of care for and quality of thinking about the patients, many of whom might not be judged sympathetically or worthy of caring for by wider society. I feel privileged to be able to play a small part in the work of such an excellent team; and lucky too to be continuing to learn through my day to day work at the Portman Clinic.

Consultant Psychiatrist

Clinical work

Working with patients at the Portman Clinic is demanding, complex and very interesting. We manage high levels of risk in our day to day work and rely heavily upon the excellent working relationships we have with our colleagues in order to do so. Our patients have suffered multiple failures of containment and so establishing a stable, well-functioning network of professionals around the patient (from both within and outside the clinic) is essential to support our direct therapeutic work. The work can be stressful at times, but when a crisis is averted or well-managed, this provides a great source of satisfaction.

One of the most rewarding things about working at the clinic is to know that we provide a service for patients who would probably not obtain the treatment they need anywhere else. Our patients are usually very grateful, not only to be offered psychotherapy, but also to be able to come to a place where they are not judged for acts they have committed which are often abhorrent both to society and to themselves. Sometimes, after a period of treatment, they manage to build a sense of self-esteem and confidence which enables them to work, or to develop a relationship.

I run two therapeutic groups, and see patients on an individual basis. I also offer supervision to clinicians working within and outside the clinic. One of my therapy groups caters for men who have accessed illegal images of children, and wish to stop doing so. This provides an insight into the multitude of factors which can contribute to a person's movement into illegal online activities, a problem that is increasing rapidly in society. Whilst other psychological interventions aim to reduce re-offending in this area, at the Portman clinic, we have the privilege of working at a depth which provides an understanding of the fine developmental aspects of these problematic behaviours. In this way, we can develop a unique perspective on problems of this sort.

Teaching and training

I am involved in the Portman's clinical training in forensic psychotherapy (D59f). Our hope is to train clinicians in providing psychotherapy for persons who struggle with perverse or violent behaviours. Organising the lectures, supervisions and seminars is at times difficult but ultimately very rewarding. We hope to train clinicians to provide a psychodynamic understanding of offending, and to take this into their workplaces.

In general, teaching others about the psychodynamic insights that we have developed over the years is well-received. Professionals find that considering the unconscious motivations behind destructive behaviour can provide a depth of understanding that enhances the

services we provide greatly, and it is always satisfying to be told after a talk or seminar that you have helped someone to understand something important about their patient.

Consultation

Some of my work involves going into prisons and secure units in order to provide a reflective space for staff working with highly disturbed clients, often within very challenging settings. This is interesting work – sometimes staff will come with a problem that they are struggling with, or a difficulty they have in managing a particular patient. Often, providing an alternative viewpoint can help to ‘unblock’ a stuck situation, whether within the patient, the staff group, or both. The probation staff whom I have supervised in a London prison for the last 3 years, are very upset that they will not be receiving supervision after the prison closes in June. I have always enjoyed working at the Portman clinic, and cannot imagine working in a better place. It requires dedication and focus, but is ultimately extremely rewarding.

15. Cross-Directorate and Trust

15.1 There are a number of cross-directorate staff roles:

- one of the Portman clinical staff member also has two Trust-wide roles, these being that of Trust Assistant Medical Director and Trust Director of Medical Education.
- one Portman clinical staff member also has sessions in the child and family directorate
- one Portman clinical staff member also has sessions in the Complex Needs Directorate
- a Portman Clinical staff member is also the DET Trust-wide Forensic Portfolio Lead
- the Portman Clinic MBT Project Implementation manager (administrative) also has sessions in the Trust Commercial Directorate

15.2 Prospects and challenges

The Portman Clinic continues to hold a National Clinical Contract, at least for the next year, and has successfully diversified its activities into consultancy, service development, teaching and training.

In relation to its 3 main developmental projects, as referred to above, the MBT project will go on for the next 3 years funded as an RCT research project. The PDKUF project will go on but will be wound down to 2018 and the probation activity has come to an end. These activities are major projects which have been very important in embedding the Portman Clinic, and the Trust as a whole, in the development of services for offenders and others with forensic presentations and/or personality disorder.

The loss of these projects is very disappointing but the Portman Clinic has begun to develop teaching and training activities (child psychotherapy and D59f courses) and, through the Trust Forensic Portfolio Lead, has begun to design and develop other teaching projects, which will add to the Clinic's and Trust's dissemination activities.

The current external climate is very difficult but the Clinic has shown over the last few years that it can diversify its activities, with both professional and financial benefits, and the challenge is to continue to do so.. Working with the Forensic Portfolio Lead and the DET is obviously a very important contribution to that aspiration, and the financial arrangement need to be designed to allow this to happen.

The Portman Clinic has made a start on training in the use of CareNotes, the use of which has been delayed because of concerns about patient confidentiality,

15.3 Any plans

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

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

Succession planning has been in place to manage the stepping down from role, on 31 July, of the current Portman Clinic Director, both in relation to his Director role, which will need to be advertised soon, but also in relation to some of his developmental activities which are being taken up by Clinic colleagues.

Stanley Ruszczyński
Director
Portman Clinic
April 2016

Appendix 1

Portman Service Line Report Month 10 15-16

Portman SLA M10 15 16		
Adult & Forensic Services	Portman	Portman
	Budget 15 16	Actual 15 16
Portman National Commissioning	986,149	986,149
Portman additional work & other	50,147	28,897
London Probation	102,338	126,947
MBT SLA	206,190	206,190
National Contract	125,839	125,839
<u>CONSULTANCY</u>		
Consultancy	100,000	98,796
PDKUF	49,998	45,833
<u>BUILDINGS</u>		
Buildings	6,324	6,630
	1,626,985	1,625,282
Adult		
Portman	-1,107,060	-923,247
Portman PDKUF	-50,980	-51,451
Portman MBT	-178,937	-163,045
<u>BUILDINGS</u>		
Buildings	-173,025	-190,236
	-1,510,002	-1,327,978
	116,983	297,304
<u>CENTRAL FUNCTIONS</u>		
Income	8,127	11,708
Expenditure	-144,980	-138,720
RETAINED SL SURPLUS	34,766	170,291

Board of Directors: April 2016

Item : 7

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. QAA

- 1.1 A team from the Quality Assurance Agency for Higher Education (QAA) will be visiting the Trust between 26th and 29th April. A very helpful rehearsal event was held on 11th April, facilitated by colleagues from the University of Essex.

2. National Training Contract

- 2.1 I met with the Directors of Education and Quality (DEQs) at Health Education England on 4th April to discuss the future of the National Training Contract. This was a constructive meeting with support from the DEQs for the direction of travel of our proposals to better align our portfolio with HEE priorities and to extend the reach of our training. We are now in discussion with HEE to confirm key milestones for the contract for 2016/7.

3. North Central London Mental Health Programme

- 3.1 We have continued to engage with work on the development of the Sustainability and Transformation Plan in North Central Plan. A first submission was made on 15th April. We have confirmed that the Trust is included in the scope of the Plan.
- 3.2 Work has continued on the mental health programme within the plan. 5 priorities for the programme have been agreed:
- Perinatal mental health
 - Children and young people's mental health
 - Primary care models of primary care
 - Acute care (including both crisis care and mental health input into acute hospitals)
 - Specialist services including rehabilitation and female PICU
- 3.3 A further stakeholder event for the programme is planned for 12th May.

4. Joint Board - relocation

- 4.1 A Joint Board meeting with Governors was held on 12th April. This was a helpful occasion to address questions about the OBC from a new group of Governors.

5. Junior Doctors' Industrial Action

- 5.1 Because of the nature of the services that we provide the direct effect on the delivery of our services as a result of the Junior Doctors strike action on the 26th and 27th April will be minimal. We continue to consider with the Junior Doctors and Human Resources the impact of the ongoing industrial action and implications of the new contract.

6. Adult and Forensic Services

- 6.1 Following interviews on 8th April I have been very pleased to appoint Julian Stern as the Interim Director of Adult and Forensic Services.

7. Simon Young

- 7.1 As colleagues will be aware Simon Young has announced his intention to retire at the end of September. Simon has been with the Trust for over 20 years and has made an enormous contribution to our work in that time. A paper will be going to this afternoon's Remuneration Committee with a proposal for starting a process to recruit his successor.

Paul Jenkins
Chief Executive
18th April 2016

Board of Directors : April 2016

Item : 9

Title : Department of Education and Training Board Report

Purpose:

To update on issues in the Education & Training Service Line.

This report focuses on the following areas:

(delete where not applicable)

- Quality
- Risk
- Finance
- Productivity
- Communications

For : Noting

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

Department of Education and Training Board Report

1. Introduction

- 1.1 The Training and Education Programme Management Board did not meet in April 2016. This report sets out key developments in the Education & Training Service Line since the last report.

2. New Structure

- 2.1 The restructuring of the professional support services is now complete with most of the staff in new roles.
- 2.2 The transitions teams has been working effectively with the first iteration of the standard operating procedures published. These will be reviewed in three months. The work on charters for collaboration have been initiated.
- 2.3 There is a directorate wide event planned for 6 May 2016 for staff to come together to further help consolidate and embed the changes including providing staff with space to interact and communicate about the changes and future collaboration.
- 2.4 Building work has now begun on phase 2b of planned works to redevelop the offices for the administrative hub and for the creation of a new student receptions area. This will be a significant enhancement for students and facilitate engagement and manage enquiries.

3. Student Recruitment

- 3.1 The student recruitment team has now taken on the responsibility for the management of the pipeline from enquiries by prospective learners and the management of the application and interview processes and the offer of places to new students. The team is bedding in well into the new structure and is working well with other involved teams including the course administrators and the portfolio managers and course leads and teams.
- 3.2 Data management has improved on last year accompanied by a far more systematic and active lead management approach.

3.3 Some recruitment highlights are as follows:

- 3.3.1 Changes to the landing pages on the current website continues to drive increased traffic to the course pages.
 - 3.3.2 April Open Evening has 200+ registrations and course specific open evenings have attracted around 100 registrations.
 - 3.3.3 Webinars with the Dean and Associate Deans are being planned for those who are unable to visit the Tavistock Centre and/or for whom such visits are not relevant.
 - 3.3.4 Engagement with Associate and alternative centres to raise profile of our work across national centres.
- 3.4 Currently we have a 37% increase on submitted applications compared with the same point last year.
- 3.5 Work is underway to combine recruitment target tracking with financial plan to provide oversight of performance.
- 3.6 Employer engagement is being mobilised with the further embedding of the Commercial Engagement and Development Unit. The portal for our LCPPD commissions will be opening on 16 May 2016. There are concerns about the impact on the levels of activity in light of the strong likelihood of reductions in workforce development.

4. QAA Review

- 4.1 Planning and preparation for the QAA visit in the week commencing 25 April 2016 is well underway. The review team will be visiting the Trust for four days from Tuesday, 26 April to Friday, 29 April 2016.
- 4.2 The QAA have asked the Trust Facilitator, who is our Head of the Academic Governance and Quality Assurance unit, to arrange nine meetings with different constituencies, including senior staff, academic tutors, students and national centre colleagues. They are, of course, able to request meetings with staff and request information during the visit.
- 4.3 The QAA inspection team have now shared their view on eight possible lines of enquiry, including enhancement; assessment; our national centres (management, links & monitoring); transfer of courses to Essex; support for students; staff development; and our plans for the future (recruitment, new centres, and training for lower level qualifications – CPD and undergraduate).
- 4.4 Colleagues from the University of Essex have helpfully engaged staff in preparation through the hosting of two mock events, which

included Sally Hodges and two NED colleagues: Edna Murphy and Ian McPherson.

- 4.5 Following the last Board meeting discussion arising from the presentation of the Social Care, Management & Leadership portfolio, I would like to give assurance that I do not believe the recent outcome of the validation of the M55 programme is a significant concern. Essex stepped up the volume and pace of the initial validation programme to facilitate new teach out arrangements with UEL that were agreed last year. These validation events have been successful and have underpinned confidence in our new collaboration. Re-validation will take place in June 2016 once the recommendations from the validation report have been addressed.

5. SIMS

- 5.1 The SIMS project has progressed since the FBC was approved by the Board in January 2016.
- 5.2 The membership of the project team and the Project Board has been refined with the requirements of this next phase of the project in mind. Edna Murphy will be joining the Project Board as we go forward.
- 5.3 Ricky Kothari is now working as the project manager and Angela Tikka is now engaged as the project management officer.
- 5.4 The kick-off sessions with the supplier are now underway and progressing to the high-level plan. DET staff engagement has been high and progress with data build is going well.
- 5.5 Further engagement with Tribal around information delivery is required. The timescales are tight for implementation.
- 5.6 There is a milestone plan for this set-up stage in place and progress is being made against plan.

6. Visiting Lecturers Review

- 6.1 The Visiting Lecturers review is now well underway.
- 6.2 Proposals will be brought to the May 2016 TEPMB before coming to the May Board.

7. HEE funding for Allied Health Professionals

- 7.1 This was discussed at the recent joint Board/Council meeting. There was a helpful discussion and an offer from the governors to be engaged further should this be useful.
- 7.2 A consultation on Education Funding Reforms has been published, which is due to end on 30 June 2016.
- 7.3 Approaches to the consultation will be considered at the May TEPMB meeting.

8. Student Support

- 8.1 Significant work has been in progress to review and consolidate our processes and procedures in relation to support for students with disabilities. This has been led by our Associate Dean, Academic Governance & Quality Assurance.
- 8.2 The Interim Operations Development Manager who oversees the work of the Course Administrators will now be the lead for assisting students with disabilities. They will be responsible for ensuring relevant staff are made aware of information regarding students with disabilities and will provide guidance and support to those staff liaising with students. They will also monitor responses and the policy itself.
- 8.3 Course Administrators will have responsibility for coordinating support for students with disabilities. They will be expected to keep accurate records of support offered to students. Recruitment advisors will be required to inform course teams within 28 days of a student with a disability accepting a place on a course to enable them to offer appropriate support.
- 8.4 The Trust is exploring the possibility of being able to carry out assessment of student needs itself which it is currently not equipped to do.
- 8.5 Our Associate Dean, Karen Tanner recently attended the Stonewall Workplace Conference. As a result we are looking to send staff on the Stonewall Leadership programme and are also reviewing our promotional materials to ensure LGBT representation.
- 8.6 An inclusive curriculum event has been set up for September. This was developed with Stonewall and is for teaching staff to ensure that our courses are covering LGBT issues and that they acknowledge and discuss historically held views regarding homosexuality and

make clear that these views are not promoted. It will consider what inclusivity looks like and how we can promote this in the Trust.

- 8.7 A further important area for both our work on supporting students with disability and our equalities initiatives is with regard to communication to relevant groups, including on the new website and on Moodle.

Brian Rock
Director of Education and Training/Dean of Postgraduate Studies
18 April 2016

Board of Directors April 2016

Item : 10

Title : Q4 Review of Strategic Objectives

Summary:

The first meeting of the Strategic and Commercial Committee, following changes to its terms of reference to reflect its role in monitoring progress against the Trust's Strategic Plan, took place on 12th April.

A primary function of the Strategic and Commercial Committee (SaCC) is now to:

'review progress against the Trust's Strategic Plan, to provide the board with a quarterly report highlighting plans which are not on track or wider issues which affect the plan and what mitigating actions could be taken.' (SaCC terms of reference).

The key purpose of this first meeting was to 'trial run' a RAG rated reporting format using Q4 2015/16 data. Full reporting, with feedback to the board, will take place after the July meeting, which will be reporting against Q1 2016/17 milestones.

A number of important learning points were identified from the first review, which included presentations on four of the strategic objectives:

- Overall support for the review format;
- RAG rating to distinguish between achievement of objectives/milestones for the previous quarter and impact on overall achievement of objectives;
- Reviews to include a section on interdependencies, with more consistency required between RAG definitions and

commentary;

- Objective/success criteria to be reviewed every 6 months to ensure that they are still appropriate;
- More explicit link between activities and the Trust's strategic objectives required in some areas.

A more detailed verbal update on the meeting will be given at the board if required.

For : Discussion

From : David Holt, Chair of Strategic and Commercial Committee

Board of Directors : April 2016

Item : 11

Title : Quarterly Quality Report 2015-16 , Quarter 4

Summary:

The report provides an update of the Key Performance Indicators (KPIs), CQUIN and Quality Indicator targets for Quarter 4, 2015-16. The report combines performance data reported to the Board and commissioners (CQRG) for the main Trust contracts.

Work has been undertaken in Q3 to validate the outcome data.

This report has been reviewed by the following Committee:

- **Management Team, 19 April, 2016**

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

This report focuses on the following areas:

- Quality
- Patient / User Experience
- Safety

For : Noting

From : Associate Director of Quality and Governance

Tavistock and Portman NHS Foundation Trust

Quarterly Quality Report for Board of Directors & CQRG

Quarter 4: March 2016

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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 RAG							
Waiting Times Waiting time no more than 11 weeks (77 days from receipt of referral) for all services except GIDS and City and Hackney which has a national target of 18 weeks (126 days). Data reported represents Internal Breaches.	Quarterly	< 11 weeks - 77 days (1% threshold) 10%	Q1		Q2		Q3		Q4*		Q1	Q2	Q3	Q4
			N	%	N	%	N	%	N	%				
			18	4.3%	15	3.0%	26	4.1%	5	0.6%				
			1	4.8%	0	0%	1	3.5%	0	0%				
			n/a	n/a	n/a	n/a	n/a	n/a	5	0.7%				
		< 18 weeks- 126 days (1% threshold 10%)	n/a	n/a	11	6.0%	12	10.5%	5	2.6%				
			n/a	n/a	n/a	n/a	n/a	n/a	250	**				
			Q1		Q2		Q3		Q4		Q1	Q2	Q3	Q4
			8%		11%		9%		7%					
			No larger than 10%	7%		8%		9%		7%				
9%		8%			8%		7%							
n/a		n/a			n/a		6%							
3%		11%			15%		11%							

*For Q4, there were 15 waiting time breaches, where patients were required to wait 11 weeks or longer for their first appointment. However, only 5 of these breaches related to factors internal to the Trust and represented 0.6% of the total number of patients who were offered a first appointment in Q4. Waiting times ranged between 11 weeks (and 1 day) to 25 weeks (internal reasons) / 26 weeks (external reasons). This data now excludes City and Hackney and GIDS data. They are reported separately due to national 18 week breach target **This relates to 248 patients who were offered a first apt but these patients aren't necessarily the 250 patients who breached during Q4. These numbers also include patients on the waiting list. Please note N/A data was data which was not requested in previous quarters.

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		Q4					
			N	%	N	%	N	%	N	%	Q1	Q2	Q3	Q4
			Patient Satisfaction (Q15 from ESQ) Patient Satisfaction: Target 92% or more report satisfied with the service	Quarterly	92%	210	92%	102	94%	143	92%	238	95%	
Personal Development Plan Quality and Development of staff: Target 80% of staff to have a PDP.	Quarterly	80%	99%		99%		99%		99%					
Sickness and Absence Sickness and absence rates. Target: <2% green (2-6% amber, >6% red)	6 monthly	<2%	n/a		0.7%		1.2%		1.2%					
Trust Service cancellation rates Target: <5% green (5-9% amber, >10% red)	Quarterly	<5%	2.4%		2.3%		2.5%		3.0%					
Staff Training* % of staff with up-to-date mandatory training for infection control. Target >95% green. 80-95% is amber < or = 80% red.	Annually	>95%	91%		N/A		96%		N/A					
DBS Checks DBS renewals - Copy of certificate submitted to trust within 1 month of renewal date	Quarterly	100%	Please see 'Enhanced DBS Checks on page 8 for further details'											

*Please note that the Trust delivers mandatory training via INSET day in Q1 and Q3 each year.

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	%	Q1	Q2
Explanation of Service (Q6 in ESQ) Number and % of children who answer certainly agree that they received a clear explanation of service	Quarterly	75%	41	77%	34	97%	30	80%	44	85%		
Care Plans A - % of care plans evidencing co-production with service users*	6 monthly	n/a	n/a		See narrative below		Report unavailable. Informatics working on pulling this information to report in Q4.		Baseline audit completed: Cohort 254 patients. See detail below*			
B - % of care plans evidencing input from primary care (Baseline for 15/16)**												

*Please see below where Careplans have evidenced co-production with service users:

Team	Sample size	Care Plans where treatment was discussed	Care Plans where risks/benefits were discussed	Care Plans where alternatives were discussed	Care Plans where alternatives were detailed	Care Plans where patient consented
Combined Total	254	237 (93%)	232 (91%)	202 (80%)	182 (72%)	195 (77%)

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

*In Q4 there were 0 complaints received by the Trust. Please see CGR Report for further details.

**CGR report covers complaints – a separate PALS report will go to Quality & Patient experience workstream meeting.

***2 complaints with the NHS Health Service ombudsman. Outcome not yet known.

Quality Key Performance Indicators									
Target	Monitoring	Target %	Progress				% Progress for 2015/16		
			Q1	Q2	Q3	Q4	Q1	Q2	Q3 Q4
B - Provide bi-annual complaints and claims lessons learnt report with: i) Themes of lessons learnt including breakdown of clinical policy/clinical pathway areas where complaints are made* ii) Detail of actions undertaken as a result of complaints	Quarterly	n/a	n/a	Achieved	Achieved	Achieved			
			n/a	Achieved	Achieved	Achieved			
Serious Incidents Improvement trajectory agreed for the following: A- No. of Serious Incidents (SI) submitted within the designated timescale B - Where SI reports are returned incomplete, % returned complete within 10 working days.	Monthly		January 16	February 2016	March 16				
			0	0	0				
	Quarterly	n/a	0	n/a	n/a	n/a			
C - Evidence of implementation of action plans	6 Monthly Audit		n/a	n/a	n/a	Achieved			
D - Organisational learning identified and actions embedded as a result in 100% of SIs.	Q4		n/a	n/a	n/a	Achieved			
Safeguarding Completion and submission of the NCL Safeguarding Children and Adult Metrics Return	Quarterly	n/a	Achieved	Agreed submission date: 17/10/15 Submitted Children's Metrics 23/10/15	Achieved: Submitted 5 th January 2016 to CCG (Jackie Dyer – Children's metric)	Achieved: Submitted 15 th April 2016 to CCG (Jackie Dyer – Children's metric)			
Female Genital Mutilation*** A - To include FGM as part of mandatory safeguarding training levels 1, 2 & 3, 80% of staff will be trained in safeguarding		80%	L1: n/a	L1: n/a	L1: n/a	L1: n/a			
			L2: 98%	L2: 98%	L2: 97%	L2: 91%			
			L3: 94%	L3: 93%	L3: 89%	L3: 90%			
B - Safeguarding alerts raised and number counted within service in accordance with NICE guidance****	Quarterly	n/a	3 Adult and 17 Safeguarding Children alerts	2 Adult and 10 Safeguarding Children alerts	1 Adult and 24 Safeguarding Children alerts	1 Adult and 18 Safeguarding Children alerts			

*Annual complaints report for the April BOD Meeting **Serious Incidents Action log audited and updated by relevant leads

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

**** Results published in Q4 Corporate Governance and Patient Safety and Risk Compliance Report

KPIs NCL Trusts

Quality Key Performance Indicators											
Target	Monitoring	Target %	Progress				% Progress for 2015/16				
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Compliance Compliance with relevant standards of the Mental Capacity Act are completed and DOL applications and outcomes.*	Quarterly	n/a	Yes	Yes	Yes	Yes					
Audit of Trust Consent Policy standards To perform an audit on 20 patient notes in Q2.	Q2 Audit	n/a	n/a	Small audit completed	Completed - reported in comprehensive case note audit report	n/a					
Assessment Reports Provide CCGs with a copy of all internal process and compliance assessment reports, action plans and progress updates	Quarterly	n/a	Relevant report submitted to regular CQRG Meetings.	Relevant report submitted to regular CQRG Meetings.	Relevant report submitted to regular CQRG Meetings.	Relevant report submitted to regular CQRG Meetings. Outcome Monitoring action plan submitted.					
Clinical Audit A - Provide CCGs with copy of Trust wide audit programme in Q1.	Q1 Audit	n/a	Provided in Q4 14/15	n/a	n/a	n/a					
B - Provide CCGs with bi-annual findings and recommendations of audits carried out, evidence of action plans and Board Involvement	6 Monthly Audit		n/a	Updated audit schedule provided to CCG	n/a	Clinical Audit update paper for Clinical Quality Patient Experience Meeting – April 16					
C - Provide CCGs with copies of Clinical Audit Annual report to include learning the lessons from audit, demonstrating achievement of outcomes	Annual		n/a	n/a	n/a	Annual Clinical Audit report due for May BOD meeting.					
Reporting on Guidelines Report on compliance with new relevant NICE Clinical Guidelines, Quality Standards and Technology appraisals within 3 months of publication date.	6 Monthly	n/a	n/a	NICE compliance report to be reviewed by the Trust Clinical Effectiveness lead in Oct 2015	NICE guidance GAP Analysis provided in November CQRG	NICE Guidance assessment report for CQPE April 16.					
Mandatory Training** % of eligible staff are currently compliant on all of their mandatory training	Quarterly	80%	93%	94%	91%	90%					
Enhanced DBS checks*** Enhanced DBS checks for 100% of all relevant staff including renewals every 3 years for all staff in direct contact with Adult at risk, children and patient data. (Data includes locums, temporary staff and sub-contractors).	Quarterly	100%	98%	96%	96%	89%					

*The Trust to provide 11 MCA training dates to staff over the course of 2015/16 – 12 provided since March 2015. DOLs training is included with the MCA training although DOLs applications are not made by this Trust as it is provided to in patient only services. **Please note that INSET/safeguarding training figures are reported on page 26. ***53 enhanced DBS certificates required in Q4, compared to 59 (Q3), 483 (Q2) and 446 (Q1). 142 certificates returned to HR and checks are in progress with DBS. Details= 21 members of staff absent – 2 career break and 19 maternity leave.

KPIs NCL Trusts

Quality Key Performance Indicators									
Target	Monitoring	Target %	Progress				% Progress for 2015/16		
			Q1	Q2	Q3	Q4	Q1	Q2	Q3 Q4
Staff FFT and Annual Staff Survey To Improve trajectory from 14/15 baseline and provide organisational response to results Last year result: Fully achieved for Q1, Q2 and Q4	Quarterly	n/a	Increase of 32% compared to Q1 14/15	Increase of 18% compared to Q2 14/15	Staff FFT not sent out in Q3.	Increase of 26% compared to Q4 14/15			
Friends and Family Test (Patient test - from Experience of Survey Questionnaire) (Q11 in ESQ) % of positive responses on the FFT	Quarterly	90%	94%	93%	92%	92%			
Staff Appraisals Number of Staff Appraisals completed	Quarterly	80%	99%	99%	99%	99%			
Staff Absence % Sickness Absence rate less than 2% for all staff groups	Quarterly	<2%	0.8%	0.8%	0.1%	0.1%			
Duty of Candour A - 100% of conversations informing patients and/or family that a patient safety incident have taken place within 10 working days of the incident being reported to local risk management systems for Medium harm, Severe Harm, Death or Profound Psychological Harm categories of incidents; and an apology has been given.	Quarterly	100%	0 Incidents	1 Incident	2 Incidents	0			
B - 100% of incident investigation reports shared within 10 working days of being signed off as complete and the incident closed by the relevant authority for Medium Harm, Severe Harm, Death or Profound Psychological Harm categories of incidents.			0 Incidents	100% Support provided via GP with PCPCS service.	0 reports	0			

Quality Key Performance Indicators										
Target	Monitoring	Target%	Progress				% Progress for 2015/16			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
GP satisfaction with communication received from Trusts > above 60% of GPs who respond to be satisfied with communication from MH Trust Services	Annual	>60%	63% GP Satisfaction Rate*				Survey results to be published Q4			
Local participation in Suicide Prevention Trust will comply with requirements on Mental Health Trusts outlined in the National Suicide Prevention Strategy (2012)	Quarterly	n/a	Achieved	Achieved	Achieved	Achieved. See Gap analysis against requirements of the National Suicide Prevention Strategy				
Physical Health Care Evidence of physical health addressed across all mental health services	Annual	n/a	n/a	Achieved: Physical health form now implemented on Carenotes. From Q3, all staff now have access and all relevant services are using the form.						
Clinical Risk Assessments Annual Audit presented to CQRG	Annual Audit	n/a	n/a				Reviewed and action plan drafted**			
Adherence to Crisis Concordat standards Baseline in 2015/16	Annual	n/a	n/a				Action Plan drafted***			
Crisis Concordat standards - Crisis plan Bi-annual Percentage of patients who have been offered a crisis plan for emergency mental health situation	6 monthly	95%	n/a	n/a	Please see below ***	Action Plan drafted				
Equality and Diversity - BME access to 'talking therapies' **** Percentage BME access to 'talking therapies' (Baseline in 2015/16)	Quarterly	n/a	Q1: 40.8% BME Q2: 38.6% BME Q3: 37.2% BME Q4: 37.4% BME							
NICE guidance - Bipolar Disorder (CG185, Sept 2014) - CBT/psychological treatment Baseline in 2015/16, Proportion of patients with a diagnosis of bipolar disorder offered CBT/psychological treatment	Quarterly	n/a	100% (13 patients out of 3135)	100% (16 patients out of 3163)	100%(18 patients out of 2922)	100% (8 patients out of 3151)				

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

**Documentation of Patient Risk level reviewed as part of the annual case record audit.

*** Reviewed by the Trust Clinical Effectiveness Lead and Action Plan drafted. Ongoing involvement with Trust Patient Safety lead.

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

Section Two: Generic Service CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q4	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
Children Young Adult and Families (CYAF) (Outcome monitoring)	For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at Time 1 and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	Q1-Q4	70%	80%	Not achieved target: 70% completed GBM at Time 1 and Time 2 with at least 2 goals.				
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	66%	75%	Not achieved target				
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	76%	50%	Achieved target: Improvement rate for period January 2015 – March 2015: Adult and Adolescent (combined) = 76% Improvement by individual services: Adolescents = 76% Adults = 75%				

Physical Health CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q4	Target %	Progress	Q1* RAG	Q2 RAG	Q3 RAG	Q4 RAG
PHYSICAL HEALTH – Smoking Cessation	Smoking status recorded at time of the first assessment appointment for 95% patients age 14 years and above between 1 April 2015 and 31 March 2016	Q1-Q4	Q1: 23.3% Q2: 26.6% Q3: 23.6% Q4: 33.6%	95%	Q4= All patients 14+ that attended first appointment between 01/01/2016 to 31/03/2016 = 524. Of these 33.6% (176) have smoking status recorded. 48 have smoking status= 'yes' (48/176=27%). 348 (66.4%) not recorded.				
	Very brief advice for 95% of patients recorded as current smoker	Q1-Q4	Achieved	95%	Q1 = Some education in the form of a presentation to clinicians has been undertaken to make them aware to ask the question and give brief advice. Education ongoing. Q2 = Referrals made to the Physical Health Nurse for further intervention/ NRT Q3= None were given VBA Q4: 2 out of 48 patients were offered VBA (4%)				
	Percentage of patients who are current smokers with a record of initiation of treatment including setting a quit date or receiving Varenicline or NRT or referred for on-going support.	Q1-Q4	Achieved – 7/48 (15%)	n/a	Q1 = Physical healthcare template created on Care Notes and rolled out Q2 = Information is being recorded on the physical healthcare template to support baseline monitoring. Q3= 30 smokers, only 2 patients asked for referral for ongoing support Q4= 48 Smokers, 7 patients referred to the Physical Health Specialist Nurse (PHSN). 3 patients saw PHSN, 4 followed up by newly appointment PHSN.				
	Quit attempts, initiation of treatment and referral of patients by Physical Health Practitioner to community stop smoking centres for on-going support.	Q1-Q4	Achieved	n/a	Q1 = Referral criteria confirmed – forms part of the physical healthcare form. Local stop smoking services have been identified in preparation for new Physical Health Nurse post. Links with services to be confirmed. Q2 = Physical Health Nurse to start on 16th October 2015. Q3= Referred identified patients to community stop smoking centres for ongoing support Q4= 3 Patients saw PHSN. Further 4 patients to be followed by new PHSN.				
	Offer Nicotine Replacement Therapy (NRT) for patients wishing to stop smoking (Prescribing to be a pass through cost to the Trust)	Q1-Q4	Achieved	n/a	Q1 = Physical Health Nurse NRT requirement included on JD (substantive post) Q2 = Physical Health Nurse to start on 16th October 2015. Q3= 4 patients referred to local stop smoking services. NRT to be offered as appropriate by external agency Q4= NRT discussed with PHSN. 2 patients requested GP referral to quit smoking and one patient confirmed that they had already quit when contacted.				
	Appointment of a BTS clinical champion to promote smoking cessation for patients and staff	Q1-Q4	Achieved	n/a	Q1 = BTS clinical champion to promote smoking cessation for patients and staff included on JD (substantive post for registration) Q2 = Physical Health Nurse to start on 16th October 2015. Q3= Physical Health Nurse is a BTS champion Q4=Newly appointment PHSN now Trust BTS clinical champion				
	Pro-active promotion of stop smoking to staff through in-house or local stop smoking service	Q1-Q4	Achieved	n/a	Staff intranet includes Stop Smoking Information for Staff. This will be added to by the new PHSN. Drop in sessions run by Camden Stop Smoking Service were undertaken in Q4. Stop Smoking information stand for Staff was provided in March.				

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

Physical Health CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q4	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
PHYSICAL HEALTH – Alcohol Misuse	To ensure the consistent offer of effective, evidence-based screening for increasing risk (hazardous) and high risk (harmful) alcohol consumption to patients presenting with selected conditions in Mental Health Services. Patients (aged 14 years or over).	Q2-Q4	Number of patients assessed using physical health form: Q1+Q2+Q3= 9.6% Q1=0.6% Q2=7.3% Q3=14.5% Q4=27%	n/a	No referrals in Q4 Age 14+= 525 No patients Assessed Q4= 139 (27%) No patients referred to Physical Health Nurse= 3				
	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	95%	Of the 139 patients assessed for alcohol misuse, 23 were identified as having a score >=3. One patient was given very brief advice by the clinician. Three were referred to the PHSN.				
	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%	Not achieved.				
	Referrals made to local alcohol services when identified as appropriate by the Physical Health Nurse.	Q2-Q4	Achieved	n/a	Three patients referred to the PHSN have been contacted and referred to local alcohol services.				
	Trust to implement system of recording instances where patients disclose either: A) Being the victim of violence in relation to alcohol or	Q2-Q4	Achieved	n/a	Both Assessment forms < & > age 18 years include questions about being a victim or perpetrator of violence in relation to Alcohol.				
	B) Perpetrating violence in relation to alcohol		Achieved		Both Assessment forms < & > age 18 years include questions about being a victim or perpetrator of violence in relation to Alcohol.				

Domestic Violence CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q4	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	In the context of in-house level 2 adult safeguarding training, a brief initial training on Domestic abuse and violence (DA and V) was delivered to staff across the adult services. Training covered definitions of domestic violence and abuse, the social and cultural contexts of DA and V, basic information on how to screen for DA and V as part of clinical work, contact details for local specialist DA and V agencies and small group case discussion of recent clinical examples where DA and V was a potential issue.				
	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	Children Services: In Quarter 4, domestic violence and abuse training was commenced for Levels 2 & 3 clinicians and practitioners requiring safeguarding children training on 3rd and 17th March. Adult Services: Following training to the adult dept in Q3, team specific training was piloted in Q4. Further bespoke trainings are planned for 2016 / 2017				

Safe and Timely Discharge CQUIN Targets

CQUIN	Detail of indicator	Reported	Performance at Q4	Target %	Progress	Q1 RAG	Q2 RAG	Q3 RAG	Q4 RAG
SAFE AND TIMELY DISCHARGE	Planned discharges: Discharge letters for GPs to be sent within 2 weeks of final appointment for planned discharges*	Reported in Q3 after completion of audit	92%	85%	In an audit of 10% of planned discharge cases between 1 st Jan – 29 th Feb 2016 (N=13) a discharge letter was sent to the GP in 92% of the cases.				
	Non-Planned discharges: 85% Patients discharged from Carenotes within 2 weeks of letter to GP	Reported in Q3 after completion of audit	93%	85%	In an audit of 10% of non-planned discharge cases between 1 st Jan – 29 th Feb 2016 (N=43) a discharge letter was sent to the GP in 93% of the cases.				
	Effective discharge plans in place - mandated fields to be added in Carenotes to ensure consistent, quality of information in discharge summaries.	Q2	n/a	n/a	Planned discharge tick-box and treatment end date field is now implemented on Carenotes.				

*In discussion with commissioners it was agreed that final apt would be amended to read "discharge from Carenotes". In reference to "planned discharges" would be removed as clinicians may keep patient record open on Carenotes after a limited period due to a further apt could be required.

	Detail of indicator	Reported	Performance at Q4	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	75%	75%	75% of patients with a PROM for Time 1 and Time 2 shown an improvement. Of the 8 PROMSs completed, 6 improved and 1 patient did not change.				

GIDS CQUIN

	Detail of indicator	Reported	Performance at Q4	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 workshop took place on 17th March 2016 and the completed CQUIN report template will be submitted to NHS England by 30th April 2016, as per CQUIN guidance document.				

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Section Three: Quality Priorities

Quality Priorities											
Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2015/16			
								Q1	Q2	Q3	Q4
(1)Outcome Monitoring	For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at Time 1 and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	Caroline McKenna	Carenotes Monitoring of progress by the OM Lead Quarterly progress report Quarterly basis, providing reports to the Patient Experience and Care Quality Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs.	• OM analysis of the % return rate for Time 1 and Time 2.	1 Jan 2016	31 Mar 2016	70% completed GBM at Time 1 and Time 2 with at least 2 goals. We have not met our 80% target, however we have improved greatly since Q3 (49%). We did not meet the target this quarter as not enough Time 2 goals were completed.				
	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).			• OM analysis of the % of patients who achieve an improvement in their score for at least two GBM targets.	1 Jan 2016	31 Mar 2016	Not achieved target: 29 improved out of 63 with 2 goals.				

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Quality Priorities

Quality Priorities											
Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2015/16			
								Q1	Q2	Q3	Q4
(1) Outcome Monitoring	Adult & AYA Service: For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.	Michael Mercer	Quarterly basis, providing reports to the Clinical Quality and Patient Experience Work stream (CQPE), the Board of Directors, Camden CCG and our clinical commissioners from other boroughs.	• OM analysis of the % of service users who achieve an improvement in their score from pre assessment to End of Treatment.	1 Jan 2016	31 Mar 2016	Achieved target: Improvement rate for period January 2015 – March 2015: Adult and Adolescent (combined) = 76% (Cohort 37 Patients – 28 of those had an improvement). Improvement by individual services: Adolescents = 76% (16 out of 21 improved) Adults = 75% (12 out of 16 improved)				
(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	Louise Lyon Sally Hodges		• The PPI team will develop and launch a quarterly PPI newsletter for Trust staff and service users to include updates on patient stories.			Q4 newsletters for CYAF and AFS are currently on display throughout the Trust including all activities. An additional PPI notice letter has been approved by the management committee and is ready to be sent out with appointment letters.				
	2. PPI Newsletters to be available on the Trust website			•PPI newsletters will be posted on the website.			The bulletins are published on the Tavistock website.				
	3. Following launch of the newsletter, a Visual Straw Poll to be run on awareness of the newsletters		The evidence will be the results of the Visual Straw Poll.	•A question on the Visual Straw Poll will be used to evaluate awareness and knowledge of the PPI quarterly newsletter.			This work stream is now complete.				

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.	Louise Lyon Sally Hodges	<ul style="list-style-type: none">The PPI team will maintain their local spreadsheet containing details of interview panels that have taken place including a service user on the interview panel.	<ul style="list-style-type: none">The PPI team has provided interview panel training sessions for service users who have volunteered to participate and now have a pool of service users who can sit on interview panels.	1 Jan 2016	31 Mar 2016	In Q4 9 Service users were asked to be on panels, 7 were able to attend.				
	2. To gain feedback from the service users who participate in interview panels. Feedback will be gained regarding three areas: preparation for the panel, participating in the panel and the debrief process. The PPI team will contact every service user who participates on an interview panel.		<ul style="list-style-type: none">We plan to monitor our progress towards achieving these targets on a quarterly basis, providing reports to the Patient and Public Involvement Committee and other various meetings.	<ul style="list-style-type: none">The evidence will be feedback reports maintained by the PPI team. The PPI team will contact service users to ask them about their experience of being on an interview panel.			5 (71%) Service users provided feedback, this was positive.				

Appendix: Quality Indicator Performance Supporting Evidence

1. Waiting Times

QUARTER 4 - TRUSTWIDE						
	AYAS	Adult	Camden CAMHS	Other CAMHS	Portman	TOTAL
Target less than 77 days (11 weeks)						
Breaches Cause internal to T & P	0	3	2	0	0	5
Breaches: Cause external to T & P	1	8	0	1	0	10
Total number of breaches (do not include no breaches)	1	11	2	1	0	15
Number of 'breaches' shown after data validation shown to be 'no breach'	0	1	14	7	0	22
Total number of patient attending first appointment in quarter	76	142	456	131	33	838
The percentage of patients that are breached in the quarter	1.3%	7.7%	0.4%	0.8%	0.0%	1.8%
% internal	0.0%	2.1%	0.4%	0.0%	0.00%	0.6%
% external	1.3%	5.6%	0.0%	0.8%	0.00%	1.2%

*Please note that City and Hackney and GIDS service are excluded from this table due to they have a national 18 week target as opposed to the locally agreed Trustwide 11 week target.

Waiting Time Breaches 11+ weeks (Quarter 4) - Trustwide

Patient ID	Service	Team	Purchaser	Referral Date	First Attended Appt	Wait Weeks	Internal/External	Reason for breach
16434	Adolescent	ADOLESCENT North and West Team	NHS BARNET CCG	16-Nov-15	09-Feb-16	11.57	External	Patient was not registered with a GP. Delay in assigning patient with GP caused breach.
24089	Adults	ADULTS Lyndhurst	NHS CENTRAL LONDON (WESTMINSTER) CCG	30-Nov-15	09-Mar-16	11.1	External	Patient delayed in communication with the Tavistock, resulting in 1 day breach.
24080	Adults	ADULTS Lyndhurst	NHS CAMDEN CCG	18-Dec-15	09-Mar-16	11.6	External	Referrer gave wrong address of patient to the Tavistock, as a result dealyed offering appt.
21728	Adults	ADULTS Individual Once Week Waiting Team	NHS CAMDEN CCG	15-Oct-15	18-Jan-16	11.9	External	Patient delayed communication with the Tavistock.
13705	Adults	ADULTS Group Team	NHS ISLINGTON CCG	28-Jul-15	04-Feb-16	12.3	External	Patient delayed in communication with the Tavistock.
23143	Adults	ADULTS Belsize	NHS CAMDEN CCG	28-Sep-2015	12-Jan-2016	12.7	External	Patient delayed in communication with the Tavistock.
9798	Adults	ADULTS Hemel Team	NHS HERTS VALLEYS CCG	08-Oct-15	21-Mar-16	12.9	External	Patient delayed in communication with the Tavistock.
22037	Adults	ADULTS Hemel Team	NHS HERTS VALLEYS CCG	13-Jul-15	15-Jan-16	14.9	External	Patient delayed in communication with the Tavistock.
10958	Adults	ADULTS Belsize	NHS BARNET CCG	08-Jun-15	15-Feb-16	17.7	External	Patient delayed in communication with the Tavistock.
22954	Adults	ADULTS Lyndhurst	NHS CAMDEN CCG	21-Sep-15	03-Mar-16	22.3	Internal	Delay in assigning clinician to patient, lack of clinical capacity.
9075	Adults	ADULTS Lyndhurst	NHS CAMDEN CCG	11-Aug-15	16-Feb-16	23.7	Internal	Delay in assigning clinician to patient, lack of clinical capacity.
22660	Adults	ADULTS Lyndhurst	NHS WEST LONDON CCG	27-Aug-15	25-Feb-16	24.3	Internal	Delay in assigning clinician to patient, lack of clinical capacity.
24107	Camden CAMHS	SOUTH Service	NHS CAMDEN CCG	21-Dec-15	10-Mar-16	11.1	Internal	Referral was sent back to JI for further investigation due to the complexities of the case. This was the first available appt the clinician could offer when case was sent to us again.
16763	Camden CAMHS	SOUTH Service	NHS CAMDEN CCG	06-Nov-15	27-Jan-16	11.6	Internal	This was the next available date we had in our Consultation and Resource Clinic
23154	Other CAMHS	Developmental - Autism	NHS ENFIELD CCG	28-Sep-15	21-Jan-16	14.1	External	Inaccurate communication information/address in referral paperwork, Family ambivalence to attending

Waiting Time Breaches 18+ weeks (Quarter 4) –Adult Unit

Patient ID	Service	Team	Purchaser	Referral Date	First Attended Appt	Wait Weeks	Internal/External	Reason for breach
22317	City and Hackney	CHPC Team A	NHS CITY AND HACKNEY CCG	27-Aug-15	25-Feb-16	25.9	External	Patient DNA'd appts, No assessment appts vacant
22931	City and Hackney	CHPC Team C	NHS CITY AND HACKNEY CCG	18-Sep-15	01-Feb-16	19.3	Internal	Clinician fully booked - patient had to wait for a suitable appointment
22834	City and Hackney	TCPs Care Planning Team	NHS CITY AND HACKNEY CCG	30-Sep-15	24-Feb-16	20.9	Internal	Was unable to book a consultation with GP as GP was away.
22962	City and Hackney	CHPC Team C	NHS CITY AND HACKNEY CCG	17-Sep-15	15-Feb-16	21.4	Internal	No assessment appts vacant
23043	City and Hackney	CHPC Team B	NHS CITY AND HACKNEY CCG	23-Sep-15	04-Mar-16	23.1	Internal	Admin error- patient was no contacted to arranged an appt
2980	City and Hackney	CHPC Community Project Team	NHS CITY AND HACKNEY CCG	16-Sep-15	11-Mar-16	25.1	Internal	Clinician fully booked - patient had to wait for a suitable appointment

Waiting Time Breaches 18+ Weeks (Quarter 4) GIDS

GIDS Breaches	Jan-16	Feb-16	Mar-16
Total to allocate	100	125	122
Number allocated	63	24	30
Number of Breaches	30	7	4
Range of breaches (weeks)	18-33	21-28	18-24
Still awaiting allocation	37	101	92
Still awaiting and breached	37	101	71
Total breaches	67	108	75

Waiting Times

London Contracts Waiting Times for Q1 - including Mean and Median data

Service	Total Seen Patients Q1	Median (Weeks)	Average (Weeks)
Adolescent and Young Adult	51	6.7	6.2
Adults*	240	6.6	5.9
Camden CAMHS	181	3.6	3.9
Other CAMHS**	92	4.9	4.9
Total	564	5.8	5.2

Specialist Contracts Waiting Times for Q1 - including Mean and Median data

Service	Total Seen Patients Q1	Median (Weeks)	Average (Weeks)
Portman	21	4.93	6.15
GIDS***	143	15.7	17.2

*Adult Directorate includes City & Hackney service

**Please note that in the Q1 BOD/CQRG report, First Step service was included in the Other CAMHS Figures. This data has now been removed as it is not included in the London Contracts remit.

***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.

Waiting Times

London Contracts Waiting Times for Q2 - including Mean and Median data

Service	Total Seen Patients Q2*	Median (Weeks)	Average (Weeks)
Adolescent and Young Adult	30	3.9	4.6
Adults*	192	6.3	6.8
Camden CAMHS	97	4.6	8.5
Other CAMHS	66	6.9	8.0
Total	385	5.5	7.0

Specialist Contracts Waiting Times for Q2 - including Mean and Median data

Service	Total Seen Patients Q2	Median (Weeks)	Average (Weeks)
Portman	39	7.0	9.9
GIDS**	189	16.3	15.4

*Adult Directorate includes City & Hackney service

**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.

Waiting Times

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

Service*	Total Seen Patients Q3	Median (Weeks)	Average (Weeks)
Adolescent and Young Adult	36	5.1	4.8
Adults	85	6.0	6.4
City and Hackney	115	7.3	8.6
Camden CAMHS	263	2.1	3.1
Other CAMHS	108	6.8	7.5
Total	607	6.0	5.6

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

Service	Total Seen Patients Q3	Median (Weeks)	Average (Weeks)
Portman	29	6.1	6.6
GIDS**	220	17.4	16.5

*Data provided in table includes all teams and services within Tavistock/National contracts. Q1+Q2 were specific to London Contracts. Average waits for Q3 for London Contracts is: **5.7 weeks and Median: 5 weeks** (total of **545** total seen patients Q3).

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

Waiting Times
Tavistock/National Contract Waiting Times for Q4 - including Mean and Median data
TRUSTWIDE contracting

Service*	Total Seen Patients Q4	Median (Weeks)	Average (Weeks)
Adolescent and Young Adult	54	5.9	5.9
Adults	82	6.7	7.5
Camden CAMHS	266	4.0	4.9
Other CAMHS	91	6.1	11.5
Portman	24	6.0	5.7
TOTAL	517	6	7.1

National Waiting Time Services (18 weeks) - including Mean and Median data

Service	Total Seen Patients Q4	Median (Weeks)	Average (Weeks)
City and Hackney*	123	8.7	8.7
GIDS	194	17.5	17.8

*From Q4, City and Hackney waiting time has changed to 18 weeks (as opposed to locally agreed 11 week target).

Waiting Times

London Contracting Waiting Times for Q4 - including Mean and Median data

Service*	Total Seen Patients Q4	Median (Weeks)	Average (Weeks)
Adolescent and Young Adult	54	5.9	5.9
Adults	81	6.7	7.5
Camden CAMHS	255	4.2	5.0
Other CAMHS	77	6.1	6.0
Portman	24	6.0	5.7
TOTAL	491	6	6.0

National Waiting Time Services (18 weeks) - including Mean and Median data

Service	Total Seen Patients Q4	Median (Weeks)	Average (Weeks)
City and Hackney*	123	8.7	8.7
GIDS	183	17.5	17.7

*From Q4, City and Hackney waiting time has changed to 18 weeks (as opposed to locally agreed 11 week target).

2. DNA Rates

Total DNA Rates*, **				
QUARTER 4				
Target <11%	2013/14	2014/15	2015/16*	
Total 1st appointments attended	641	727	872	
Total first appointments DNA's	68	101	118	
Total first appointments	789	904	1286	
% 1st appointments DNA'd	8.6%	11.2%	9.2%	
Total subsequent appointments attended	12986	12810	16042	
Total sub. appointments DNA'd	1001	1114	1411	
Total subsequent appointments	13987	14993	21064	
% DNA subsequent Appointments	7.2%	7.4%	6.7%	
Total % DNA	7%	7.6%	7%	
Adolescent and Young Adult DNA Rates				
QUARTER 4				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	57	51	55	
Total first appointments DNA's	5	5	6	
Total first appointments	62	56	76	
% 1st appointments DNA'd	8.1%	8.9%	7.9%	
Total subsequent appointments attended	1192	1134	1351	
Total sub. appointments DNA'd	149	174	127	
Total subsequent appointments	1341	1308	1828	
% DNA subsequent Appointments	11.1%	13.3%	6.9%	
Total % DNA	11%	13.1%	7%	

*Please note total figures now include Gender Identity Service and Westminster Service data. Data which does not add up in 'total first apt column' is due to apt cancellations.

**Please note CAMDEN TAP Service is not included in this data set. A separate report is produced to commissioners from the EMIS system.

DNA Rates

Adult DNA Rates				
QUARTER 4				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	64	73	83	
Total first appointments DNA's	5	5	18	
Total first appointments	69	78	142	
% 1st appointments DNA'd	7.2%	6.4%	12.7%	
Total subsequent appointments attended	2521	2481	2725	
Total sub. appointments DNA'd	168	205	212	
Total subsequent appointments	2689	2686	3471	
% DNA subsequent Appointments	6.2%	7.6%	6.1%	
Total % DNA	6%	7.6%	6%	

Camden CAMHS DNA Rates				
QUARTER 4				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	206	183	277	
Total first appointments DNA's	29	16	39	
Total first appointments	235	199	456	
% 1st appointments DNA'd	12.3%	8.0%	8.6%	
Total subsequent appointments attended	3272	3510	4937	
Total sub. appointments DNA'd	178	242	472	
Total subsequent appointments	3450	3752	6705	
% DNA subsequent Appointments	5.2%	6.4%	7.0%	
Total % DNA	6%	6.5%	7%	

DNA Rates

Other CAMHS DNA Rates				
QUARTER 4				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	60	69	107	
Total first appointments DNA's	2	4	5	
Total first appointments	62	73	131	
% 1st appointments DNA'd	3.2%	5.5%	3.8%	
Total subsequent appointments attended	2442	2290	2966	
Total sub. appointments DNA'd	140	123	157	
Total subsequent appointments	2582	2413	3653	
% DNA subsequent Appointments	5.4%	5.1%	4.3%	
Total % DNA	5%	5.1%	4%	

City and Hackney DNA Rates				
QUARTER 4				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	99	161	124	
Total first appointments DNA's	22	49	22	
Total first appointments	164	252	191	
% 1st appointments DNA'd	13.4%	19.4%	11.5%	
Total subsequent appointments attended	979	1051	1158	
Total sub. appointments DNA'd	185	171	186	
Total subsequent appointments	1164	1838	1670	
% DNA subsequent Appointments	15.9%	9.3%	11.1%	
Total % DNA	16%	10.5%	11%	

DNA Rates

Westminster Service DNA Rates				
QUARTER 4				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	23	16	9	
Total first appointments DNA's	0	0	0	
Total first appointments	23	16	9	
% 1st appointments DNA'd	0.0%	0.0%	0.0%	
Total subsequent appointments attended	335	274	183	
Total sub. appointments DNA'd	7	3	11	
Total subsequent appointments	342	305	220	
% DNA subsequent Appointments	2.0%	1.0%	5.0%	
Total % DNA	2%	0.9%	5%	

Portman DNA Rates*				
QUARTER 4				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	22	30	24	
Total first appointments DNA's	0	5	6	
Total first appointments	22	35	33	
% 1st appointments DNA'd	0.0%	14.3%	18.2%	
Total subsequent appointments attended	1238	1125	1334	
Total sub. appointments DNA'd	110	79	128	
Total subsequent appointments	1348	1204	1770	
% DNA subsequent Appointments	8.2%	6.6%	7.2%	
Total % DNA	8%	6.8%	7%	

*Data which does not add up in 'total first apt column' is due to apt cancellations.

DNA Rates

Gender Identity Service DNA Rates				
QUARTER 4				
Target <11%	2013/14	2014/15	2015/16	
Total 1st appointments attended	110	144	193	
Total first appointments DNA's	5	17	22	
Total first appointments	152	195	248	
% 1st appointments DNA'd	3.3%	8.7%	8.9%	
Total subsequent appointments attended	1007	945	1388	
Total sub. appointments DNA'd	64	117	118	
Total subsequent appointments	1071	1487	1747	
% DNA subsequent Appointments	6.0%	7.9%	6.8%	
Total % DNA	6%	8.0%	7%	

*Data which does not add up in 'total first apt column' is due to apt cancellations.

3. **Patient Satisfaction** – See ESQ Report 2015-2016 Q4. A hardcopy of this Report can be provided by Louise Lyon (Director of Quality and Patient Experience).
4. **Patient Experience** - See Annual PPI Report. A hardcopy of this Report can be provided Louise Lyon (Director of Quality and Patient Experience).
5. **Patient Information** - See patient leaflets on Trust Website.
6. **Outcome monitoring**- Please refer to CQUIN Targets in Section Two and see 2015-16 CQUINs Outline. A hardcopy of this CQUINs Outline can be provided by Omer Kemal (Quality Team).
7. **Quality and Development of Staff** - Patient Development Plans (“PDPs”) are managed on an annual cycle with performance reported at end March each year, for implementation over the course of the next year. However, updated figure for Q3 in table below.

Quality and Development of Staff - PDPs:		
Number of staff who require a PDP at 31 st March 2016	Number of staff with a PDP	% of staff with a PDP
482	481	99%

7. Safety – Safeguarding Training

Level 1 Safeguarding Training – Adult + Children (Provided at Trust INSET days – May & November and Clinical and Trust induction days held twice a year)				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	93%	94%	91%	90%
Narrative	Quarter 4 results			
Total numbers requiring training:	546			
Number of staff trained:	496			
Number of staff NOT trained:	50			
%:	90%			
Rationale (Reason for non-attendance):	15 staff exempted by their Directors to attend INSET day held in Nov 15 and will be attending the May 2016 INSET day. 10 new starters to attend the next induction in 19 May 2016 and 40 will attend INSET day on 26 May 2016 as they will be overdue. Reminders are being sent to these staff.			
Level 2 Safeguarding Training – Children only				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	98%	98%	97%	91%
Narrative	Quarter 4 results			
Total numbers requiring training:	36			
Number of staff trained:	33			
Number of staff NOT trained:	3			
%:	91%			
Rationale (Reason for non-attendance):	3 staff need to complete the training now in 17 March - April 2016. 1 staff member had returned from Maternity leave.			
Level 3 Safeguarding Training – Children only				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	94%	93%	89%	90%
Narrative	Quarter 4 results			
Total numbers requiring training:	326			
Number of staff trained:	295			
Number of staff NOT trained:	31			
%:	90%			
Rationale (Reason for non-attendance):	11 new starters have confirmed training dates between March - May 2016. 4 staff have returned from Maternity/CB leave. 3 have been given exemptions previously. 3 DNA's, 1 had sick leave they had booked, 1 was not invited to attend. 9 staff are due their training now in April 2016 and some have booked the 19th April date continuing to follow-up on the others.			

8. Glossary

AYA (AYAS): Adolescent and Young Adult Service

BME: Black Minority Ethnic

BTS: British Thoracic Society

CAMHS: Children, Adolescent, Mental Health Service

Care Plans: A documented plan that describes the patient's condition and procedure(s) that will be needed, detailing the treatment to be provided and expected outcome, and expected duration of the treatment prescribed by the clinician

CCG: Clinical Commissioning Group

Clinical Outcomes in Routines Evaluation (CORE) Form: This is a client self-report questionnaire designed to be administered before and after therapy. The client is asked to respond to 34 questions about how they have been feeling over the last week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'.

CQUIN: Commissioning for Quality and Innovation Payment Framework

CYAF: Children, Young Adult and Family Service

DA: Domestic Violence

DBS: Disclosure and Barring Service

DNA: Did not attend

DV: Domestic Violence

ESQ: Experience of Service Questionnaire

GBM: Goal Based Measure

GIDS: Gender Identity Service

KPI: Key Performance Indicator

MDT: Multi-Disciplinary Team

NCL: North Central London

NICE: National Institute for Health and Care Excellence

NRT: Nicotine Replacement Therapy

OM: Outcome Monitoring

PCT: Primary Care Trust

PDP: Personal Development Plan

PPI: Patient Public Involvement

PROM: Patient Reported Outcome Measure

SWAP: The Shedler-Westen Procedure

TPFT: Tavistock and Portman Foundation Trust

V: Violence

VSP: Visual Straw Poll

Marion Shipman
Associate Director Quality & Governance
January 2016

35

Board of Directors

April 2016

Item : 12

Title : Q4 Performance Indicator Dashboards

Purpose:

Our new Key Performance Indicator Dashboards are the tool we will use to introduce a more systematic and consistent system of performance management, from board to team level.

The vision for the dashboards is to provide a visual presentation of performance, which identifies trends, where further interrogation/attention is needed and enables total visibility of the whole system instantly.

Please note that we have not yet undertaken a comprehensive validation process, so there may still be a small number of inaccuracies.

The board is asked to consider the new performance management dashboards for the first time.

Feedback on the overall content and format is sought from board members.

We suggest that unless there are any glaring omissions, our focus is on validation and improving 'what we have' i.e. systematically introducing benchmarks where available, trends data, RAG ratings, indications of data quality, rather than including more measures.

The board is also identify what issues the board should note and what, if any, areas would benefit from further investigation.

For : Discussion

From : Julia Smith, Commercial Director

Performance Indicator Dashboards

1.0 The Development of the Dashboards

Our aim is to introduce a more systematic and consistent system of performance management using dashboards as a tool, from board to team level.

The vision for the dashboards is to provide a visual presentation of performance, which identifies trends, where further interrogation/ attention is needed and enables total visibility of the whole system instantly.

Please note that we have not yet undertaken a comprehensive validation process, so there may still be a small number of inaccuracies.

The dashboards are still very much in development and the next stage is to

- 'fill in the gaps'
- include more benchmark data
- undertake a systematic validation process
- provide historical data for most items, so trends can be seen
- introduce a RAG performance and 'data quality' ratings for each item
- expand the dashboards to include some financial data e.g. underperformance on contracts and financial impact, cases per WTE
- consider how best to represent team variation and outliers

1.0 Points to Note

- 1.1 The first sheet contains indicators which are updated on a quarterly basis rather than an annual basis.
- 1.2 Reach: The number of patient attendances YTD will be updated in a report which is emailed later in the week. The key point is the significant increases in referrals to our Gender Identify Development Service, City and Hackney Service and Camden CAMHS. The number of students benefiting from our training increased again this academic year.
- 1.3 Quality Well Led: Most indicators indicate the Trust is performing extremely well in this domain and compares very favourably when benchmarked to other Trusts. The number of staff recommending the Trust as a place to work significantly increased from Q3. The number of staff appraised compared to last year is cause for concern, but perhaps accounted for by delays in paperwork reaching Human Resources. If figures do not improve, the Director of HR will address this.
- 1.4 Quality Safety: Incidents continued to increase again in the last quarter, due to a significant increase in incidents at Gloucester House.
- 1.5 Quality Effective: The outcome data requires full validation. However if the information is accurate the apparent reduction in outcomes

should be examined. Significant work is underway to improve collection rates.

- 1.6 Quality Responsive: The large numbers of patients who are waiting more than 11 weeks is primarily due to a significant increase in demand for our Gender Identity Service. Discussions about increasing resources to address the demand are ongoing with NHS England.
- 1.7 Education and Training: Around the same number of applications were made for longer courses, but we accepted a higher number than in previous years and therefore we have a higher number of students than in previous years. There was a drop in students who attended CPD and conferences in 2015-16. Student feedback outlined indicates good outcomes and high levels of satisfaction.

2.0 Conclusion

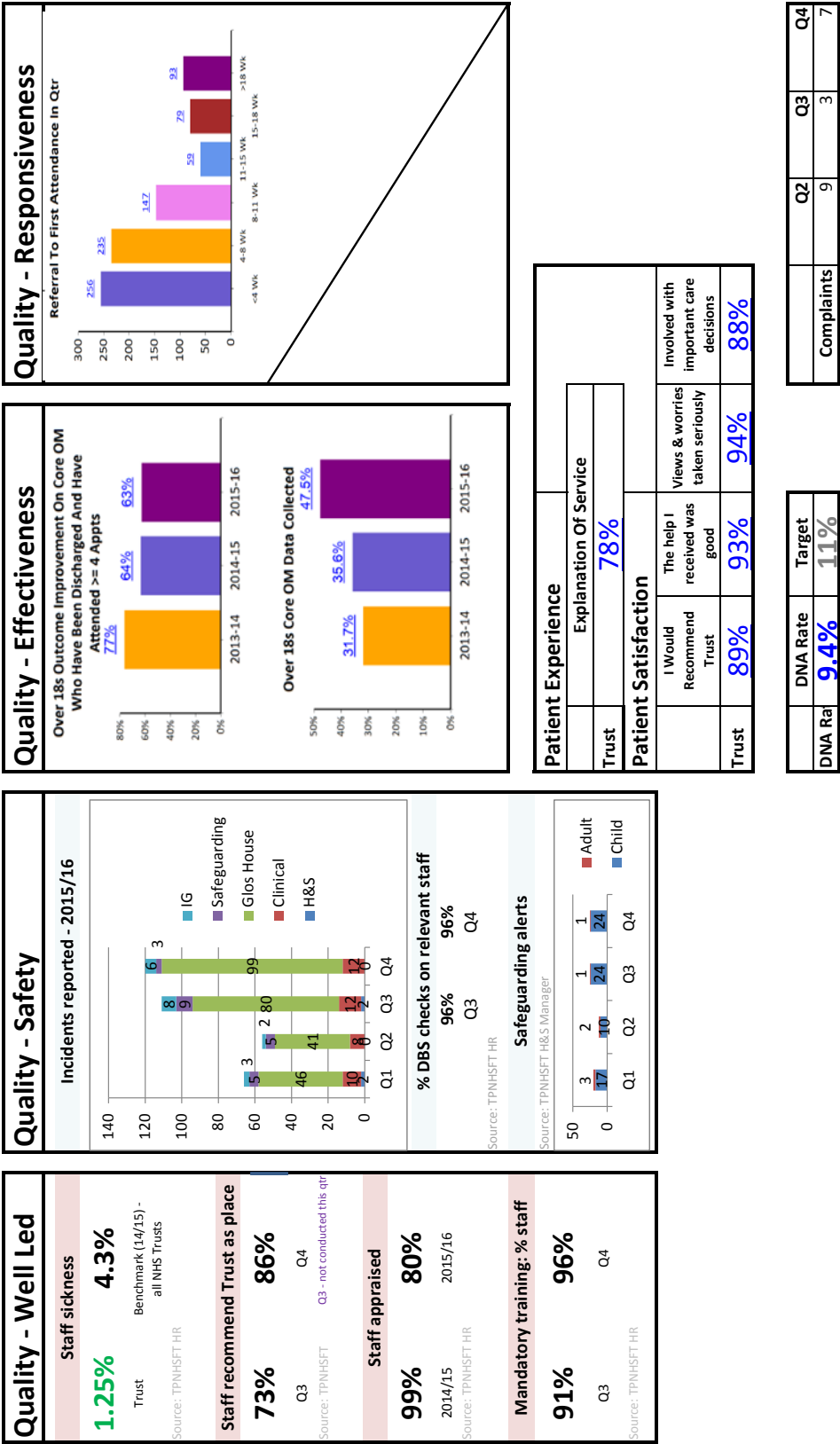
Feedback on the overall content and format is sought from board members.

We suggest that unless there are any glaring omissions, our focus is on validation and improving 'what we have' i.e. systematically introducing benchmarks where available, trends data, RAG ratings, indications of data quality, rather than including more measures over the next 3- 6 months.

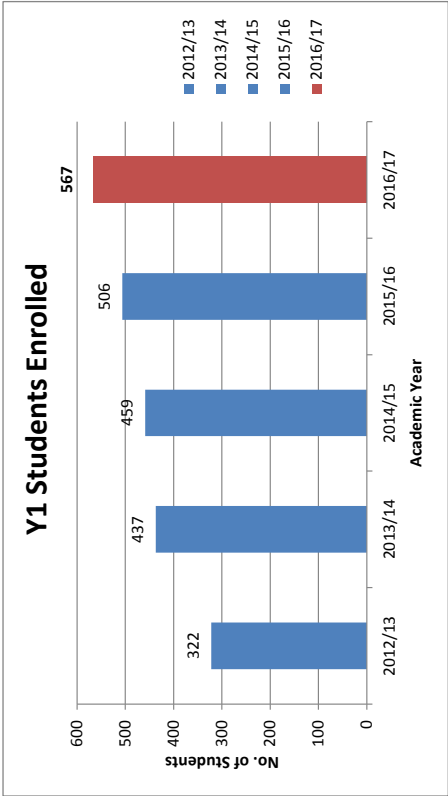
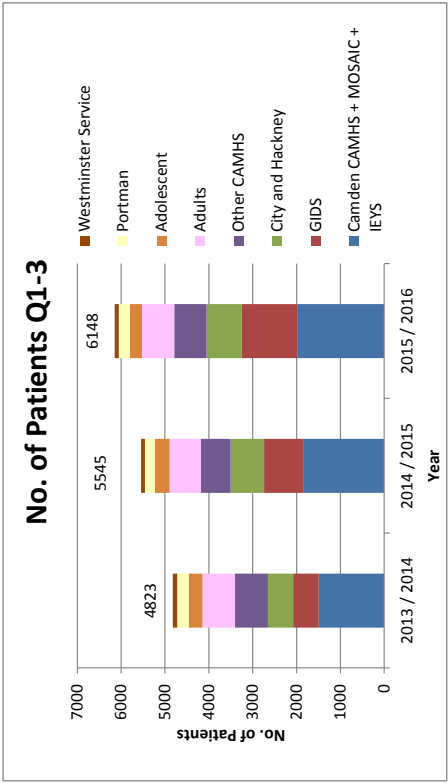
The board is also asked confirm whether or not the issues outlined above are the ones to note or/and whether there are others observations it is important to note at board level and what areas, if any, would benefit from further investigation.

Julia Smith
Commercial Director
April 2016

KPIs which change Quarterly



Trust Reach



Social Media and Media coverage to follow

Intellectual Output KPI to be developed

Quality - Well Led

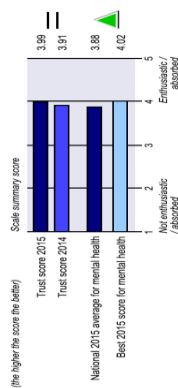
MORALE

Staff sickness

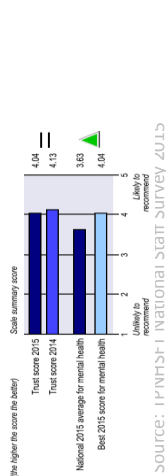
1.25%
Q4 Trust
4.3%
Benchmark (14/15) - all NHS Trusts

Source: TPNHSFT HR

Staff motivation at work



Staff recommend Trust as place to work



Source: TPNHSFT | National Staff Survey 2015

73%
Q3
86%
Q4

Source: TPNHSFT FFT

Q4 15/16

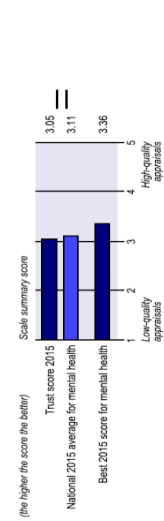
TRAINING

Staff appraised

99%
2014/15
80%
2015/16

Source: TPNHSFT HR

Staff opinion on quality of appraisals

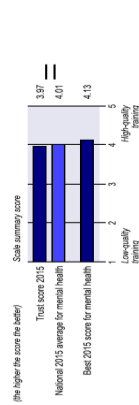


Mandatory training: % staff

91%
Q3
96%
Q4

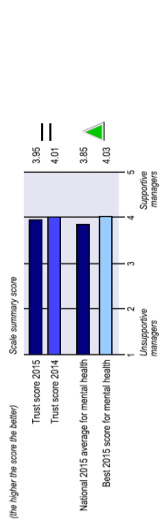
Source: TPNHSFT HR

Staff opinion of training

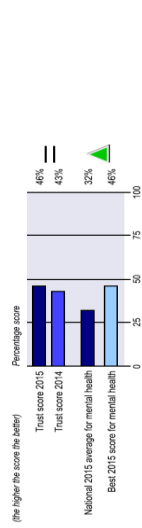


MANAGEMENT

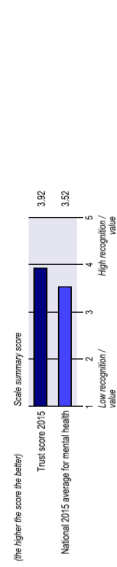
Support from immediate managers



% staff reporting good comms between senior mgmt and staff



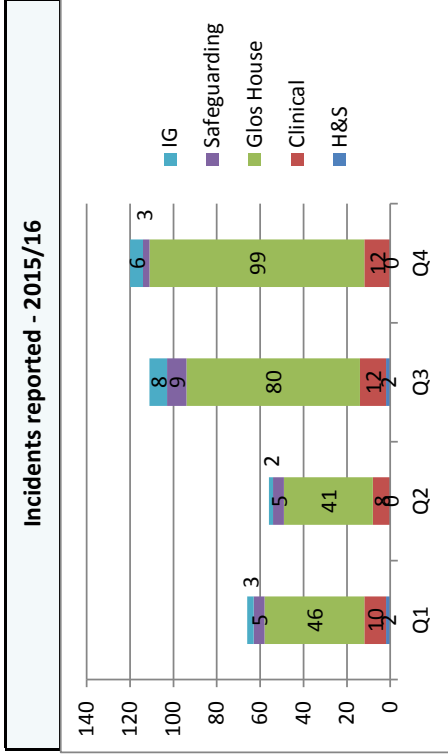
Recognition and value of staff by managers and the organisation



Sources for graphs: TPNHSFT National Staff Survey 2015

Quality - Safety

Q4 15/16



Serious Incidents reported

- Q1: OD: Patient took overdose in Portman waiting room
- Q2: Death: Patient jumped in front of train Family MH
- Q3: Data: Personal data stolen from staff's locked car
- Q4: No Serious Incidents Reported

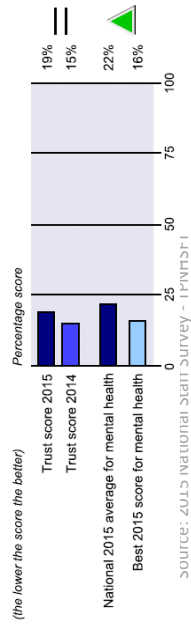
Source: TPNHSFT H&S Manager

% DBS checks on relevant staff

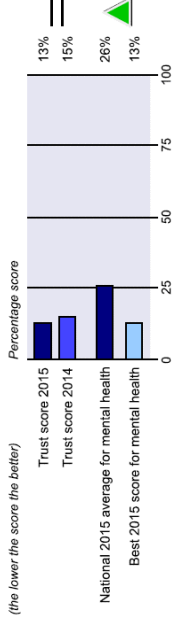
96% Q3 **96%** Q4

Source: TPNHSFT HR

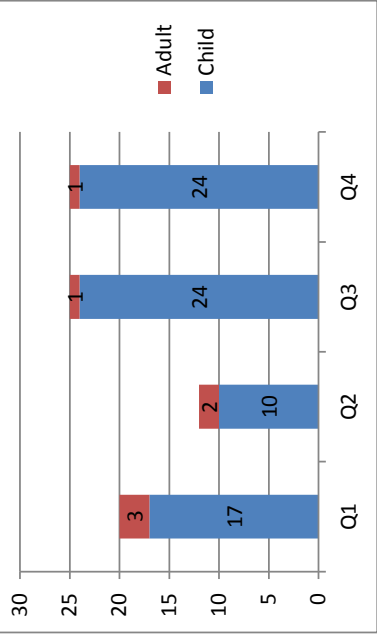
% staff experiencing harassment/bullying last 12m



% staff witnessing potentially harmful errors/near misses or incidents in last month



Safeguarding alerts

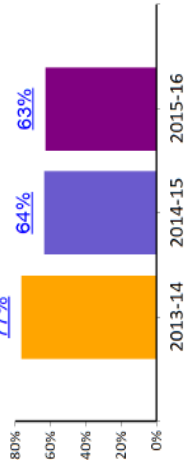


Quality - Effective

Q4 15/16

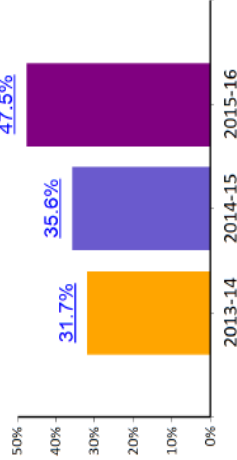
Outcomes

Over 18s Outcome Improvement On Core OM Who Have Been Discharged And Have Attended >= 4 Appts



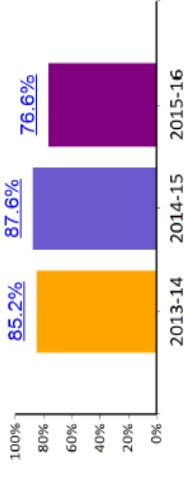
Q4 75 Positive Outcomes Out Of 98 Outcomes
Q4 98 Positive Outcomes Out Of 154 Outcomes
Q4 73 Positive Outcomes Out Of 116 Outcomes
Excluding Portman, TAP, City and Hackney and CYAF (apart from adolescent team).

Over 18s Core OM Data Collected



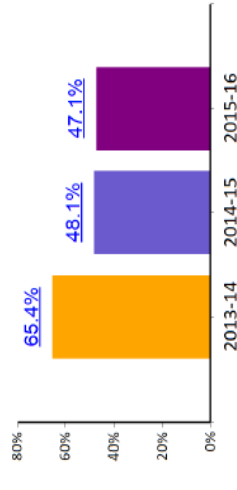
Q4 98 Collected Out Of 309 Discharged Patients
Q4 154 Collected Out Of 432 Discharged Patients
Q4 116 Collected Out Of 244 Discharged Patients
Excluding Portman, TAP, City and Hackney and CYAF (apart from adolescent team).

Under 18s Outcome Improvement With >=2 Goals Who Have Been Discharged And Have Attended >= 4 Appts



Q4 322 Positive Outcomes Out Of 378 Outcomes
Q4 346 Positive Outcomes Out Of 395 Outcomes
Q4 281 Positive Outcomes Out Of 367 Outcomes
Excluding AYA, FDAC, YPDAS, First Step, Westminster, Mosaic, GIDS and Portman.

Under 18s Core OM GBM Scores Collected



Q4 378 Collected Out Of 578 Discharged Patients
Q4 395 Collected Out Of 822 Discharged Patients
Q4 367 Collected Out Of 780 Discharged Patients
Excluding AYA, FDAC, YPDAS, First Step, Westminster, Mosaic, GIDS and Portman.

DNA

	DNA Rate YTD	Contract Target
Trust	9.4%	11.0%

*Excluding Mosaic, BYDAS, TAP

Patient Experience

	Explanation Of Service YTD
Trust	78%

Source: Experience of Service Questionnaire

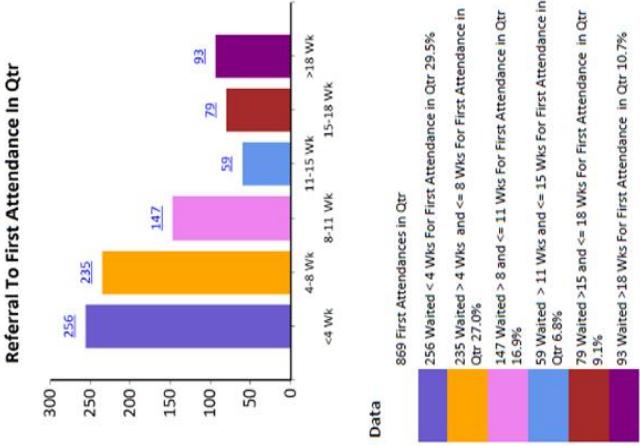
Patient Satisfaction

	I Would Recommend Trust To Others YTD	Help I Received At Trust Is Good YTD
Trust	89%	93%

Source: Experience of Service Questionnaire

Quality - Responsive (YTD)

Q4 15/16



	Views And Worries Were taken Seriously YTD	Involved With Important Decisions About My Care YTD
Trust	94%	87%

Source: Experience of Service Questionnaire

Letters Sent Within 2 Weeks Of Discharge	Planned Discharge Letters Sent Within 2 Weeks Of Last Appointment
## IN DEVELOPMENT ##	## IN DEVELOPMENT ##

No Of Complaints	Q2	Q3	Q4
	9	3	7

Student Experience and Outcomes

Satisfaction with Quality		Benchmark	Tavistock
2013/14		88.3%	92.8%
2014/15		87.0%	93.0%
2015/16		83.0%	94.0%

*excludes associate centres

Student Preparation: "I feel better prepared for my future career"		Benchmark	Tavistock
2013/14		72.4%	82.3%
2014/15		77.9%	86.2%
2015/16		81.0%	91.0%

*excludes associate centres

"Attending a course has increased my effectiveness in undertaking my job"		Benchmark	Tavistock
2013/14		80.3%	87.1%
2014/15		77.0%	81.3%
2015/16		78.0%	87.0%

*excludes associate centres

Benchmark UK data: www.hefce.ac.uk/it/nss/results (UK)

Activity

Student Offers - 15/4/16

Year	Total Offers Made	Total Offers Accepted	Total Applications
2012/13	492	352	775
2013/14	597	451	758
2014/15	588	469	602
2015/16	659	514	749

CPD and Events

	12-13 FY*	13-14 FY	14-15 FY	15/16 FY
Number of Courses / Conferences / Events	39	45	58	70
Number of Students / Delegates	1195	2079	2738	2063
Income excluding LCPD	£347,455	£533,547	£638,702	£500,678
Percentage income growth on previous year	-44%	35%	16%	-11%

*anomalous data due to inconsistency with data collection

Board of Directors : April 2016

Item : 13

Title : Quarter 4 Governance statement

Purpose:

The Board of Directors is asked to approve three elements of the governance statement to be submitted to Monitor for quarter 4:

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.

[Note: the statement "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." does not apply in quarter 4.]

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.

This paper was reviewed at the Executive Management Team on 19 April. 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 4 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 30 April, 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 are:
 - 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.
 - Our current rating on "Variance from Plan" is **4**, due to exceeding Plan in 2015/16. To retain this rating at each quarter through the year, we need to achieve or exceed the Plan I&E margin. If the margin is less than 1% below Plan (i.e. breakeven or very slightly below), the Variance from Plan rating will only reduce from 4 to 3.
 - Our Liquidity rating is projected to be **3** for all quarters of 2015/16; though this could fall to 2 with a relatively small variation in performance.
 - Our Capital Service Cover rating is projected to be 4 for all quarters of 2015/16.
- 2.3 The four elements are each given a 25% weighting; so based on the ratings predicted, our FSRR will be 3.5 which is rounded to **4**, the highest rating.
- 2.4 If the Variance from Plan rating and/or the Liquidity rating reduce by one point (see the relevant bullet point above), then the overall FSRR will be 3.25 or 3, either of which is rounded to 3 and remains satisfactory.

- 2.5 The liquidity rating is assisted by the securing of the medium-term loan from ITFF to fund the capital expenditure on continuing preparatory work for the relocation project.
- 2.6 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 by over £400k (pro rata), or almost 1% of income. This is not expected to occur.
- 2.7 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.
- 2.8 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.

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 below.
- 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 4 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

Target/Indicator	Weighting	Quarter 4 result	
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

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.

3.2.3 Following the CQC inspection in January, the report is awaited; but in the meanwhile, no moderate or major concerns have been notified to the Trust.

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

3.3.1 The Lifespan team manager carried out the Green Light audit, the self-assessment tool for our services for people with a learning disability, in January. This confirmed that the Trust meets the access requirements for this group. Action is being taken on two points for further development: (a) continue to develop the gathering and recording on CareNotes to show how we meet the needs of people with a Learning Disability via CareNotes; and (b) continue to develop literature describing our services for patients with a learning disability.

3.3.2 The Trust has continued to develop its services for LD service users, and actively involves users to further refine and tailor provision. The Lifespan team has introduced Photosymbols, a picture based system, to ensure that where necessary correspondence is written in ways that fit the communication needs of service users. They are also continuing to work on a phone App to act as an adjunct to therapeutic support; though this is initially being tested for people with autism spectrum conditions, it may later be applicable to a wider population.

3.4 Data Completeness

- 3.4.1 The target is 97% completeness on six data identifiers within the Mental Health Services Data Set (MHSDS). This replaced the MHLDDS on 1 January, and includes children and young people's services; so the number of patients covered for this Trust has almost doubled. Current statistics confirm that we are still meeting and generally exceeding the completeness target: see table below.

	Month 10, final	Month 11, provisional
Valid NHS number	99.56%	98.93%
Valid Postcode	99.71%	97.66%
Valid Date of Birth	100.00%	99.98%
Valid Organisation code of Commissioner	99.06%	99.00%
Valid Organisation code GP Practice	99.03%	99.70%
Valid Gender	99.98%	99.98%

4. Other matters

- 4.1 The Trust is required to report any "incidents, events or reports which may reasonably be regarded as raising potential concerns over compliance with [our] licence." The Risk Assessment Framework gives – on page 22 – a non-exhaustive list of examples where such a report would be required, including unplanned significant reduction in income or significant increase in costs; discussions with external auditors which may lead to a qualified audit report; loss of accreditation of a Commissioner Requested Service; adverse report from internal auditors; or patient safety issues which may impact compliance with our licence.
- 4.2 There are no such matters on which the Trust should make an exception report.

Simon Young
Deputy Chief Executive and Director of Finance
19 April 2016

Board of Directors : April 2016

Item : 14

Title : Nurse Revalidation April 2016

Purpose:

The purpose of this report is to provide information to the Board on the arrangements in place to prepare and support Trust Nurses to meet the NMC (Nursing & Midwifery Council) Nurse Revalidation requirements effective from April 2016.

The NMC agreed the introduction of the new model in November 2015 and introduced updated Guidance in December 2015.

The new Revalidation model replaces the current three yearly Renewal and Notification of Practice. The additional requirements introduced in the new model include:

- Third party confirmation by a line manager that they remain fit to practice in accordance with the NMC Code of Practice (April 2015)
- Evidence of CPD
- Evidence of reflective practice confirmed by another Registered Nurse
- A health & character declaration

The aim is to build on existing processes such as Supervision and Appraisal systems to provide the main source of third-party confirmation and confirmation of reflective discussion.

This report has been reviewed by the following Committees:

- Management Committee, 14th April.

This report focuses on the following areas:

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

For : Noting

From : Lis Jones, Nurse Director

NMC Revalidation April 2016

1. Introduction

- 1.1 In April 2016 the Nursing and Midwifery Council (NMC) will introduce its version of '*revalidation*'.
- 1.2 Revalidation is the health professional regulators' means of ensuring those on its register demonstrate a '*continuing fitness for practise*' by collating a portfolio of evidence.
- 1.3 Nurse Revalidation is the process by which nurses and midwives demonstrate to the NMC that they practise safely. The process encourages reflection, recording evidence to demonstrate fitness to practise thus promoting safe, effective practise.
- 1.4 Nurse Revalidation is a three year cycle. The first nurses to undergo revalidation will be those with a revalidation date of April 2016. This date is determined by the current regulatory requirements for nurses and midwives to pay an annual registration fee and complete a Renewal of Practice Declaration every 3 years. By March 2019 all nurses will have been through the first cycle of revalidation.

2. Tavistock & Portman Nursing Profile

34¹ Registered Nurses currently work for the Tavistock and Portman.

23 of these Nurses are in Clinical Services (7 in Adult & Forensic Services; 16 in Children Young Adult & Families Services).

1 in the Quality & Governance Department

1 in Child Psychotherapy Training

1 Executive Director

8 Family Nurse Partnership (FNP) Registered Nurses

- 2.1 Through the Heads of Nursing Discipline in Adult & Forensic Services, CYAF, and the FNP Clinical Director we have kept nursing staff updated on NMC requirements and worked towards clarity in relation to requirements of Managers in multi-disciplinary teams and support to develop Portfolios.
- 2.2 High standards of training, CPD opportunities, Clinical Supervision, Reflective Practice are deeply embedded in clinical practice at the Tavistock and Portman and within the Family Nurse Partnership (FNP).

¹ Accurate at January 04 2016, subject to fluctuation related to service developments; redundancies; voluntary severance; starters & leavers;

- 2.3 Although all nurses work in multi-disciplinary teams, given the small nursing workforce, it is possible to ensure that in the first instance most 'third party confirmers'² will be line managers closely attuned to the work of nursing colleagues. There will be some variation in this given the diverse settings in which nurses work within the organisation. All nurses will have an identified third party confirmer by March 2016.
- 2.4 Currently nurses work in multidisciplinary teams across 11 sites. Joint appraisal systems between operational line managers and Heads of Discipline are well established.

3. Background

- 3.1 Following the recommendations of the Francis Report (2013), the NMC has reviewed and updated its Code of Conduct and processes for Nurse Registration and Validation. The revised NMC Code³ effective from March 2015 provides greater emphasis on four themes:
- Prioritise people
 - Practice effectively
 - Preserve safety
 - Promote professionalism and trust
- 3.2 The new revalidation model aligns to these four themes and gives assurance to patients and the public, employers and other healthcare practitioners that registered nurses are up to date and practicing to the appropriate professional standards.
- 3.3 The requirements for revalidation are:
- 450 practice hours or 900 if revalidating as both a nurse and midwife
 - 35 hours CPD including 20 hours participatory learning
 - Five pieces of practice related feedback
 - Five written reflective accounts
 - Reflective discussion
 - Health and character declaration
 - Professional indemnity arrangements
 - Confirmation by a third party
- 3.4 Nurses will be required, as they are now, to maintain an electronic-portfolio to collate supporting evidence. All submissions to the NMC will be made electronically through each individual nurse's personal NMC account.

² Third part confirmers will be Supervisors or Line Managers with whom staff will have discussed their Revalidation requirements, for example through the Annual Appraisal System.

³ Nursing & Midwifery Council (2015) The Code of Professional Standards of Practice and Behaviour for Nurses and Midwives. NMC: London

4. Implications for the Trust, Line Managers, Nurses and Supervisors

4.1 Revalidations should not be problematic in any way for the majority of the Trust's nursing staff and requirements will be incorporated into existing supervision models and annual appraisal systems.

4.2 All nursing staff are engaged in the following:

- Annual Appraisal
- Clinical Supervision
- Managerial Supervision
- Access to Continuing Professional Development
- Clinical discussions in Team Meetings

4.3 In addition some staff are engaged in the following:

- Group supervision
- Peer supervision
- Case based specialist supervision
- Conference presentations
- Teaching

5. Trust Nurse Revalidation Plan

5.1 The Director of Nursing supported by the Heads of Discipline for Adult & Forensic Service and CYAF Services have worked with the Nursing Discipline to identify any outstanding requirements in relation to revalidation.

5.2 The main challenge has been to establish revalidation dates for all staff as HR procedures were not in place until recently, but clear arrangements are now in place. A manual collection of NMC data through individual reporting has established a baseline that will need to be verified against the NMC database.

5.3 FNP has developed its own national plan that is consistent with the Trust's approach.

5.4 For Registered Nurses in non-clinical facing roles such as FNP, Quality & Governance and Executive Nurses, revalidation builds on the existing re-registration requirements and multiple approaches can be adopted to meet all of the requirements. The revalidation model takes into consideration variability in roles and diversity in practice is taken into account.

5.5 We have developed a communications lecture facility online that will be accessible to all nurses and a series of personalised tutorials for those revalidating 2016. All nurses have been issued with a Trust Guidance document and received individual confirmation of their revalidation dates, a named nurse

with whom they can confirm their reflective practice feedback and who will be able to verify and confirm that they meet the revalidation requirements.

6. Issues for Consideration

- 6.1 Consideration has been given to acquiring revalidation software and portfolios. In accordance with many larger NHS Trusts, we have concluded that expenditure on dedicated sophisticated software would not be necessary or cost effective.
- 6.2 We have already alerted that we require an Intranet space that will provide nurses with all the Revalidation Documents in one location. We aspire to each nurse having a folder to gather supporting evidence electronically through the emerging Intranet renewal.
- 6.3 HR need to be capable to access the NMC database in order to maintain updated Revalidation dates.

7. Conclusion

Trust arrangements for Nurse Validation are in place. The first staff to go through the process in April 2016 are being supported by their Heads of Discipline and individual tutorials.

Lis Jones
Nurse Director
March 2016

Board of Directors : April 2016

Item : 15

**Title : Annual Clinical Complaints and Whistleblowing Report
2015-16**

Purpose:

The purpose of this report is to provide a summary of the formal complaints received by the Trust in 2015-16 and to identify any lessons learned from these complaints.

The report also includes details of all whistleblowing cases in the past year: this year there were none.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, that complaints have been managed in line with NHS requirements.

This report has been reviewed by the following:

- Corporate Governance and Risk Workstream Committee
- Patient Safety Workstream Lead
- Management Committee, 14th April 2016.

This report focuses on the following areas:

- Patient / User Experience

For : Noting

From : CEO

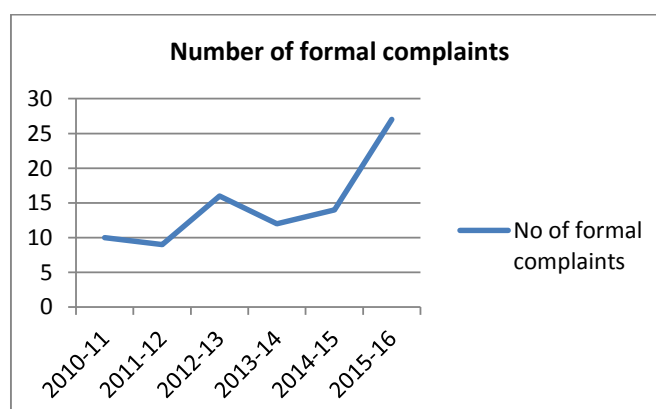
Annual Complaints Report

1. Introduction

The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. The number of formal complaints received by the Trust in 2015-16 has risen to 27. Although significantly higher than in previous years (in 2014-15 we received 14), this is still relatively low compared to other NHS Trusts. The formal complaints received mostly relate to aspects of clinical care with a small number relating to facilities issues. This short report summarises the complaints received in the year, and the lessons learned from this important form of patient feedback.

2. Formal complaints received

Year	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
No of formal complaints	10	9	16	12	14	27



During 2015-16 the Trust received 27 formal complaints. These were all acknowledged by the Chief Executive, investigated under the Trust's complaints procedure and a detailed letter of response was sent by the Chief Executive to each complainant.

3. Time to respond to complaints

Of the 27 complaints received in 2015-16, 4 remain open at the end of the year (in time for a response). 23 received formal responses, of which 22 were sent full responses within 25 days and 1 received a full response outside 25 days. The delay in responding to this complainant was due to having received two separate complaints from the same person. One was completed in full before the second complaint was investigated. The patient was kept informed and the Trust did not receive any negative feedback from the complainants as a

result of this delay. As detailed in last year's report the Trust is aware of the need for timely responses and has taken steps to put in place systems to ensure that complaints are acknowledged within 3 working days and, whilst no longer a national requirement, the Trust seeks to respond to complaints in full within 25 working days.

4. Complaints by Service

During the year services were reconfigured so comparisons are shown by Directorate rather than by service for 2015-16. The previous chart has been included for information.

Service	Number of complaints	
	2013-14	2014-15
Adult services	5	7
Portman service	2	2
Adolescent service	0	1
GIDS service	2	0
CAMHS (excluding GIDS and adolescent)	3	4
TOTAL	12	14

Data source: Complaints database

Directorate	Number of Complaints
	2015-16
Children Young Adults and Families	19
Adult and Forensic	6
Corporate Governance and Facilities	2
Total	27

Data source: Complaints database

5. Topics of Complaints

In 2015-16 most complaints related to aspects of clinical care, however two complaints related to facilities issues.

The following table provides a summary of topic of complaints.

Topics of complaints received
Clarity over process involved with clinical treatment (2 cases)
Attitude of facilities staff (2 cases)
Unhappy with involvement of FDAC
Parent feels that therapist had biased view towards them
Insufficient information given to patient about referral processes (2 cases)
Parent unhappy with treatment given to young person (18 years old) (2 cases)
Delays in referral due to administration errors (3 cases)
Misleading, biased and incorrect information included in report
Alleged discriminatory treatment
Alleged incorrect diagnosis and breach of NICE guidelines
Unhappy about the clinical assessment of the family
Unhappy about timings of appointments and resulting delay in commencement of family therapy
Breach of confidentiality (safeguarding issue)
Unhappy with appointment times and lack of timely communication from therapist

Alleged failure to acknowledge patient's mental health when presenting to FDAC
Alleged clinical negligence
Delay in sending case notes following contact sessions between father and child

Data source: Complaints database

6. Complaints Upheld

An assessment of whether a complaint is upheld or not is always made in order to support the lessons that can be learned within the organisation. In 2015-16 more than half (52%) of complaints were upheld fully or in part. Complaints have been reviewed and the increase is likely to relate to a change in emphasis on openness, transparency and learning. There is a recognition that patients feel listened to when it is acknowledged that even small errors have occurred, even if the main basis of their complaint has not been upheld.

Was the complaint upheld?	2013-14	2014-15	2015-16
Upheld in full	0	0	7
Upheld in part	2	3	7
Not upheld	9	9	9
Under investigation at time of report	0	2	4
Total complaints	12	14	27

Data source: Complaints database

7. Lessons learned

Complaints are always considered as opportunities for lessons to be learned, whether or not the complaint is upheld.

All complaints are fully investigated and a detailed report drawn up to address all the issues raised. When a complaint is upheld either in full or in part, an action plan is drawn up to ensure that where appropriate changes are made or further training is offered.

Complaints are discussed quarterly at the Executive Management Team so that the senior staff are made aware of any themes from the complaints and appropriate action taken. From 2015-16 one of the key issues was communication with patients concerning administration delays.

When corresponding with the complainants we seek to ensure that they feel listened to and that their concerns are being taken seriously. Where appropriate further appointments are offered to complainants with senior staff, including the Chief Executive Office, to ensure that any issues over our processes and their clinical treatment is clarified.

A number of specific actions have been taken during the year in direct response to complaints and these are shown in the table below:

Topic	What was upheld	Lessons learned
Insufficient information given about the referral process	The Trust apologised for this and for delays to the referral process.	Clinician reminded of the procedures and a process was established to send a standard letter to patients to confirm they are on a waiting list and who to contact for support during this time
Delays in referral	This was an administration error	Staff reminded of procedures
Unhappy with appointment time and lack of communication from therapist.	Apology given for delays in communication and appointment times for young people reviewed	Action plan has been put into place to communicate with young people by text who are on the waiting list. Review of out-of-hours appointments was undertaken and this was found to be adequate.
Breach of confidentiality	Disclosure of an incident to police without the consent or knowledge of the patient	Clarification given to staff on when to report a safeguarding incident. Patient advised of alternative private therapist
Rudeness of facilities staff	Facilities staff appeared rude to patients/members of the public when carrying out their security duties.	De-escalation training arranged for facilities staff.

8. Parliamentary Health Service Ombudsman (PHSO) Investigations

If a patient is dissatisfied with a response to a complaint that they have received from an NHS Trust they have the right to refer their complaint to the NHS Healthservice Ombudsman who will review the concern and may take one of three options:

- Refer the matter back to the trust for further investigation
- Under an investigation itself (if the complaint involves clinical matter the Ombudsman's office is required to seek expert opinion)
- Take no action

During the year two patients referred a complaint to the Ombudsman compared to none in either 2014-15 or 2013-14 .

9. Next steps

For 2016-17 the Trust is committed to ensuring that all staff are fully aware of the different ways that patients can raise concerns. Further guidance has been issued to staff and new posters have been displayed in all patient areas on who to contact should a patient wish to make a complaint.

Complaints management will continue to be promoted at staff induction and mandatory training days (INSET) and in other settings as appropriate during the year. Further information on complaints was issued to staff in November 2015 and this is shown in Appendix 1. In addition the PALS Officer, the Complaints Manager and Patient and Public Involvement (PPI) staff will continue to work together as to ensure that patients are appropriately supported when they raise an issue.

The changes proposed for last year have been completed and the new Associate Director of Quality and Governance, reporting to Louise Lyon as Director of Quality and Patient Experience, is now in post. A new Complaints Manager has been appointed as our very experienced former Complaints Manager is nearing retirement and they are working together at present to ensure continuity of service.

Report prepared by
Amanda Hawke, Complaints Manager
on behalf of Chief Executive Officer

April 2016

10. Whistleblowing

There were no formal whistleblowing cases raised in 2015/16.

There were no formal whistleblowing cases raised in 2014/15.

Gervase Campbell
Trust Secretary, April 2016.

11. Report from the Freedom to Speak Up Guardian

The Francis Review recommended that all NHS Trusts appoint a Freedom to Speak Up Guardian. Gill Rusbridger began in this role on behalf of the Trust in October 2015.

The Trust has had no members of staff coming forward and raising formal complaints about patient care. However, this does not mean that we should become complacent. Just as in every other NHS trust, we need to build on a culture of openness and responsiveness to staff speaking out about anything that might place the care of our service users into question.

Actions Since Being Appointed.

To raise the profile of the role with staff a number of actions were undertaken:

Between November and December 2015, an email was sent to the whole Trust with my photograph attached so that everyone could recognise me, and a page set up about the role on the staff intranet. Since January 2016, posters with my contact

details have been distributed to staff noticeboards, as well as information cards about the National Whistleblowing Helpline. A small version of the original poster was then attached to everyone's pay slip.

A further email was sent out informing staff about the appointment of a National Guardian, Dame Eileen Sills, and an email was sent to staff managers attaching information about 'top tips for managers' for when staff raise concerns. An additional email was sent to everyone that spoke in particular of the difficulties for BME staff in feeling able to speak out and raise concerns.

Staff seem curious about the role and often say spontaneously that they think it is a good thing. They liked the posters and flyers and some have commented on the Trust needing to be aware of how hard it might be to speak up. As a result of the emails being sent out, between October 2015 and March 2016, I have had 6 members of staff visit me. They all seemed relieved to be able to contact someone in confidence. Their concerns were mainly to do with feeling pressured and at risk of being overlooked and bullied. These concerns mirror an issue raised in the 2013 staff survey about staff bullying, which is being actively addressed elsewhere in the Trust. This was seen to have improved in the 2014 survey. However, it is important to recognise that feeling bullied can be linked with feeling unable to raise concerns. One member of staff did raise a concern about patient safety and I believe that this is now being dealt with directly with managers.

I spoke to the CYAF management group about the role and intend to arrange to attend an equivalent meeting with managers in AFS, and I met with Angela Haselton, Staff side Representative, to share information about staff raising concerns.

I met with Paul Jenkins, CEO, Louise Lyon (Director of Quality and Patient Experience) and Edna Murphy (NED) in March to report back on my experience so far.

Links Outside The Trust.

I contacted the National Whistleblowing Helpline and now receive regular newsletter updates from them via email. I have also joined the NHS Employers local Guardian hub and my details are on the freedom to speak up Guardian map. I have been in touch with another local Guardian, based at the Royal Free Hospital.

The National Guardian Office is becoming more active and there are now meetings for NHS Guardians, held alternately in Leeds and in London. I attended one that was held in London in March. Unfortunately, the National Guardian had by then resigned, but recruitment is underway to appoint a replacement. I anticipate there being more linking up with other Guardians – to share questions about the role and take part in training initiatives. A first conference for FTSU Guardians is being planned for next year.

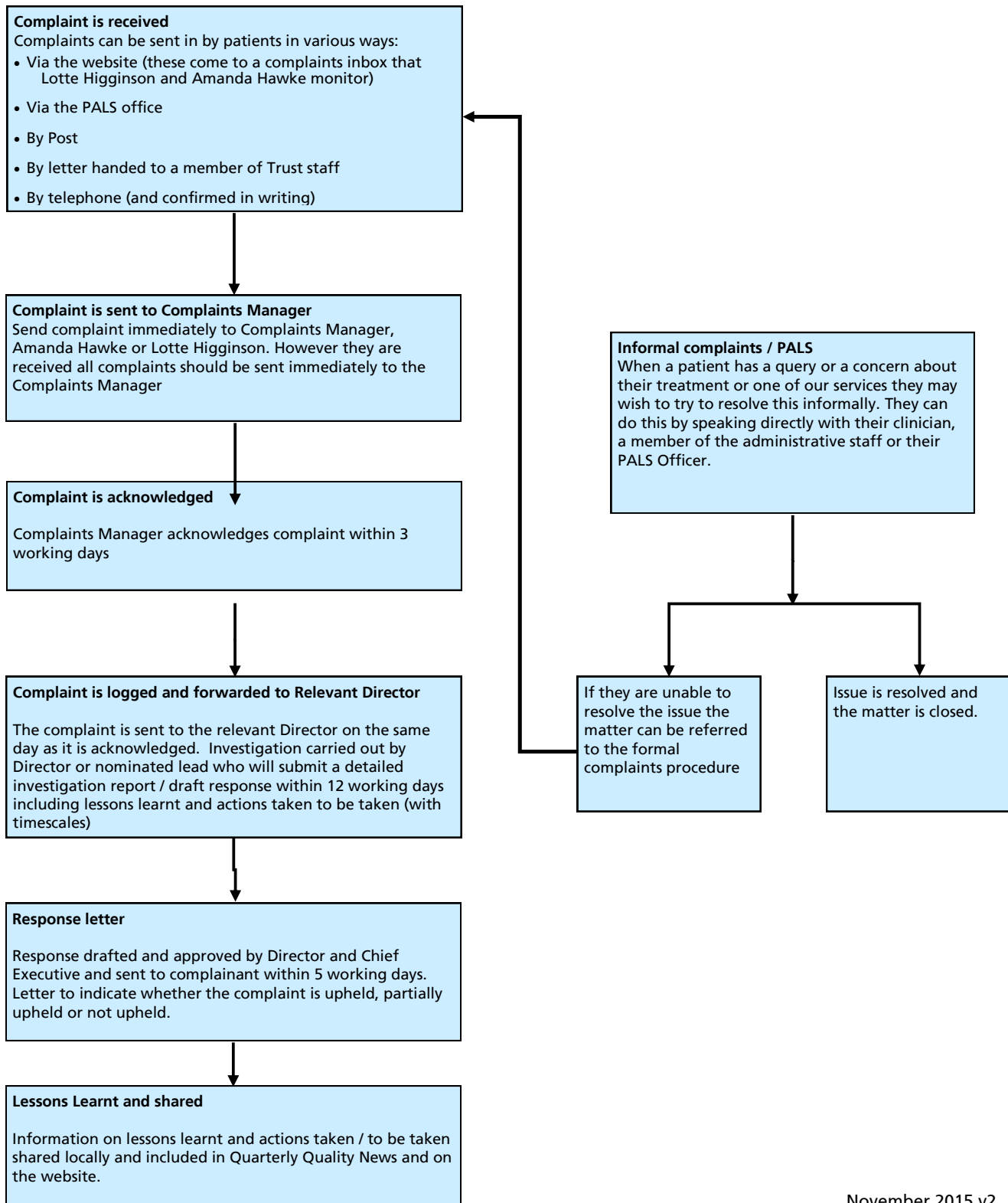
For The Future.

- I will be sending out regular emails reminders to all staff about my role and availability as an independent person with whom to consult about concerns they may have.
- I will continue to arrange particular meetings with groups of staff and managers.
- I am arranging a slot at our next Inset day.
- I will be attaching a question to the next staff survey relating to staff views on how comfortable they feel about speaking up.
- I will extend my connections with other local FTSU Guardians and with the National Office.
- I will continue to keep the profile of the Guardian in the Trust as high as possible. This is an important role that actively addresses and acknowledges the Trust's commitment to ensuring a culture of openness where staff are encouraged to speak up about patient safety.

Gill Rusbridger
Freedom to Speak Up Guardian
April 2016.

Appendix 1 Complaints Flowchart for staff issued November 2015

Complaints and Concerns (PALS) Procedure for Staff



Board of Directors : April 2016

Item : 15b

Title : Education and Training Annual Complaints Report
2015-16

Purpose:

The purpose of this report is to provide a summary of the formal complaints received by the Department of Education and Training in 2015-16 and to identify any lessons learned from these complaints.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance that complaints have been managed in line with requirements.

This report has been reviewed by the following:

- Exec Management Team

This report focuses on the following areas:

- Student / User Experience

For : Noting

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

Annual DET Complaints Report

1. Introduction

The Department of Education and Training currently handles student complaints under four different procedures depending upon whether the student/potential student/user is complaining about a Trust course or a course validated by one of our university partners. The policies are:

- Trust Student Complaints Procedure
- UEL-Tavistock Student Complaints Procedure
- Essex-Tavistock Student Complaints Procedure
- Middlesex Student Complaints and Grievances Procedure

The Department of Education and Training received 6 complaints in 2015-16, 4 of which became formal complaints. These complaints mostly related to being provided with what the complainants regarded as inaccurate information (from Course Administrators and the Finance Department in relation to such things as intermitting/deferring and fees) with a small number relating to course content. This short report summarises the complaints received in the year as well as detailing the review of our complaints policy that we are currently undertaking.

2. Formal complaints received

During 2015-16 the Department of Education and Training received 4 formal complaints. These were acknowledged by the Complaints Liaison Officer on behalf of the Dean of Postgraduate Studies, investigated by one of the Associate Deans and a detailed letter of response was sent by an Associate Dean or the Chief Executive to each complainant.

In addition, we have 2 complaints which have been on-going since around 2014. These complaints have been complicated by, in one instance, being referred to lawyers and, in the second, progressing to a Complaints Review Panel at the University of East London.

3. Time to respond to complaints

Of the 4 complaints received in 2015-16, 2 remain open at the end of the year. The complex nature of complaints in the Department of Education and Training means that there is often on-going correspondence between the complainant and the investigating Associate Dean before the matter is concluded. This has led to difficulties in monitoring time lines and is an issue we are looking to resolve in our review of the Trust Student Complaints Procedure. The Department of Education and Training is aware of the need for timely responses and seeks to respond to complaints in full within 15 working days. Part of our review of the process will consider timelines as 15 days to respond creates a lot of pressure given most of our

students and staff are part-time. It is worth noting that the clinical complaints procedure allows for 25 days to respond.

4. Topics of Complaints

In 2015-16 most complaints related to provision of perceived inaccurate information, however two complaints related to the content of courses attended.

The complaints we receive are often complex multi-stranded complaints, covering a range of topics. The following table provides a summary of topics of complaints.

Topics of complaints received
Clarity over process involved in withdrawing or intermitting
Unhappy with having to pay a cancellation fee when withdrawing
Unhappy with the content of a lecture attended
Issues in obtaining accurate statements of account from the Finance Department
Alleged discriminatory treatment
Delays in receiving certificates following completion of CPD courses
Incorrect information provided regarding a delay in providing a course certificate due to outstanding fees
Unhappy with response to a reference request
Alleged lack of support from course supervisor
Inaccurate information provided regarding intermitting/deferring

Data source: DET Complaints log

4. Complaints Upheld

In 2015-16 3 of the complaints (75%) were upheld in part (though 2 of these are still under investigation) and 1 was not upheld. There is a recognition that we need to look at how information is provided to students and how to ensure this information is accurate. This will be addressed in part by the Charters and Standard Operation Systems being put in place across the Department of Education and Training.

Was the complaint upheld?	2015-16
Upheld in full	0
Upheld in part	1
Not upheld	1
Under investigation at time of report	2
Total complaints	4

Data source: Complaints log

5. Reviews of Complaints

If a student/potential student/user is dissatisfied with a response to a complaint they have received, they have the right to ask for a review either by the Chief Executive/Trust Board or one of our university partners if the complaint is about a validated course. During the year 2015-16 no complaints were referred to the Chief Executive or a University review panel.

6. Next steps

The Department of Education and Training is currently undertaking a review of the Trust Student Complaints Procedure to ensure alignment with both our joint University-Tavistock Student Complaints Procedures and other Tavistock policies and procedures, including the clinical complaints procedure and disciplinary procedures. This will also make the procedure for handling student complaints easier for both students and staff.

The Dean's Office Manager has been appointed Complaints Liaison Officer and will manage the complaints process, including logging informal and formal complaints, monitoring timelines and reporting on lessons learned.

Staff have been advised to notify the Complaints Liaison Officer of any informal complaints so that we can monitor and log complaints received. There will also be a briefing for all staff and we are looking to create a complaints 'tool kit'. We will also create clearer guidance for students on how to make a complaint and the process that follows.

As part of our review, we are considering guidance provided by the Office of the Independent Adjudicator (OIA). We have recently been informally told that we will be registered with the OIA in the near future. Once we are formally notified we will be discussing the effect of this on both our own and join Complaints Procedures and will be ensuring that any changes to the Trust Student Complaints Procedure comply with the OIA requirements.

Report prepared by
Isabelle Bratt, Dean's Office
On behalf of
Dean of Postgraduate Studies

April 2016

Board of Directors: April 2016

Item : 16

Title : Human Resources and Organisational Development 2015/16 Year
End Report

Purpose:

To share the work undertaken by the HR directorate over the last year and to detail the Trust's workforce metrics.

The report incorporates the results from the NHS staff survey and a forward looking action plan detailing the work required to respond to the results.

Incorporated within this report is a one year, proposed, strategic HR and organisational development business plan. The activities reflect on feedback received from operational managers and the priorities for the coming year and also detail the development process for an organisational development and workforce strategy.

This report focuses on the following areas:

(delete where not applicable)

- Communications
- Quality
- Workforce

For : Noting

From : Craig de Sousa, Director of Human Resources

Human Resources and Organisational Development 2015/16 Year End Report

1. Introduction

This report summarises some of the activities undertaken by the HR directorate over the last financial year and provides the trust board with key workforce indicators. The report covers:

- The Care Quality Commission (CQC) inspection process and impacts for the HR directorate;
- Our health and wellbeing strategy;
- Results and the action plan resulting from the 2015 NHS staff survey;
- A proposed strategic HR business plan for 2016/17; and
- Key workforce indicators including mandatory training and appraisal compliance

2. CQC inspection process and impacts for the HR directorate

The CQC inspection process prompted a lot of action and made the HR team focus very carefully on our areas of statutory compliance. We were able to credibly demonstrate our compliance with the fit and proper person requirement (FPPR) for directors and non-executive directors and how we have responded to the NHS staff survey in previous years.

The process did, however, identify weaknesses in some of our processes and systems. The two most prominent being our professional registration monitoring process which we have taken immediate corrective action and the other being the way in which we record our statutory and mandatory training, the latter being an area that we have more work to do.

3. Our health and wellbeing strategy

In collaboration with our staff partners we have started an engagement process to develop a bottom up health and wellbeing strategy. We had aimed to deliver a documented strategy by the end of the financial year, however, with the arrival of the new HR director it was felt this work should take a pause to undertake more engagement with staff.

To complement the strategy we have also signed up to the London health workplace charter. This is regional piece of work being led by Public Health England who are developing a set of resources to support employers to make their organisation a healthier and happier one. We will be engaging with a public health strategist in the first quarter of 2016/17 to explore where there are potential synergies.

A mental wellbeing event has been scheduled to take place on 21 April 2016 which will incorporate data gathering from staff and understand what they wish for us to explore and develop. There will also be a further health and wellbeing event in June which is being led by the director of quality and patient experience.

4. Action plan arising from the 2015 NHS staff survey

The NHS staff survey results were released in February 2016 and again place have some exceptionally positive messages placing our organisation as the best amongst our peer group for engagement and staff recommending the trust as a place to receive treatment.

We adopted a different approach to responding to the staff survey this year equipping our managers with data at directorate level to understand the issues and support the development of a corporate action plan.

The table below summarises areas which require attention and actions which we hope will support changes to future results. It is recognised, though, that many of the problem areas are long standing and will require some extensive cultural engagement work and that we may not see many changes when the next survey results are received.

Theme	Action Required	Responsible	By When
Bullying and harassment from staff and colleagues	Document and publicise our channels for raising concerns	HR Business Partner and Freedom to Speak Up Guardian	End of May 2016
	Develop a confidential tracking method for staff concerns	Freedom to Speak Up Guardian	June 2016
	Revise the trust bullying and harassment policy incorporating new methods for reporting bullying and harassment	HR Business Partner	June 2016
	Distil the Trust's values and create a behavioural framework which resonates with staff	HR Director and Director of Communications	August 2016
Staff working extra hours	Complete a review of bank and agency expenditure and ensure that vacant positions are actively being recruited to	HR Business Partners, Management Accountants, Team Managers	May 2016
	Develop a framework which promotes alternative communications channels to email	HR Business Partner and Head of Communications	July 2016
	Incorporate effective communications in to the relocation project	Workforce Development Leads	Ongoing
	Promote the importance of reporting incidents in the Children, Young Adult and Families Directorate	Director – CYAF	May 2016
Staff experiencing violence and not reporting the incident	Commence monitoring of all flexible working applications and incorporated in to future monthly workforce reports	HR Business Partners	Recording from May 2016 and reporting from September 2016
Flexible working	Review the Flexible Working Policy and promote its existence	HR Business Partner and HR Director	June 2016
	Review the Trust's appraisal documentation and process	HR Director	September 2016

5. A proposed strategic HR business plan for 2016/17

The trust's five year ambitions and two year objectives set out a number of key priorities for the HR directorate. One of the main deliverables within the corporate strategy is to develop a comprehensive organisational development and workforce strategy. This section of the report outlines our strategic directorate objectives to create an aligned strategy but also a number of key workstreams required in the coming financial year.

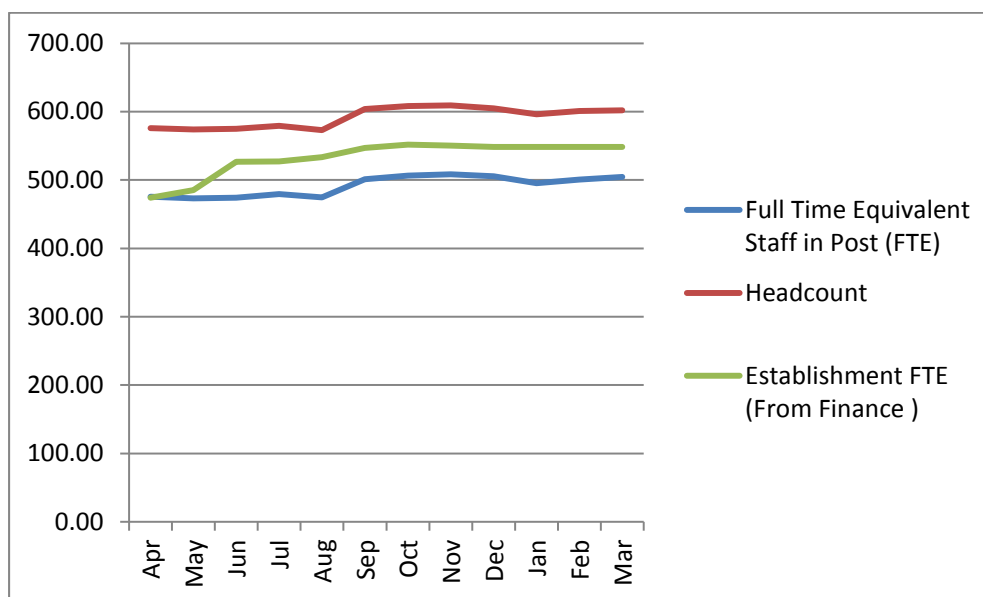
Activity	5 Year Ambition Alignment	Responsible	Q1	Q2	Q3	Q4
Organisational development and workforce strategy						
Commence the narrative activities for the strategy	Reinforce our reputation as one of the best places to work in the NHS	HR Director	X	X		
Draft strategy consultation process		HR Director			X	
Final strategy for board approval		HR Director				X
Health and Wellbeing						
Finalise the health and wellbeing strategy	Enhance the capability of our organisation	HR Business Partner	X			
Re-procure the occupational health contract		HR Business Partner	X	X	X	
Staff engagement						
Managers to implement immediate actions to the staff survey and HR report on progress	Reinforce our reputation as one of the best places to work in the NHS	HR Business Partner	X			
Plan for launch of 2016 survey and agree granular reporting levels		HR Business Partner		X		
Launch the staff survey promoting actions taken to respond		HR Business Partner			X	
Report on findings from 2016 survey and re-engage with staff		Head of Communications HR Business Partner				X
Employee relations						
Review key HR policies – disciplinary, grievance, capability, sickness management and change management	Reinforce our reputation as one of the best places to work in the NHS	HR Director & HR Business Partner	X	X		

Activity	5 Year Ambition Alignment	Responsible	Q1	Q2	Q3	Q4
Medical Staffing						
Support the Trust's training programme directors to map existing rotas on to the new contract	Enhance the capability of our organisation	Resourcing and Development Manager and HR Business Partner	X			
Appoint a rota guardian to oversee the safety monitoring process for the new contract		Resourcing and Development Manager	X	X		
Implement the new contract		Medical Director				
		Resourcing and Development Manager			X	X
Recruitment and sourcing						
Review the trust's recruitment and HR administration procedures with involvement from line managers and introduce KPI metrics	Reinforce our reputation as one of the best places to work in the NHS Enhance the capability of our organisation Improve our use of information and technology	Resourcing and Development Manager	X	X		
Explore opportunities for enhancing our e-recruitment solution		Resourcing and Development Manager		X	X	
Review our branding and marketing information for prospective applicants		Resourcing and Development Manager			X	X
		Head of Communications				
Learning and organisational development						
Finalise organisation learning needs analysis and commission educational requirements	Reinforce our reputation as one of the best places to work in the NHS Enhance the capability of our organisation Improve our use of information and technology	Resourcing and Development Manager	X			
Scope and develop a trust wide management development programme harnessing the resources from the NHS Leadership Academy Programmes		Organisational Development Consultant				
Launch cohorts 1 – 4		Organisational Development Consultant	X	X		
		Resourcing and			X	X

Activity	5 Year Ambition Alignment	Responsible	Q1	Q2	Q3	Q4
Transition all training records on to Oracle Learning Manager Develop a succession planning framework Review and revised the Trust's appraisal process		Development Manager				
		Resourcing and Development Manager		X	X	
		HR Director			X	
		Organisational Development Consultant		X		
Reward and recognition						
Explore the flexibilities that existing with Agenda for Change and whether we ought to explore local terms and conditions of service	Reinforce our reputation as one of the best places to work in the NHS	HR Director and Chair of Staff Side		X	X	
Assess the existing mechanisms for recognising and rewarding staff	Reinforce our reputation as one of the best places to work in the NHS	HR Business Partner			X	
Develop a recognition framework and process		HR Business Partner				X

6. Key workforce indicators

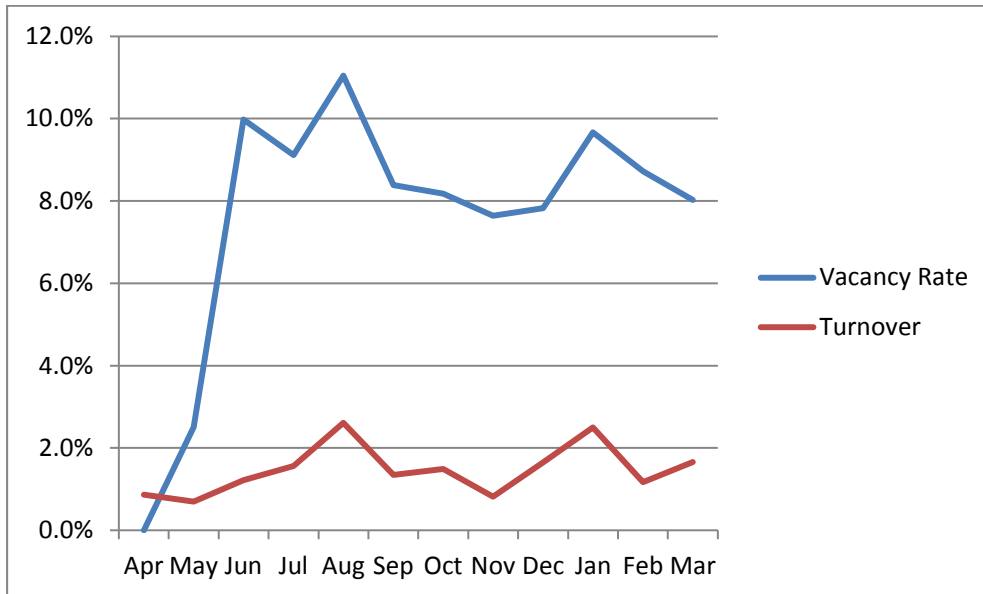
Period: April 2015 - March 2016																
Report Title	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4
Full Time Equivalent Staff in Post (FTE)	475.29	473.19	473.90	474.13	479.20	474.64	501.13	484.99	506.63	508.23	505.33	506.73	495.25	500.45	504.27	499.99
Headcount	576	574	575	575	579	573	604	585	608	609	605	607	596	601	602	599
Vacancy Rate	0.0%	2.5%	10.0%	4.1%	9.1%	11.0%	8.4%	9.5%	8.2%	7.6%	7.8%	7.9%	9.7%	8.7%	8.0%	8.8%
Turnover	0.87%	0.70%	1.22%	0.93%	1.56%	2.61%	1.35%	1.84%	1.49%	0.82%	1.65%	1.32%	2.50%	1.17%	1.66%	1.78%
Stability Index	86.5%	86.8%	86.6%	86.6%	87.3%	86.6%	90.0%	88.0%	90.0%	88.5%	88.5%	89.0%	86.2%	87.1%	95.1%	89.4%
Sickness Absence Spot Month	1.31%	1.02%	0.99%	1.11%	0.76%	0.92%	1.35%	1.01%	1.51%	1.41%	1.25%	1.39%	1.27%	1.38%	1.94%	1.53%
Sickness Absence 12 month rolling average	1.19%	1.17%	1.17%	1.18%	1.17%	1.15%	1.17%	1.16%	1.19%	1.17%	1.18%	1.18%	1.19%	1.17%	1.38%	1.25%
Appraisal Compliance	82%	98%	99%	93%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Establishment FTE (From Finance)	474.20	485.36	526.45		527.25	533.55	547.00		551.75	550.25	548.25		548.25	548.25	548.25	



The headcount and FTE have slowly grown throughout the financial year, at the end of quarter 1 the budget was adjusted to account for additional posts within a number of central functions. All other growth has been attributed to acquisition of new services and growth within the gender identity service.

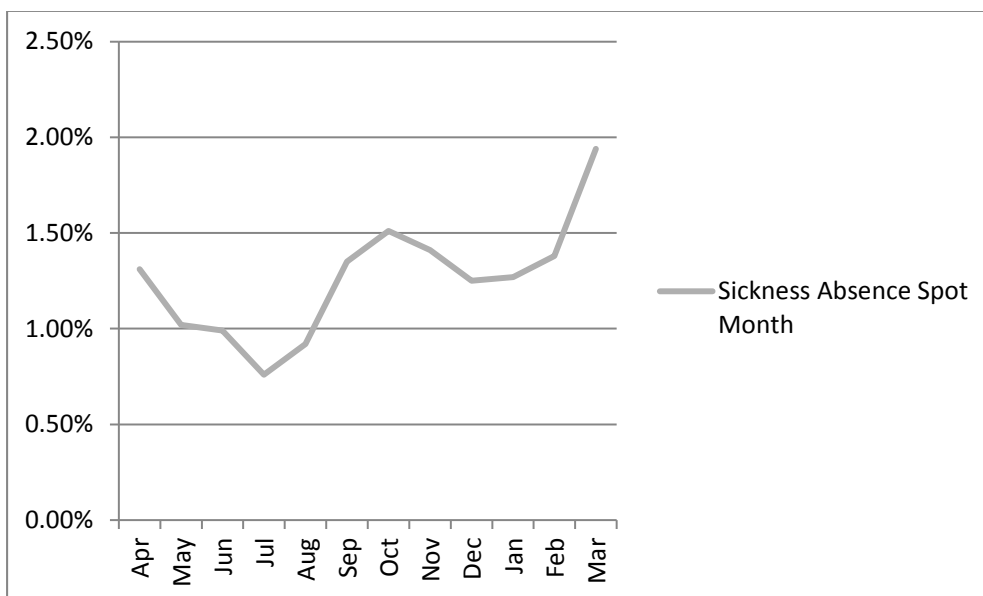
Based on the current commissioning negotiations we are aware that there is likely to be further growth in 2016/16 within the gender identity service which is reflective of high patient demand for the service and insufficient capacity.

The HR business partners will be working with managers throughout April also exploring agency expenditure. This is to understand where we have contingent workers, the reason and plans to reduce expenditure. This is also in response to NHS Improvement's agency expenditure ceiling which was issued at the end of March, in 2016/17 the trust's agency expenditure should not exceed £728,000. We are confident that we can work within this limit and the action planning processes will support this. There are, however, some areas which we need to seek exemptions because services are not standard healthcare delivery services, Gloucester House being an example.



The vacancy rate spiked in May 2015 following an increase to the trust's establishment and the current trajectory signals that recruitment activity is underway to fill vacant posts and newly created sessions. This is positive taking in to account that there is turnover which has fluctuated throughout the year.

At present time is not possible to quantify the length of time to recruit nor the number of vacancies in the recruitment pipeline. The strategic HR business plan details that these metrics will be developed and implemented by quarter 2 of 2016/17.



Our sickness absence rate is slowly increasing, however, the reasons for this are not clear right now. The HR business partners will be working collaboratively with their managers throughout quarter one with the granular level of detail to understand what work health issues exist and the ways in which we can proactive support staff return to work.

Concurrently a review of the trust's sickness absence policy is taking place with the view to simplifying the process, making the support and rehabilitation processes clearer and setting a level of when sickness absence is excessive and requires informal and formal monitoring.

7. Mandatory and Statutory Training Compliance

Description	Quarter 1 2015-16	Quarter 3 2015-16
Mandatory Training Compliance – INSET Attendance	91%	96%

Description	Quarter 4 2015-16
Safeguarding Level 2	91%
Safeguarding Level 3	90%
Online Safer Recruitment	45%
Information Governance Compliance	96%

Statutory and mandatory training compliance is positive with the exception of staff having completed online safer recruitment training. Granular detail of staff that are non-compliant will be shared with operational managers to ensure that this metric is improved throughout Quarter 1 - 2016/17.

8. Conclusions and recommendations

Members of the Trust Board are asked to note the contents of this report.

Craig de Sousa
Director of Human Resources
April 2016

BOARD OF DIRECTORS (PART 1)

Meeting in public

Tuesday 26th April 2016, 14.00 – 16.20

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

AGENDA

PRELIMINARIES				
1.	Chair's Opening Remarks Mr Paul Burstow, Trust Chair		Verbal	-
2.	Apologies for absence and declarations of interest Mr Paul Burstow, Trust Chair	To note	Verbal	-
3.	Minutes of the previous meeting Mr Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	Outstanding Actions Mr Paul Burstow, Trust Chair	To note	Enc.	p.9
4.	Matters arising Mr Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	Service Line Report – Portman Clinic Mr Stan Ruszczyński, Director	To discuss	Enc.	p.10
6.	Trust Chair's and NEDs' Reports Mr Paul Burstow, Trust Chair	To note	Verbal	-
7.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To note	Enc.	p.29
8.	Finance and Performance Report Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Late	-
9.	Training and Education Report Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.32
10.	Q4 Review of Strategic Objectives Mr David Holt, Chair of the Strategic and Commercial Committee	To note	Enc.	p.38
11.	Q4 Quality Report Ms Marion Shipman, Associate Director of Quality & Governance	To discuss	Enc.	p.40
12.	Performance Indicator Dashboards Ms Julia Smith, Commercial Director	To discuss	Enc.	p.76

13.	Q4 Governance Statement Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.86
14.	Nurse Revalidation Update Ms Lis Jones	To note	Enc.	p.91
15.	a. Clinical Complaints and Whistleblowing Report Ms Amanda Hawke, Complaints Manager b. Education and Training Complaints Report Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.96 p. 105
16.	Q4 HR Annual Report and Staff Survey Action Plan Mr Craig DeSousa, HR Director	To note	Enc.	p.109
CLOSE				
16.	Notice of Future Meetings <ul style="list-style-type: none">Tuesday 24th May 2016: Board of Directors' Meeting, 1.00pm – 5.00pm, Lecture TheatreTuesday 7th June 2016: Directors' Conference, 12.00-5.00pm, Lecture TheatreTuesday 28th June 2016: Board of Directors' Meeting, 1.00pm – 5.00pm, Lecture TheatreThursday 30th June 2016: Council of Governors' Meeting, 2.00 – 5.00pm, Lecture Theatre		Verbal	-