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

Board of Directors Part One

Agenda and papers
of a meeting to be held in public

2.00pm–4.00pm
Tuesday 28th February 2017

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

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

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 28th February 2017, 14.00 – 16.00
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

	PRELIMINARIES			
1.	**Chair's Opening Remarks** Ms Edna Murphy, Deputy Trust Chair		Verbal	-
2.	**Apologies for absence and declarations of interest** Ms Edna Murphy, Deputy Trust Chair	To note	Verbal	-
3.	**Minutes of the previous meeting** Ms Edna Murphy, Deputy Trust Chair	To approve	Enc.	p.1
3a.	**Outstanding Actions** Ms Edna Murphy, Deputy Trust Chair	To note	Enc.	p.6
4.	**Matters arising** Ms Edna Murphy, Deputy Trust Chair	To note	Verbal	-
	REPORTS			
5.	**Service User Story** Student from the M34 Course, Psychological Therapies Portfolio	To note	Verbal	-
6.	**Service Line Report – Psychological Therapies Portfolio** Mr Peter Griffiths, Portfolio Manager	To discuss	Enc.	p.7
7.	**Trust Chair's and NEDs' Reports** Ms Edna Murphy, Deputy Trust Chair	To note	Verbal	-
8.	**Chief Executive's Report** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.25
9.	**Draft Risk Strategy and Policy** Ms Marion Shipman, Associate Director of Quality and Governance	To note	Enc.	p.28
10.	**Board Assurance Framework, BAF** Ms Marion Shipman, Associate Director of Quality and Governance	To approve	Enc.	p.56
11.	**Mission and Values Statement** Mr Paul Jenkins, Chief Executive	To approve	Enc.	p.78
12.	**Finance and Performance Report** Mr Terry Noys, Deputy Chief Executive and Finance Director	To note	Enc.	p.82
13.	**Q3 CQSG Report** Dr Rob Senior, Medical Director	To note	Enc.	p.87
14.	**Physical Health Report** Mr Tim Quinn, Physical Health Nurse	To note	Enc.	p.95
15.	**Waiting Times Analysis** Ms Marion Shipman, Associate Director of Quality and Governance	To note	Enc.	p.105

16.	**Freedom to Speak Up Guardian Report** Ms Gill Rusbridger, FTSU Guardian	To note	Enc.	p.119
17.	**Training and Education Report** Mr Brian Rock, Director of Education and Training	To note	Enc.	p.125
18.	**CareNotes Optimisation Report** Mr David Wyndham Lewis, Director of IMT	To note	Enc.	p. 129
CLOSE				
19.	**Notice of Future Meetings:** • Thursday 2nd March 2017: Council of Governors' Meeting, 2.00-5.00pm, Lecture Theatre • Tuesday 7th March 2017: Leadership Group, 2.00-5.00pm, Lecture Theatre. • Tuesday 28th March 2017: Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre			

Board of Directors Meeting Minutes (Part One)
Tuesday 31st January 2017, 2.00 – 3.50pm

Present:			
Mr Paul Burstow Trust Chair	Prof. Dinesh Bhugra NED	Ms Chris Caldwell Nursing Director	Ms Helen Farrow NED
Ms Jane Gizbert NED	Dr Sally Hodges Director of CYAF	Mr David Holt NED, SID, Audit Chair	Mr Paul Jenkins Chief Executive
Ms Louise Lyon Director of Q&PE	Ms Edna Murphy NED	Dr Julian Stern, Director of AFS	Mr Brian Rock Director of E&T/ Dean
Attendees:			
Mr Gervase Campbell Trust Secretary (minutes)	Mr Anthony Levy, Governor		
Apologies:			
Mr Terry Noys Deputy CEO and FD	Dr Rob Senior Medical Director		

Actions

AP	Item	Action to be taken	Resp	By
1	6	Race Equality Strategy to come to the Board	LL	April
2	6	Arrange a board lunch meeting with GIC staff and patients	SH/GC	April
3	7	Include more detail on agency spend in the February finance report	TN	Feb

1.   Chair's Opening Remarks
Prof Burstow welcomed the directors to the meeting.

2.   Apologies for Absence and declarations of interest
Apologies as above.

3.   Minutes of the Previous Meeting
The minutes were approved.

4.   Matters Arising
Action points from previous meetings:
AP1 – (red rated risks discussion) – planned for February board lunch.
AP2 – (IG Update) – included in CEO's report. Completed.
AP3 – (update on metrics) – included in CEO's report. Completed.

5.   Trust Chair's and NED's Reports
Prof Burstow gave an update on his activity over the month, including a meeting with Mr Anton Obholzer, a former CEO of the Trust, to discuss the 100 year anniversary, and a visit to Hive to discuss social enterprise and their guided tour programme.

Ms Gizbert reported she had met the Fostering, Adoption and Kinship Care team and been impressed by the high calibre of the staff. One of the concerns they had discussed was the increasing time constraints they worked under.

Minutes

Prof Bhugra noted that he had had three meetings with potential international partners, and was working with Ms Rita Harris on opportunities for collaboration.

6. Chief Executive's Report

Mr Jenkins highlighted the race equality element of his report, commenting that following the third meeting with BAME staff it had been decided that the work needed more prominence and accountability, and therefore he was looking to the Board for support for the development of a formal Race Equality Strategy to bring together and amplify existing work in three areas: measures on recruitment, selection and opportunity to be included in the HR people strategy; transparent benchmarking; and a focus within education and training on student recruitment, course curricula and the profile of the teaching group. The Board discussed the initiative and commented that whilst the focus would be helpful, it was important to keep attention on the wider range of equalities work. They also discussed setting up a group of BAME staff to lead on the strategy, how best to get useful benchmarking data, and how to measure the effect of the changes that were introduced. The Board approved the proposal to develop a Race Equality Strategy.

AP1

Mr Jenkins reported that the Trust would officially take over the contract for West London GiC on the 1st April, and a lot of work was being done with the staff to engage them and help them move onto CareNotes. It would be helpful to invite some of their patients, administrators and clinicians to meet the board at one of their lunches.

AP2

Mr Jenkins also noted the update on the IG toolkit, adding that a report going to the CQSG predicted they would have achieved all standards by year end. Mr Holt added that reports received at the audit committee had been positive over the systems put in place.

The Board **noted** the report.

7. Finance and Performance Report

Mr Doherty presented the report, highlighting that the surplus remained £400k above plan, largely due to underspend in the GIDS service, and the expectation was that the control total would be met at year end. Agency spend was 9% above cap, but this would not affect the Single Oversight Framework rating.

Mr Holt asked why staffing was underspent, given the pressure on staff. Mr Doherty explained that following the funding increase for GIDS it had taken some time to decide the new skill mix required, and then to fill the new posts. It was expected that all posts would be filled for the whole of the coming year.

Ms Murphy asked about the cost of the agency staff, and Mr Doherty explained that whilst the average agency use in the NHS was 10% the Trust was at about

2%, and it was purely for administrative roles, which meant there was little cost implication. Prof Burstow requested further detail on agency spending to be **AP3** included in the next report.

The directors discussed the visiting lecturer overspend, and performance under the better payment code.

The Board noted **the report**.

8. Clinical Quality Development Strategy

Ms Lyon presented the strategy, noting that it had been developed thoughtfully so as to adopt standard methodology to the needs of our services and enable the engagement of clinical staff in the process. The next step would require training of staff in a range of approaches, and funding was available from HEE for this purpose. It would also be necessary to develop informatics so that the data required was available. To keep the board involved they would like to invite a NED to join the quality group, and to hold a training session for board members.

The directors discussed the importance of data, and the pressure that IMT were already under. They also discussed how to share good practice and initiatives between service lines, and how to capitalise on the work done so far by engaging staff. It was agreed that supporting team managers and building a group of champions was important, but leadership from the top and a commitment to following through

The Board approved **the strategy.**

9. Annual Equalities Report

Ms Lyon introduced the report, noting the work that had been done over the past year in making data collection catgories consistent across staff, student and patient systems. The statistics showed that main priority now was in issues for BAME staff and students, and that is where the focus would be in the coming year.

The Board discussed the staff data, and Ms Caldwell noted that performance was better at Band 4 and with doctors in training, and asked if there was anything that could be learnt regarding best practice from those groups, especially as trainees were not selected by the Trust. Mr Holt noted that there was nothing in the report about the recruitment process, which had been discussed at the Board before. Ms Lyon confirmed that this would be treated at some length in the coming Workforce Race Equality Standard update.

The Board **noted** the report.

10. Quality Accounts Readiness Report

Ms Shipman introduced the report, and noted that there were now going to be

Minutes

six service vignettes included in the report rather than four (para. 3.1). She noted that the indicators for review by the external auditors were in the process of being confirmed by the Governors, and asked for comments on the quality priorities selected for 2017/18. Prof Burstow asked how the indicators matched with the priorities under the Quality Strategy, and Ms Shipman explained that whilst they tried to match them to some degree it was important to listen to the voice of staff in making the selection, in line with quality improvement collaborative working, so they were not identical.

The Board **noted** the report.

11. Q3 Quality Report Commentary

Ms Shipman noted that the commentary focussed on targets that had not been met or where the position was worsening, and highlighted the issues with physical health performance. This would be covered in detail in the dedicated report coming to the Board in February.

The Board **noted** the report.

12. Q3 Performance Dashboards

Ms Smith noted that discussions of the dashboards at the Management Team had identified waiting times as the most significant performance issue, but asked if there were other areas the board would like investigated. Mr Holt noted an increase in safeguarding alerts in Q3, and Ms Smith commented that Dr Senior had explained to the Management Team that this reflected a change in how alerts were recorded and reported under CareNotes.

The Board **noted** the report.

13. Q3 IMT report

Mr Wyndham Lewis introduced the report and asked for any questions. Prof Burstow asked about cyber-attack concerns and whether there were any additional steps that could be taken. Mr Wyndham Lewis explained that they were working both on upgrading their technology, and on training staff to improve responses, and it was a constantly evolving field. Ms Hodges asked about the introduction of Microsoft 365, which was currently being trialled to a generally positive response. Ms Gizbert asked for further details of how connectivity problems would be resolved, p100, and Mr Wyndham Lewis explained that remote sites were vulnerable both when Trust systems failed and also when their local systems went down, but the first step was to improve the Trust's systems which would resolve most problems. Once this was done there would be a phased move of remote sites to the new platform. The board discussed the priorities and whether any of the programmes that were being postponed could be considered for cancellation, given the team's workload. It was agreed a more detailed look at this should be included in the Q4 report.

The Board **noted** the report.

14. Training & Education Report

Mr Rock introduced the report, and noted a correction, section 6.5 - Kate Billingham had opened 80 sites, not 8.

The Board **noted** the report.

15. Charitable Funds Annual Report, Accounts, ToR

Mr Holt noted the requirement within the terms of reference for the committee to assess its own performance, and it was agreed that whilst this was a standard requirement for all committees it was difficult for a small group to achieve, however some external scrutiny was given by submission of accounts.

Ms Farrow asked whether the Trust actively fund raised, and Mr Jenkins explained that the approach had been passive historically, but it might be time to look at this as part of a strategic review of income sources.

The Board **noted** the report, and **approved** the accounts and terms of reference.

16. Emergency Planning Report

Mr Jenkins gave the context of the report and explained the changes in the scoring system.

The Board **noted** the report.

17. Ratification of the Operational Plan

Mr Jenkins noted that the plan had been approved by email by the directors before submission to NHS Improvement in December, and was being presented here for ratification of that approval.

The Board **approved** the operational plan.

18. Any Other Business

The Board noted its future meetings.

Part one of the meeting closed at 3.50pm.

Minutes

Action Point No.	Originating Meeting	Action Required	Director / Manager	Due Date	Progress Update / Comment
2	Oct-16	Report on Physical Health to come to the Board	Tim Quinn	Nov-16	Included in February papers. Completed.
1	Oct-16	Report on business plan of Tavistock Consulting to come to the Board.	Brian Rock	Mar-16	Scheduled for the March meeting.
1	Nov-16	Red-rated risks to be assessed and acceptable levels of risk to be proposed for discussion at lunch session	Terry Noys	Jan/Feb 2017	Discussed at February Board lunch. Completed.
1	Jan-17	Develop Race Equality Strategy	Louise Lyon	Apr-17	
2	Jan-17	Invite GiC staff to meet directors	Sally Hodges	Apr-17	
3	Jan-17	Include detail on agency staffing in finance report	Terry Noys	Feb-17	Included in Finance report. Completed.

Outstanding Actions

Board of Directors : February 2017

Item : 6

Title : Service Line Report – Psychological Therapies Portfolio

Purpose:

The purpose of this report is to provide the Board of Directors with an update of progress on the Psychological Therapies Portfolio within the Directorate of Education and Training (DET).

This report has been reviewed by the following Committees:
* Management Team, 14th February

This report focuses on the following areas:
* Quality
* Patient / User Experience
* Risk
* Finance

For : Noting

From : Peter Griffiths, Portfolio Manager, Psychological Therapies

Portfolio Report

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Service Line Report
Department of Education and Training
Psychological Therapies

Executive Summary

1. Introduction

1.1 The re-structuring of the Department of Education and Training in 2015 included the establishment of six Portfolio Manager posts in order to give a greater degree of operational coherence and strategic management to our comprehensive training programme. Each Portfolio Manager falls within the remit of one of two Associate Deans, and functions to oversee, lead and develop a portfolio of linked courses.

1.2 In keeping with the aforementioned structural change and following on from the previous introduction of a separate service line for Education and Training, this is the fifth Service Line report focusing on a particular portfolio.

1.3 The Psychological Therapies portfolio is a portfolio which largely focusses on training for those working with children, adolescents, young people, families and parents. It is a portfolio that has developed and contains a range of multi-modal courses that draw upon both the psychoanalytic/psychodynamic and systemic traditions of the Trust. It delivers two postgraduate certificate courses and one long MA course, all of which are accredited by a professional body (Association of Family Therapy (AFT) or British Psychoanalytic Council (BPC)), a training for educational psychologists to doctoral level and an Interprofessional Doctoral programme for educational psychologists and psychologists who wish to undertake CPD modules at this level of study or, where they have not already, acquire a professional doctorate. Over the last year the Portfolio has hosted the perinatal training developments which have grown significantly in scope and range.

1.4 The portfolio delivers a range of CPD courses within the Trust. It offers CPD modules in conjunction with the Anna Freud Centre, through the International Training School for Infancy and Early Years (ITSIEY) and is the host portfolio for Mindfulness training in the Trust.

1.5 The staffing consists of 1 Portfolio Manager, 3 Course Leads, a Placement Tutor, the Director of the Educational Psychology programmes, his 2 Associate Directors, an Infant Mental Health Lead in the International Training School for Infancy and Early Years (ITSIEY) and a Portfolio Course Administrator. There are a range of other permanent staff who give proportions of their time to education and training and the portfolio also makes use of visiting lecturers as seminar leaders, clinical supervisors and trainers.

2. Areas of Risk and/or Concern

2.1 All of the validated courses within the portfolio (except for the educational psychology courses) have a close connection with HEE priorities. While this is implicit in course brochures and website information, these links could be

made more explicit in some of our publicity material. Our annual review of course publicity is addressing this.

2.2 An ongoing area of risk within the portfolio primarily centres on the reduced availability of funding for training in the public sector and the study time for staff to attend such training. Of necessity employers are privileging mandatory training and there has been less possibility for releasing staff for additional continuing professional development.

2.3 Moreover, we are operating in a competitive market. Balancing the need to achieve increased recruitment with a cost effective fee structure, whilst paying regard to these market forces, is a continuing challenge and making the case for what are the unique selling points (USPs) for our postgraduate certificate courses and MA leading to BPC and AFT accredited professional trainings.

2.4 Staffing on both the postgraduate certificate courses (D24 and D24A) and on the MA (M34) is over reliant on Visiting Lecturer staff (former key course staff who have retired) and/or staff on temporary fixed term contracts. This situation is due to senior staff retirements and previous uncertainties about student recruitment and staff on fixed term contacts because of this or covering maternity leave (Course Lead for D24). This is not a robust state of affairs for the continuation of the existing courses, or a solid base for the planned expansion of these courses within the Trust and at alternative centres. In addition the Portfolio Manager's departure due to retirement later this year needs to be planned for in terms of succession and handover.

2.5 Two very popular courses appear to make a low contribution against Trust income. M34 is one, although it is unclear whether all of the shared learning that takes place has been fully costed against the course. The M4 Educational psychology course makes a low contribution to the Trust in terms of income. It does not report against the National Training Contract and it is difficult to argue for subsidy as it is an educational psychology course. It is a popular course with 258 applications for 16 places (14 funded and 2 self-funded) this year. It is a funded course through a consortium, where there are a fixed numbers of students receiving bursaries and where overall contract income has been frozen for the last 5 years. This has to be set against rising staff costs (for seconded Educational Psychologists or those contracted through a consortium) and where increased Essex payments have eaten into the course's financial contribution to the Trust. There are requirements of the BPS in terms of student-tutor ratio and the consortium also limits what we can do, as well as employer placements. We need to explore the limitations on increasing numbers of students.

3. Proposed Action Plan

3.1 Work is underway to ensure that HEE priorities are more explicit in our course publicity across the portfolio. The annual update of website information is being used as an opportunity to revise course information with regard to this and USPs, such as possible placements and on-going training to a professional level (be that psychodynamic psychotherapist with children and families, systemic therapist or child psychotherapist). All new course developments and new CPD events are now more closely informed by HEE priorities.

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3.2   D24 and D24A are already available as part-time courses over two years and this has been successful in enabling students without adequate experience, funding or study time, to undertake the courses. Over this academic year we will, through module variation, be enabling all the modules to be undertaken at any time over 5 years and through credit accumulation. Students will be able to undertake modules in a way that best suits them (providing any given pathway makes educational sense). This possibility will also be available for students at alternative centres of delivery such as Pen Green in Corby or Gloucestershire Counselling Service (GCS) in Stroud, Gloucester. Students will also be able to take these modules as standalone CPD modules.

3.3   In addition the development of online learning modules for D24 at GCS and Pen Green will mean that some of the modules will be available nationally through online learning and bespoke webinars and can be taken as standalone CPD modules in this manner.

3.4   Staff succession planning and development is being actively planned for within courses and in relation to the expansion of courses, through the development of module leader role descriptions, the recruitment of local staff and mentoring by existing staff. On M34 we are writing a proposal to make the case for a permanent Associate Course Lead/Placements Lead to strengthen the existing role holder positions within the Trust and the development of M34 in alternative centres. There is still HENCEL award money for rolling out and development/scaling up of D24. The Portfolio Manager will explore how this can be utilised to aid this development. The Portfolio Manager's departure later this year is being planned for with the Associate Dean; advertising and recruitment to the role and in terms of succession and handover.

3.5   The M34 budget and costs per student will be re-examined in the light of student teaching activity, in shared forums and in relation to student's contribution to Trust clinical work in dedicated placements. M34 will also be assessed against BPC accreditation requirements to see whether it is being over taught and or whether it's USP of multimodal approaches might be better advertised and costed accordingly.

3.6   The M4 Educational Psychology course will be explored in depth in terms of the limitations of the SEEL Consortium contract of which we are part and in relation to the BPS requirements for the training of these students. On-costs need to be considered and how much this is a cost pressure to the Trust. Equally we need to cost what the first years' input into the clinical teams represents, in terms of an educational service delivery within the CAMH teams and its possible contribution to training in relation to teachers and schools (i.e. the wider picture). We will look to what savings may be made within the course teaching costs and through shared teaching with other courses. We will also explore what possibilities there may be for more self-funded places at a national level (dependent on placement requirements) and what might

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be possible in terms of a market for EU (i.e. collaboration with Kent around EU students) or international students.

Main Report

4.   Overview of the Portfolio

4.1   Core identity and purpose

The Psychological Therapies portfolio comprises a number of courses that are either tri-modal (psychodynamic, systemic and developmental) or multimodal (tri-modal plus incorporating cognitive behaviour therapy, parenting/couple approaches, mindfulness approaches etc.) The courses within these theoretical frameworks have in innovative ways attempted to not integrate but compare and contrast the range of differing therapeutic approaches that derive from them and make them available for short and long courses for the child, adolescent and family mental health workforce.

The portfolio is also host to a training collaboration between the Tavistock Clinic and the Anna Freud Centre, through ITSIEY and the delivery of Infant mental health modules to a range of professionals. It is also home to the development of perinatal mental health training and its growth in activity from training the trainers, to the development of a national competency framework in collaboration with Health Education England (HEE) and a plan of further training over the coming year at many levels (see Appendix 1). It is also host to Mindfulness training and the development of this in bespoke and specialist ways, in terms of training for CAMH practitioners.

All of the validated short and long programmes within the portfolio lead to an academic award from the University of Essex and a professional award by a professional body; The Association of Family Therapists (AFT), The British Psychoanalytic Council (BPC), The British Psychological Society (BPS) and Health Care Professions Council (HCPC). The Tavistock Society of Psychotherapists (TSP) functions as the Member Institution of the BPC. The portfolio also includes a wide range of short CPD courses. The main validated programmes in the Portfolio are:

- Postgraduate certificate in child, adolescent and family mental well-being: multidisciplinary practice (AFT) (D24)

- Postgraduate certificate in mental health and well-being: multidisciplinary practice with young people and adults (AFT) (D24A)

- MA in Psychological therapies with children, young people and families (BPC) (M34)

The portfolio delivers a 3 year training for educational psychologists:

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- Professional doctorate in child, community and educational psychology (BPS and HCPC) (M4)

There is also one former and one new post-training Doctoral programme:

- M5 (pre-existing) Professional doctorate in child and educational psychology (in teach out mode)

- M5 Integrated professional doctorate in advanced practice and research (educational and community psychology)

The Portfolio Manager for the Psychological Therapies portfolio came into post in April 2015 and has five sessions per week in this role. The portfolio represents a now well established range of multimodal courses ranging from the equivalent of a first year pre-clinical training (D24 and D24A) leading potentially to pathways to professional trainings (M34, M6 or M80) and a training in educational psychology and post qualifying training for those who have already training in educational psychology.

The Postgraduate certificate in child, adolescent and family mental well-being: multidisciplinary practice (AFT) (D24) won the HENCEL Interprofessional course of the year award in 2014/15. It has recruited well since its inception in 2010, drawing students from across the public and statutory, as well as voluntary, sectors, representing a range of disciplines and agencies and has been well received by students (as evidenced in student evaluations and surveys). It serves as an accessible introduction for students new to the Trust to both its theoretical paradigms and experiential learning. This is situated both in the course and within group relations experiential learning, through its popular hosted annual 4 day conference, Exploring the complex realities of inter-agency working: a group relations conference (D42C). This takes place each spring attracting up to 90 conference members and has now run annually for 13 years consecutively. It now forms part of the portfolio of Tavistock group relations conferences and offers places to students from across a range of courses and caters for an external membership.

The Postgraduate certificate in mental health and well-being: multidisciplinary practice with young people and adults (AFT) (D24A) was developed to address the needs of staff working with older adolescents and young adults. It makes use of shared teaching with D24 in a number of areas and increases the rich possibilities for multidisciplinary engagement and the shared learning that exists and is explicitly developed. This course started in 2014 and, whilst low to recruit at the start, has with better advertising, marketing and a gathering reputation recruited very well this year and now has a spinoff CPD module (CPD7) that may well also be developed as an online learning module (the Course Lead having experience with running e-CPD29).

For those who undertake the family systemic observation module, both of these courses are accredited by AFT, as a foundation course in systemic psychotherapy. This is a qualification students can either use within the Trust to enter other systemic training pathways, up to training as a systemic psychotherapist, or use elsewhere in the country to gain entry onto other systemic professional trainings. Both serve as stand-alone or entry-level certificate courses through to other areas of Trust training provision and advanced professional training. Students have gone on to train as systemic therapists (D4/M6), train as child psychotherapists (M7/M80), or have undertaken health and social care doctoral studies (M55/D60) or the training on M34 to become a BPC-accredited psychotherapist in work with children and families.

The MA in Psychological therapies with children, young people and families (BPC) (M34) was designed to meet the increasing needs of the child and adolescent workforce (and plethora of CAMH practitioner roles in many different settings), for a training that was professionally recognised and yet which trained therapists with a core group of skills in psychodynamic and systemic work but equally the ability to use other paradigms and capabilities in cognitive behavioural therapy, parenting working/ models of parent work and mindfulness.

The course has grown in stature, reputation and size over the 7 years since its original validation in 2010. Students complete the MA within 2 years but then are often undertaking clinical work requirements over the next year or two, to be able to gain accreditation with the BPC through the Tavistock Society of Psychotherapists, as professionally accredited therapists. In total there are some 100 students on this course at different stages in training.

Year one students are now registered with the University of Essex while other cohorts of students remain registered with the University of East London, as the teach-out arrangement allows for the completion of the programme of study for which they have enrolled within a set timescale. Relating to two university partners with their own distinctive structures, processes and academic regulations in this interim period, is likely to endure for a number of years and this presents some time consuming additional pressures for the course team.

The course has traditionally recruited students through D24 and D24A graduates, these students having undertaken the pre-clinical year and they still provide a significant number of applicants. However, the course has increasingly seen students apply for accreditation for prior taught and or experiential learning (APEL) into the first year of the course, from other Trust courses, such as M9 and M7 and from courses outside of the Trust; 10 doing so in this academic year.

Some D24 and M34 students who are sufficiently qualified and experienced mental health professionals contribute clinical work to teams across the Trust

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on placement. Others have clinical placements within a number of other NHS Trusts and other settings such as Place2Be or schools.

We are in the process of creating collaborative arrangements around a number of placement providers largely within London but with some providers who exist outside of London to provide suitable placements for both students and placement providers, with well supervised trainees working alongside existing staff. There are close monitoring structures in place in relation to all placements, with a dedicated Placement Tutor, whose work is of necessity increasing because of the above developments. However, we see this potentially as a USP for this course that will attract more students and potentially allow us to charge more in course fees.

The course has now seen the professional accreditation of 24 students, to date, by the BPC and we are working with students to produce testimonials as to how the course has developed and their employment possibilities and to develop alumni data as to the roles taken up by students post training.

The Professional doctorate in child, community and educational psychology (M4) is a very popular course attracting increasing numbers of applicants (258 applications in 2016/17) for its 14 bursary places. This increase in popularity seems to be directly related to it offering a unique CAMH training experience within the CAMH clinical teams at the Trust in the first year and this ethos running through its second and third years and students recognising the increasing emphasis in policy of schools being the fulcrum for such work. However, this is a funded course and the income has been frozen for the last 5 years and is for the next contract, which runs for 3 years from September 2017. The financial contribution has diminished, due to real issues around staff costings and additional payments to the University of Essex.

Our clinical applications, interdisciplinary and multidisciplinary practice, in terms of CAMH and Education (see CPD developments), means we have a lot to offer. There is a need to gather up everything around education and consider whether there is a course we could offer to those applicants who do not get onto M4 or to support applicants in their applications. We also need to investigate what the block is to self-funders and whether there is an international market for fee-paying students.

The Integrated professional doctorate in advanced practice and research: educational and community psychology (M5) was validated in May/June 2016 and represents the development of an Integrated Professional Doctorate sharing teaching with 3 other Trust professional doctorates and all the benefits that this might accrue in terms of learning and cost savings. There are currently concerns about student experience due to low student numbers. M5 had very low recruitment last year after late validation but entry requirements are very specific. It attracted a lot of enquiries but people were not able to apply. Integrated professional doctorate marketing for 2017/18 may help. There could be CPD modules for those with educational psychology

doctorates who want to develop their clinical ability and this is being explored with the University of Essex. With 5 students over 4 years and HEFCE, this course would reduce its costs.

The portfolio team is working closely within new DET structures around such issues as recruitment, marketing and course administration. There is now one Recruitment Officer for the portfolio and recruitment to courses within the portfolio has been greatly helped by this dedicated position which looks after all recruitment matters up to the point of students accepting a place on a course. This new role has been a major asset in promoting our courses (alongside much better marketing), proactively following up course enquiries, organising shortlisting and interviewing processes and so forth. The general impression from Course Leads is that this has streamlined recruitment, aided communication and led to a much more efficient process (the Recruitment Officer has personally contributed significantly to this). In addition the new Student Information Management System is aiding the recruitment process and streamlining response to students.

In 2016/17 there was an overambitious setting of targets which did not reflect the drop off in student numbers in 2015/16 and the climate we are now operating within, though I am confident with the new emphasis on marketing and recruitment, we can reach our targets for 2017/18 and increase the Trust contribution through efficiencies in teaching.

There is now one main Course Administrator for the portfolio with some additional input from another course administrator. This represents a considerable change over the last year (as 2 previous administrators left) and there remains anxiety about the impact of reduced administrative time on the quality of our course delivery and the student experience. However, continuing work on developing standard operating procedures for administrators is expected to streamline work more effectively.

4.2   Overall vision and strategy

The portfolio's vision and strategy is in accordance with the DET strategic objectives:

(a) Increase intake of Year 1 student numbers to 900 for 2017/2018

We have set targets for increased recruitment to courses within the portfolio (see below). We have participated in all the Trust Open Events to promote our courses so far this year, convening course specific open events within these, which were very well attended and organising separate longer course specific Open Evenings in March and May. These efforts are proving successful and we are likely to meet, or in some cases exceed our targets for recruitment. This success does bring challenges, especially in terms of available rooms, appropriate room space and the effects of size on group dynamics and the student learning experience. We are working

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with DET on identifying sufficient rooms and identifying suitable staff (in the light of limited permanent staff as previously described in 2.4) but this remains a challenge. We are reviewing resources within the portfolio with plans for permanency of staff and the development of existing and new staff into key roles to enable succession and development. We are also thinking about new learning and teaching strategies, further shared learning with other courses and/or online learning (e.g. the research module on M34).

Online learning developments will allow us to potentially expand the range of CPD modules on offer (D24, D24A and potentially M34) and with module variation allow students to undertake aspects of course provision outside the building at times of their choosing. However, this development in TEL, in and of itself, needs to be adequately resourced with staff with the appropriate skills; to ensure both its development in terms of learning materials and technology, how it is sustained as a learning activity overtime with students and in the revision of online materials, so that they remain fresh and relevant over time.

The MA in Psychological therapies (M34) offers a qualification which would and does have a role in both NHS provision and in the development of CAMH services within and around schools. We are looking through the expansion of D24, to enable other students to be able to undertake M34 at the Trust and at GCS. We are also exploring whether we are making enough of the BPC's equivalency to enable more people to APEL onto M34 from within and outside of the Trust; both from other relevant CAMH's trainings but equally by adult trained counsellors, who may wish to re-train or extend their training for use in therapeutic work with children and families.

The educational psychology doctoral 3 year full time doctoral training (M4) has increased its student numbers within the consortium contract from 12 to 14 bursary students, with the addition of 2 self-funded students in this academic year. We will be looking to see whether this number can be expanded further, in particular an increase in self-funded students, mindful of the caveats already described in 2.5.

The Perinatal mental health developments are at the forefront of HEE strategic objectives and have grown in stature and complexity over the year. The Trust has moved from hosting the Perinatal mental health Network (led by Jo Maitland and Lis Jones), to being commissioned by HEE to develop a national set of competences for perinatal mental health incorporating competences established elsewhere into a set that are now being piloted and will inform training and service developments (see appendix 1). In addition Jo Maitland has been appointed as Perinatal Mental Health Lead to take this work forward and it needs to be decided where this major training initiative sits within the Trust and in relation to portfolio structures.

(b) Increase the national reach of our training and education offer through greater regional presence

Last year we validated Pen Green Child Development and Research Centre in Corby Northamptonshire (recognised through numerous awards as a Centre of Excellence) as an alternative centre for the delivery of D24 and M7 in the East Midlands. This took place rather late in the summer of 2016 and Pen Green failed to recruit students to start in September last year. However, we are working with them on a marketing and CPD developmental strategy over the next 6 months with a view to recruiting a student cohort for D24 and M7 to commence in September this year. We are also developing module variation as a way of increasing the viability of modules running and their uptake at Pen Green.
https://tavistockandportman.nhs.uk/training/courses/child-adolescent-and-family-mental-well-being-multidisciplinary-practice-d24p/

Gloucestershire Counselling service (GCS) is a counselling training organisation based in Stroud, Gloucester and Cheltenham, with 30 years of experience and BPC-accredited trainings. GCS wants to lead in developing the child adolescent and family mental health workforce in the West of England and in providing training and CPD to further this. They have sought partnership with us as an alternative centre of delivery and requested to run D24 in September 2017 with a view to running M34 from September 2018. We have been working since the summer of 2016 to enable this to happen and are awaiting a site validation visit by the University of Essex in March to confirm this. In the meantime we are working with them on a marketing and CPD developmental strategy over the next 6 months, with a view to recruiting staff and a student cohort for D24 to commence in September this year.
https://tavistockandportman.nhs.uk/training/prospective-students/courses-by-type/outside-of-london/stroud/

We are also continuing to build our links with international colleagues in particular in India and China who have expressed interest in acquiring more knowledge of child and adolescent mental health and in particular some of the modules of D24 which, whilst in 2014 was put on hold as a development, has now been revived and is being developed with Rita Harris (international developments) in particular looking at the possibilities for online and webinar based learning.

Long courses recruitment data per year (this does not include the on-going registration of 2nd year students on M34 or 2nd and 3rd year students on M4):

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Course Owner	Peter Griffiths						
Portfolio	Psychological Therapies						
Course Code	Enrolment 2015/16	Enrolment Target 2015/16	Enrolment Target 2016/17	Enrolment 2016/17	Regional target	Proposed Target 17/18	Regional Target 17/18
M4	13	13	16	16		16 (14 +2)	NA
M34	24	20	30	25	0	30	NA
D24/ D24A	35	60	50 / 25	37/16	8 PG	40/20	24 GCS 16/PG8
M5	0	0	4	2	0	Min 5	NA
M22	5	6	6	0	0	Exit	NA
Grand Total	72	99	131	95	8	111	24

There are in addition up to 40 students on M34 who have qualified with an MA but are registered to receive on-going supervision for ongoing work to enable them to meet clinical requirements and seek BPC accreditation.

(c) Broaden our portfolio of training to reach a wider section of the workforce and respond to emerging issues in health and social care

CPD online modules and webinars will be targeted at a broader range of students across the child and families workforce in health and social care, who are working with emotional and mental health difficulties.

Similarly we are developing shorter CPD courses that are less time intensive and more affordable. We are also mindful of tailoring our courses to be relevant to the modern NHS and in keeping with contemporary policy for service developments such as those around the development of perinatal services and care of perinatal mothers and/or vulnerable children.

Offering courses and CPD that grow expertise in shorter length treatments and in specialist interest areas are good examples of this. These also accord with HEE priorities around developing psychological therapies, reflective practice and increased resilience in staff.

Perinatal mental health

We have taken the lead in the development of a nationally recognised competency framework in partnership with HEE for those working in perinatal mental health. This, alongside the DoH national programme of service development in this field, in the development of specialist community teams and the development of mother and baby units, offers real training opportunities. This is an opportunity to offer training to a variety of workers, at many different levels of experience and at different levels of contact with perinatal mothers, babies and families, in a

multitude of various services and agencies. It will also enable us to aid others in the development of training in this field, in different parts of the country.

We currently have a programme of training scheduled for the year (see Appendix 1) developing skills and capabilities in the workforce. The design, execution and evaluation of these, will enable us to both evolve these training developments and plan for on-going skills development and sustainability of these in the workforce. It will also enable us to offer expertise and consultancy to others, as they develop more standardised training packages across the country.

5.   Portfolio Developments

5.1   Since the establishment of the portfolio in July 2015, the following developments have taken place:

- Re-validation of D24, D24A, M22 and M34 by UEL in 2014 and then in 2015 all of these courses by the University of Essex

- AFT accreditation of D24 in 2015 and D24A in 2016

- BPS re-accreditation of M4 in 2015 and re-validation by the University of Essex in 2015

- Validation of M5 IPD Professional Doctorate in Advanced Practice and Research (Educational and Community Psychology) in May 2016

- University of Essex site validation of D24 at Pen Green in 2016

Up and coming developments:

- University of Essex site validation of D24 at GCS (March 2017) and M34 in 2018 and the development of the delivery of both courses at GCS

- D24 Module variation agreement with the University of Essex

- Development and delivery of D24 at Pen Green

- BPC re-accreditation of M34 this year

- Re-development of ITSIEY modules

- Developing and piloting Perinatal Competences, running and evaluating the impact of Perinatal training courses on offer this year (see appendix 1) and establishing this training initiative in relation to the Portfolio structure and within DET

- M22 CPD module developments

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5.2   Current recruitment to short and long courses

In the current academic year 2016/17 there are a total of 197 students enrolled on courses within the portfolio across all year groups. The duration of each course is between 1 and 4 years.

Our recruitment to the next academic year 2017/18 has just begun; a D24 student being the first to enrol for the academic year 17/18 in the Trust. There has been a lot of sign-up for our course specific open evenings.

5.3   The Role of the Tavistock Society of Psychotherapists (TSP)

The Tavistock Society of Psychotherapists (TSP) is the professional body for psychotherapists who have trained at the Tavistock and Portman NHS Foundation Trust. It has an important function for many of the training programmes within the portfolio as it is a Member Institution of the British Psychoanalytic Council (BPC). Graduates of our adult and child psychoanalytic trainings get membership of the BPC by virtue of being members of the TSP. The TSP organises a number of CPD events for its membership. It has also had a role in processing applications for Equivalence from individuals who have completed psychoanalytic psychotherapy trainings elsewhere and are seeking to become members of the BPC. This sometimes involves 'top-up' training to be provided by programmes within the portfolio to achieve Equivalence.

When the Chair of the TSP stepped down last year it was an opportunity to revisit discussions about the place of the TSP within the Trust. A financial review is imperative to explore whether membership fees can cover the structural and functional requirements of the TSP. We also want to ensure that Trust provision, especially in relation to M34, is able to meet requirements stipulated by the BPC. The last M1 re-accreditation report by the BPC in 2013 highlighted what it saw as some structural flaws, for example the need for the TSP to have a more formal and written constitution. This has been written and it seems timely for the role, functions, structures and financial underpinning of the TSP to be reviewed in full. To this end the Associate Dean Elisa Reyes-Simpson is undertaking a review of TSP functioning.

5.4   CPD and CPD developments

The portfolio runs a range of CPD courses, primarily for those working with children, young people and families, professionally qualified mental health professionals and those who have a lot of work experience but who need knowledge frameworks and ideas to help them frame their experience and thoughts and guide their practice.

The planned developments in relation to CPD modules from D24 and D24A have already been mentioned with both direct entry onto these and

attendance at the Trust and other sites, through module variation, or by way of online learning and webinars (i.e. CPD28 online and CPD7 online).

In relation to making use of M34 for CPD purposes we are considering how to market a CPD top-up without the validated aspect. Modules A, D and C can be undertaken as a top-up via e-CPD, provided we can negotiate the delivery of this with the University of Essex without its validation. There are in addition potential opportunities for CPD top up for M34 graduates and others (i.e. perinatal and forensic mental health work).

Some CPD modules have been extracted from the former MA From safeguarding to permanence (M22) and we believe these have a market for those working with vulnerable children (e.g. developmental assessments; children suffering neglect/maltreatment; supervision and leadership). The module CPD41 Developmental assessments ran successfully twice but further runs were put on hold due to staffing issues. These would be an additional source of income and will return in January 2018.

There has been the development of new Education Psychology CPD modules:

- CPD32 Supervision for applied psychologists in schools and community settings

- Psychoanalytic, systemic and attachment perspectives in education psychology practice conference

 These have recruited well and have potential for further development.

Mindfulness and mindfulness trainers sit within the portfolio. The Introduction to Mindfulness course (CPD3) has been a popular course for external members and run for staff as part of the Human Resources CPD programme. However, the recruitment of external members may wane due to cheaper introductory training modules being offered by other organisations. A recent bid to offer Mindfulness to staff in a local authority, whilst commended, was beaten by a cheaper alternative training provider. However, our USP is that our Mindfulness training courses run at the Trust are run largely by CAMH clinicians and this does attract professionals in the field who wish to develop their thinking in this area in relation to their own therapeutic practice. Bespoke courses that develop this USP will probably recruit those wishing to develop their practice further and or develop clinical applications of mindfulness for clients and patients.

The portfolio also hosts the International Training School for Infancy and Early Years (ITSIEY) and the 5 CPD modules that have been run at the Anna Freud Centre annually for the last 4 years. This year ITSIEY is running the first 3 modules and re-working and re-thinking this contribution in light of the perinatal training developments aforementioned. The Under 5 IAPT training

(Kings/UCL and Anna Freud) will be run from the Anna Freud Centre this year and in the light of work to be undertaken in comparing the infant mental health competencies (developed by ITSIEY) and perinatal mental health competencies. The Infant Mental Health Lead role holder (a post jointly funded by the Trust and the Anna Freud Centre) is on maternity leave until May.

The CPD portfolio of courses in the Psychological Therapies portfolio makes a good return to the Trust and in fact leads in this endeavour in percentage terms.

CPD Short courses recruitment data

Month	Title	Course Code	Total Course Income	Total No. Students	Target No. Students	Total Cost	Balance	%
Sep-16	Neuroscience and Psychoanalysis	CPD110	3825	25	14	2,807	1,018	27
Sep-16	Lecture Series in Child Development Research for Professionals Working with Infants and Young Children	CPD28	7410	19	10	4605.75	2,804	38
Oct	M34 Supervision	CPD34	4250	19		3468	782	18.4
Nov-16	Relating to self-harm and suicide in adolescents and young adults (ONLINE)	e-CPD29	5175	9	10	3855.76	1,319	25
Jan-17	Introduction to psychodynamic and systemic practice: applications in work with young people and adults (D24a CPD)	CPD7	1500	5	4	483	1017	67.8
Jan	Mindfulness	CPD3	6230	18	10	2697	3883	62.33
Feb	Supervision for applied psychologists in schools and community settings	CPD32	4250	10	10	3373	877	20.64
Apr-17	Relating to self-harm and suicide in adolescents and young adults	CPD29	1875	3	10	4725		
Apr 17	Mindfulness	CPD3						

May 17	Talking with Children about difficult things	CPD116							
Jun-17	Compassion Focused Therapy	CPD11							
July 17	Introduction to Psychodynamic Concepts	CPD60							
July 17	Mindfulness – Nurturing Parents	CPD18							

- Those in orange above are currently still recruiting/tbc

Total income to date (as of 20/01/17) for the portfolio is £34,515 predicted income (to include all courses running and currently recruiting up to August 2017) is £81,265.

Average contribution is currently standing at 37% for 2016-17AY. Short course Income prediction is £90,000 at 37% contribution for 2017/18 AY.

There is an assumption that the majority of courses will run again in 2017-18, and we are also considering launching CPD41 (existing modules of M22) in January 2018.

Potential bids and tenders for Mindfulness are on the increase and may present an opportunity for additional income.

6.   **Financial Situation**

The tables listing the courses within the portfolio and including student numbers in year one and associated income for the year 2016/17 are included in a separate document.

Peter Griffiths
Portfolio Manager Psychological Therapies
February 2017

Appendix 1
London Perinatal Mental Health Network Workforce Training Programme 2017

Programme of courses

Course Title	No of days	Dates	No of places	Venue
Perinatal training for Community and Inpatient Perinatal Mental Health Team Managers	3 days	27 February – 1 March	20 places	Tavistock Centre
Perinatal training for Community Perinatal Mental Health Practitioners in Specialist Perinatal Mental Health Teams	11 days	13 - 17 March, 7 & 27 April, 2 & 30tJune, 29 July, 29 September	30 places	Freud Museum and Tavistock Centre
Perinatal training for RMNs, OTs and SWs within HTT / Crisis / Emergency and Urgent Care and Psychiatric Liaison Teams	2 days	5 & 6 April	120 places	Tavistock Centre
'Train the Trainer' Training to develop 'Perinatal Training Champions' for Inpatient and Community Specialist Perinatal Mental Teams; Maternity & Health Visiting Services*	2 days (3 Cohorts)	Cohort 1: 3 & 4 May Cohort 2: 8 & 9 May Cohort 3: 22 & 23 May (tbc)	60 places (20 places per cohort)	TBC
'Perinatal Awareness, Change and Transformation' – Action Learning Sets for the 'Perinatal Training Champions'*	3 half days & 1 full day	May - December	60 places (20 places per cohort)	TBC
Perinatal Mental Health Training for Psychologists and Therapists in CAMHS and Adult Mental Health Teams; and Psychologists and Therapists wanting to apply to work in specialist perinatal services.	2 days	3 & 4 July	100 places	Tavistock Centre

Attendees on all training courses must be working within a London-based team. Managers must identify suitable candidates and authorise attendance of their staff on the training. Participants must commit to attending all days of the training.

* "'Train the Trainer' Training to develop 'Perinatal Training Champions' for Inpatient and Community Specialist Perinatal Mental Teams; Maternity & Health Visiting Services" and "'Perinatal awareness, change and transformation' – Action Learning Sets for the 'Perinatal Training Champions'" must be done together.

Board of Directors : February 2017

Item : 8

Title : Chief Executive's Report – Part 1

Summary:

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

For : Discussion

From : Chief Executive

CEO's Report

Chief Executive's Report

1.   CQC

1.1   On 2nd February CQC published their report following their further inspection of the Trust at the end of 2016. This was focused on adult and forensic services.

1.2   In their report the CQC have concluded that we have successfully delivered our "must do" actions from our original inspection. They have also revised their ratings for the safety domain for our specialist psychological services from "requires improvement" to "good".   As a result the overall rating for the Trust for this domain also moves from "requires improvement" to "good".

1.3   This is a great achievement and I would like to record my appreciation of the hard work which has gone into addressing the original areas of concern and to delivering this new rating.

2.   National Training Contract

2.1   We have now received confirmation from HEE of their agreement to the proposed changes in our National Training Contract.

2.2   We are proceeding to implementing the new contract including recruitment to the new Workforce Skills Development Unit.

2.3   This is a major milestone for the Trust. As we have previously discussed, the changes bring some significant challenges in terms of a reducing value of the contract but also major opportunities for the Trust to play a much more central role in mental health workforce development.

3.   National Mental Health Training Hub

3.1   A further meeting of the 7 partner organisations which have committed to developing a National Mental Health Training Hub is being held on 22nd February in Birmingham. The intention is to agree key priorities and the process by which formal support for the project from Trust Boards will be secured.

4.   Cavendish Square Group meeting with Jim Mackey

4.1   On 16th February I chaired a meeting of Mental Health from the Cavendish Square Group and other networks with Jim Mackey, Chief Executive of NHS

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Improvement. The meeting was held to address issues about the impact of the latest contracting round on mental health. We were able to raise a number of issues in relation to gaps in investment, the impact of reductions in social care funding on NHS services and the role of mental health in STPs and the wider transformation of services.

5. NHS England assurance of Mental Health Investment

5.1 NHS England have written to CCGs seeking assurance that investment in mental services has been made which in line with the Mental Health Investment Standard and which:

- Is in line with the uplift in allocations
- Supports delivery of the "must dos" in the 5 Year Forward View for Mental Health
- Ensures the use of the additional funding for CAMHS for the purposes for which it was intended

5.2 Lead providers are also being asked to sign the letter of assurance from their CCGs by 27th February.

Paul Jenkins
Chief Executive
20th February 2017

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

Board of Directors : 28ᵗʰ February 2017

Item : 9

Title : Risk Management Policy and Strategy

Summary:

Risk management is part of an overall approach to helping the Trust successfully deliver the organisational objectives.

The Risk Management Policy and Strategy has been reviewed and updated along with the Risk Management Procedure to better align risk management processes across the organisation. Amendments have been made to give greater clarity to issues raised by the CQC about lack of service level risks registers and by internal audit in respect of risk escalation processes.

Definitions have been updated for clarity and these are now consistent across both documents.

Organisational and individual roles and responsibilities around risk have been clarified, including for students within DET. The process for agreeing, treating and escalating risks has been more clearly defined, including involvement of the directorate clinical governance and quality meetings and non clinical directorate meetings. Risks to operational objectives will continue to rest on the Operational Risk Register which is made up of directorate risk registers, and those which impact on the ability to deliver strategic risks will rest on the BAF. The escalation of risks from the operational risk register to the BAF has been more clearly defined.

Risks to project objectives will remain on the individual project risk register. Should delivery of the project or any aspect of the project delivery adversely impact on delivery of operational or strategic objectives then a risk should also be included on the operational risk register or Board Assurance Framework as agreed by the relevant director or Management Team.

Finally, the concept of 'risk appetite' has been left unchanged but it should be noted that further discussions will be required as Trust risk management processes mature.

This report has been reviewed by the following Committees:
- EMT, (14ᵗʰ February 2017), Wider Management Team 23 Februaty

Page 1 of 2

2017)

The Board of Directors is asked to note that this is a DRAFT policy and strategy. Key information will remain unchanged but there may be minor updates and some formatting. It will be bought back for approval to the March meeting. Please note that a Risk Management Procedure will be approved through usual management processes to support implementation.

This report focuses on the following areas:
(delete where not applicable)
- Quality
- Patient / User Experience
- Patient / User Safety
- Risk
- Productivity

For : Noting

From: Marion Shipman, Associate Director Quality and Governance

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Risk Management Policy and Strategy

Jonathan McKee to update this section

Version:	9.1
Bodies consulted:	Directors and Managers responsible for risk
Approved by:	PASC
Date Approved:	8.6.16
Lead Manager:	Associate Director of Quality and Governance
Lead Director:	Deputy Chief Executive
Date issued:	Jun 16
Review date:	Jul 18

Contents

Risk Management Policy and Strategy

1	Introduction

The Tavistock and Portman Foundation NHS Trust (the Trust) recognises that healthcare provision and the activities associated with caring for patients, employing staff, providing premises, managing finances and operating in a commercial environment are all, by their very nature undertakings which involve a degree of risk. The Trust is committed to managing all strategic, and operational risks and working within the appropriate regulatory and legislative frameworks.

At its simplest, risk management is good management practice. It should not be seen as an end in itself, but as part of an overall approach to helping the Trust successfully deliver the organisational objectives. All staff have a role to play in managing operational risks. Risk management and internal control is central to the effective running of any organisation. It is through this system of internal control and accountability the Chief Executive fulfils his responsibility as accountable office and the Board its responsibility of stewardship.

The Trust places the delivery of *high quality care* at the centre of our objectives, which are underpinned by a range of more specific objectives and work programmes to ensure delivery.

Key systems will be fully embedded at every level of the organisation to ensure compliance with current and future risk management related standards and legislation. Assurances will be provided to the Trust Board so that members are able to make judgements as to the degree to which risks to its objectives are being managed effectively and efficiently. The Board Assurance Framework will contribute to the ability of the Trust to be able to confidently sign the Annual Governance Statement, Annual Accounts and Annual Quality Report and it is through this process we monitor adherence to the standards and regulatory requirements of the Care Quality Commission and other regulators.

Subject to constraints within which the Trust operates, the Trust is committed to the following:

- ensuring effective frameworks, structures and accountabilities are in place for the effective management of risk at all levels throughout the Trust, achieving a clear line of sight of risks from service delivery to the board.

- managing identified risks in an integrated way and not in silos

- ensuring sufficient resources including people, training, finances, work processes and systems of work are in place to successfully implement the risk management policy and strategy and reducing the exposure of risk to an acceptable level.
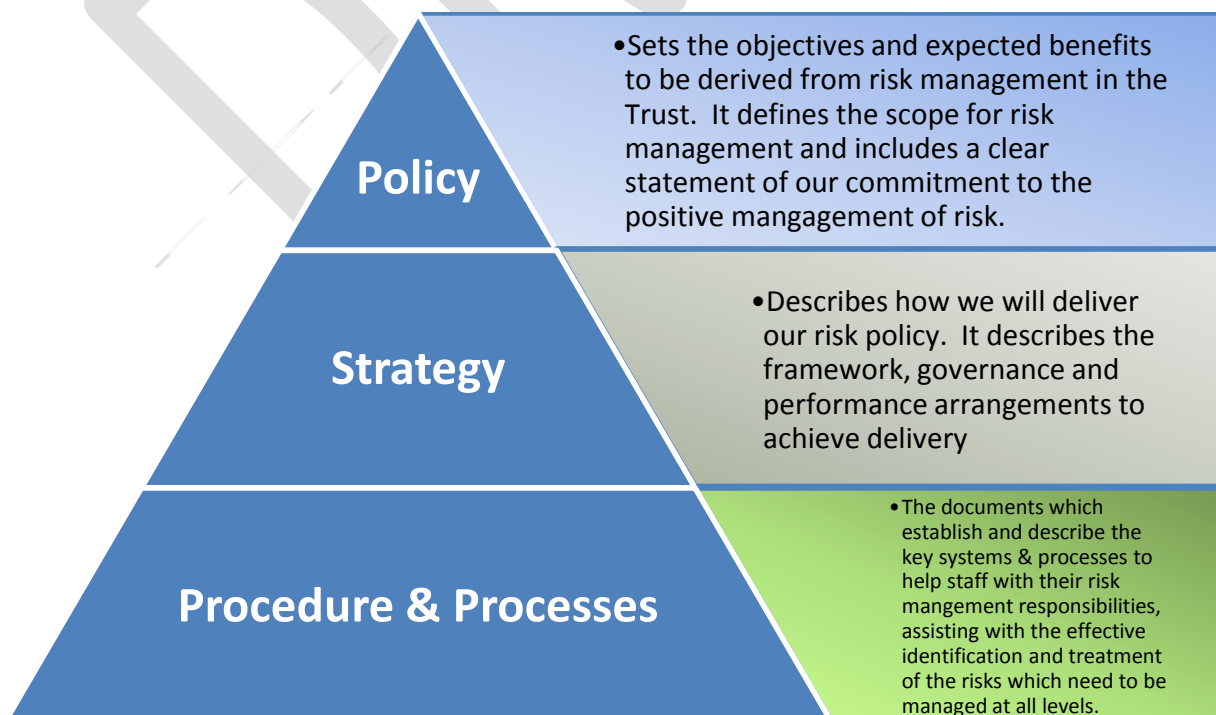
- ensuring staff feel empowered to report risk and have the systems and tools to formally assess and escalate risk where necessary.

- ensuring risk is managed in a positive, sensible and proportionate way to maximise opportunities to achieve objectives and deliver services

- Ensuring that when risks materialise, despite proactive control actions, there are plans and arrangements to respond and recover, particularly in regards to patient care

- Focusing on experience and learning to eliminate or reduce all risk to an acceptable level

2   Purpose

The purpose of having a risk management framework is to:

- Identify and control risks which may adversely affect the Trust's ability to deliver on strategic and operational objectives at every level in the organisation
- Reduce risks to our service users, staff, visitors and public to an acceptable level
- Ensure high levels of regulatory and best practice compliance
- Protect our assets, interests, reputation and financial sustainability
- Provide a systematic and proactive approach to prioritising and managing risk

The risk management framework is outlined as follows:

Policy
- Sets the objectives and expected benefits to be derived from risk management in the Trust. It defines the scope for risk management and includes a clear statement of our commitment to the positive mangagement of risk.

Strategy
- Describes how we will deliver our risk policy. It describes the framework, governance and performance arrangements to achieve delivery

Procedure & Processes
- The documents which establish and describe the key systems & processes to help staff with their risk mangement responsibilities, assisting with the effective identification and treatment of the risks which need to be managed at all levels.

3 Scope

This Policy and Strategy and separate Risk Management Procedure applies to all Trust employed staff, including contractors, volunteers, students, bank and agency staff and staff employed on honorary contract.

4	Definitions

Effective risk management can be described as:

- the systematic application of principles, approaches and processes to the task of identifying, analysing, assessing and controlling risks

It has the following attributes: is proportionate, aligned to Trust objectives, organisational-wide and embedded in the business cycle.

Action owner(s)	The action owner or owners will be responsible for taking the actions to control the risk on behalf of or as delegated by the Risk Owner.
Assurance(s)	Provides information on the adequacy and effectiveness of the controls in place
Board Assurance Framework (BAF)	Provides the Trust Board with a simple but comprehensive method for the effective and focused management of the principle risks to meeting strategic objectives.
Control(s)	Arrangements and systems that are intended to mitigate / control the likelihood and consequence of a risk. An effective control will reduce to an agreed level (target risks score), either the likelihood of a risk occurring, and/or the consequence. If this is not the case, then the control is not fully effective and needs to be reconsidered.
Current risk score	This is the risk score with current completed controls in place. The first current score will also be the same as the initial score. It is expected that the current risk score will move towards the target risk score as treatment plans are developed and implemented. However, the current score can increase due to changes in circumstances (maybe external changes) or to controls being changed or removed.

The current risk score will be used to demonstrate the effectiveness of the treatment plan in mitigating the risk. It will be used to formally report the risk profile of the Trust and be used for the aggregation and escalation of risks. |
| Gaps in assurance | Exist where there is a lack of evidence that the controls are effective |
| Gaps in control | Exist where adequate controls are not in place or where |

	they are not sufficiently effective
Initial risk score	This is the score when the risk is first identified with pre-existing controls in place. This score will not change for the lifetime of the risk and will therefore be used as the benchmark against which risk management actions will be measured.
Operational risks	Risks associated with the delivery of operational objectives including the delivery of patient care, in a safe environment.
Project risks	Project risks are those risks to the objectives of a project and as such should be recorded on that projects risk register.
Risk	Risk is an uncertain event which, should it occur, could have an impact upon the achievement of objectives. Note: Risks are things that <u>might</u> happen and are differentiated from Incidents which are things that <u>have</u> happened and issues which are things that either <u>will</u> <u>happen</u> or are <u>already happening.</u>
Risk Appetite	The levels and types of risk the Trust is prepared to accept, and not accept, in pursuance of its objectives.
Risk Assessment	A systematic process to measure and establish risk levels to help prioritise actions at all levels within the Trust.
Risk Owner	All risks must have a single named owner. The owner will usually be the individual who owns the objective to which the risk relates. There are four responsibilities: to monitor the risk throughout the lifetime of the risk; to report on the status of the risk whenever required; to ensure the appropriate actions are taken to control the risk; to ensure all requirements of the risk management policy, strategy, and procedure are met when managing the risk.
Risk Reduction	The process by which the risk is managed to reduce the consequence and/or likelihood of the occurrence of the event.
Risk Register	A management tool that allows the various levels of the organisation to capture and understand its comprehensive risk profile. It is a repository of risk information linking risk, control, action and assurance for the whole organisation in a risk priority order. It is a source of reporting to support decision making and provide

	assurance.
Strategic risk	Risk that **directly** impacts on the ability of the Trust to fulfil its strategic objectives
Target risk score	The level of risk which the Trust is willing to accept after all necessary measures have been applied.

5	Organisational Roles and Responsibilities

5.1 The Trust Board

The Trust Board is responsible for endorsing the organisation's system of internal control, including the arrangements for risk management. The Board meets monthly and considers reports from the Board level committees in order to verify that risks are being managed appropriately and that the organisation can deliver its objectives. The Trust Board has reserved for itself the adoption of the Risk Management Policy and Strategy and has collective responsibility for:

- Providing leadership on the management of risk
- Ensuring risk management systems within the Trust are effective and fully operational across the whole organisation
- Directing the reduction, elimination and exploitation of risk in order to increase resilience and achieve objectives
- Determining and communicating the risk appetite statement for the Trust
- Ensuring a consistent approach to the application of the risk management strategy
- Ensuring that the Trust is able to manage all types of risk faced, and at an appropriate level
- Reviewing and requesting assurances to demonstrate that risks have been identified, assessed and all reasonable steps have been taken to manage them effectively and appropriately
- Receiving assurance that resources are available to support the risk management system and to manage risk within the agreed risk appetite
- Protecting the reputation of the Trust and correctly scoring risks to the achievement of the Trust's strategic objectives, via the Board Assurance Framework, through regular reviews
- Ensuring all members of the Trust Board attend Board development and awareness training in relation to risk management in line with the Training Needs Analysis.

5.2 Audit Committee

The Audit Committee is responsible for providing assurance to the Trust Board that an effective system of integrated governance, internal control and risk management is maintained within the organisation. The Audit Committee also has a specific remit to review and provide verification on the systems in place for risk management as part of its assurance for the Annual Governance Statement.

5.3 Clinical Quality Safety and Governance Committee (CQSG)

This committee, comprising Executive Directors, Non-Executive Directors, and Governors will seek assurance that the Trust is managing risks to operational objectives and will provide a quarterly assurance report to the Board.

The CQSG will receive assurance reports from the following workstreams to an agreed reporting schedule:

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

All reports submitted to the CQSG by the workstreams are first reviewed by the Executive Management Team to ensure that operational risks are being addressed appropriately.

The CQSG will report to the Board on its level of assurance in respect of management of risk, and confirm that in the event risks are identified, and an effective action plan is in place which is being monitored.

In addition the CQSG will advise the Board of any new significant risks on an exceptional basis between CQSG reports to the Board, and it will receive the full operational risk register to review annually.

6	Individual Roles and Responsibilities

6.1   Chief Executive

The Chief Executive is accountable to the Trust Chair and Trust Board for ensuring that there is an effective system of risk management and internal control in place and for meeting all statutory, regulatory and corporate governance requirements.

The Chief Executive has overall responsibility for risk management, and ensuring that the Council of Governors is consulted when the Trust's policy, strategy and procedures for the management of risk are being considered and approved at Board level. He has delegated responsibility for the maintenance of the system of internal control to the Trust Executive Directors as follows:

- Director of Finance for strategic and non clinical risk
- Medical Director for clinical risk
- Director of Education for education risk
- Senior Information Risk Owner for information risk
- All Directors for risks in their directorate

6.2   Deputy Chief Executive

- The Deputy Chief Executive is responsible for supporting the Chief Executive in his/her role – acting as the overall lead for Risk Management, with responsibility for coordinating the implementation of this strategy;
- He/she is also responsible for ensuring that processes are in place to identify risks to strategic objectives and that these are recorded in the Board Assurance Framework, monitored, and reported to the Executive Management Committee and the Board of Directors.

- Has responsibility for presenting the updated BAF following approval of the annual plan. This will be updated and represented at a frequency agreed by the Board during the year but at least quarterly.

- Has responsibility for non clinical risk management throughout the Trust.

6.3   Director of Finance

The Director of Finance, on behalf of the Chief Executive has responsibility for ensuring a sound system of internal financial control and providing adequate financial information. He/she is the key contact for the auditors and is responsible for providing assurances to the Board. The Director of

Finance will have ultimate responsibility for any financial implications of plans to control risk and the method used to incorporate such into the business planning process.

6.4   Senior Information Risk Owner (SIRO)

- The SIRO, on behalf of the Chief Executive will be responsible for ensuring that risk relating to information is managed in accordance with the Information Governance Framework. This Framework is monitored by the Information Governance work stream reporting to the Clinical Quality, Safety, and Governance Committee. Has responsibility for the management of Information Technology system risks and contingency plans.

6.5   Medical Director

The Medical Director, on behalf of the Chief Executive, is responsible for the management of clinical risk throughout the Trust. The Medical Director is responsible for informing the Trust Board of the key risks emanating from clinical activity throughout the Trust and for ensuring the Trust has effective systems for managing these risks. The Medical Director is responsible for providing written advice to the Chief Executive on the content of the Annual Governance Statement in regards to the management of these risks.

In fulfilling this duty he will:

- chair the Clinical Quality, Safety and Governance Committee (the quality committee of the Board of Directors);
- have overall responsibility for clinical governance and management of clinical risk;
- ensure the development, review and publishing of appropriate Trust policies and procedures for the management of clinical risks;
- oversee the provision of internal clinical advice in relation to clinical risk management;
- ensure that the responsibilities for the provision of adequate arrangements for clinical risk management are assigned, accepted and implemented at all levels within the organisation;
- bring to the attention of the Chief Executive details of incident trends, levels of performance, clinical claims trends, and matters of clinical risk concern requiring attention, as advised by the Patient Safety and Risk workstream lead;
- advise the Chief Executive on investigations into serious clinical incidents;
- report to the Executive Management Committee and Board of Directors on serious clinical risks;
- act as Lead Director for Emergency preparedness and Major

Incident planning;
- be responsible for the management of risks within his/her areas of operational responsibility.

The Medical Director will be supported by the Associate Medical Director (Patient Safety) in delivering on these responsibilities.

6.6 Quality and Patient Experience Director

The Quality and Patient Experience Director is responsible for:

- Developing, implementing and sustaining the Trust's Clinical Quality, Assurance and Safety agenda;
- Governance, incident management, quality, litigation and complaints.

6.7 Service line directors

The directors are responsible for managing risk across their directorates. They must ensure the following:

- that local risk management activities, including risk assessments, are carried out to support Trust-wide learning from risks;
- staff in the directorate are aware of their roles and responsibilities where appropriate in relation to reducing the consequence and/or likelihood of risks;
- that the Health and Safety Manager (Non Clinical Risk Manager) is advised of all new risks (clinical and non clinical) to be added to the risk register.

6.8 Non-Executive Directors

Non-Executive Directors have a duty to review the Trust's risk management arrangements and be assured that these are robust and defensible. In particular, as members of the Audit and Clinical Quality Safety and Governance (CQSG) Committees Non-Executive Directors will review the adequacy of the risk management strategy, and receive regular monitoring information against the management of risks judged as 'extreme'.

6.9 Associate Director for Quality and Governance

The associate director is responsible for developing and overseeing the risk management framework and procedures. He/she is responsible for providing expert advice and support on risk management and for providing training for all levels of staff on risk assessment, risk management and risk processes. He/she will provide regular reports to

the work streams reporting to the Clinical Quality Safety and Governance Committee (CQSG) as required and ensure risk information and reports are compiled to inform the organisation, including the Board Assurance Framework and Operational Risk Register.

6.10 Governance Manager

The Governance Manager is the Information Governance Lead and responsible for ensuring the data and information asset risks are identified and controlled appropriately. The Lead is also responsible for facilitating an annual programme of risk assessments of information governance assets to be undertaken by information asset owners on behalf of the SIRO.

6.11 Clinical Governance Manager

This manager will provide advice and support on safeguarding, PREVENT, revalidation and related clinical governance matters. The manager is also responsible for the operational management of the Clinical Quality, Safety, and Governance Committee.

6.12 Estates Manager

To undertake annual environmental site risk assessments for buildings fabric and utilities.

6.13 Health and Safety Manager

The Health and Safety Manager is responsible for:

- Fulfilling the requirements of Health and Safety Advisor to the Trust;
- Undertaking health and safety risk assessments and safety audits including annual site risk assessments for staff and service provision;
- Promoting the use and understanding of risk assessment throughout the Trust;
- Arranging, in conjunction with the Associate Director Quality and Governance, training on risk assessments;
- Maintaining the operational risk register and Board Assurance Framework and acts as an enabler/ facilitator for managers.
- Providing regular reports to the workstreams reporting to the Clinical Quality Safety and Governance (CQSG) as required;
- Acting as the Emergency Planning Liaison Officer (EPLO) for Emergency Planning – supporting services in risk management and local business continuity plans.

6.14 Managers

All Managers are responsible **for ensuring that risks in the area under their management** are identified, monitored and controlled in line with the Trust's risk management strategy. They are responsible for:

- ensuring risk assessments are conducted as appropriate for their area of responsibility;
- ensuring actions are taken to mitigate any unacceptable risks;
- ensuring that identified risks that require an action plan to provide satisfactory mitigation are added to the service level risk register which forms the Trust operational risk register.
- Undertaking 'horizon scanning' to identify future issues that may threaten delivery of operational or strategic objectives. These should be relevant to their service area.

6.15 Fire Adviser

A Fire Safety Adviser is engaged under contract to provide expert advice, regular inspections and training for all staff in relation to fire hazards and their management. The Advisor liaises with both the Estates Manager and Health and Safety Manager.

6.16 Human Resources (HR)

The HR department is responsible for ensuring that the Trust appointed Occupational Health and Wellbeing Service undertakes appropriate risk assessments and implements appropriate control measures associated with the maintenance of employee health, including providing advice on the management of any uncontrolled risk as it relates to staff.

6.17 All Staff (permanent, temporary, voluntary, contract) and students

All staff and students have a key role in identifying and reporting risks promptly thereby allowing risks to be managed and where necessary add to the local risk registers. All staff and students are accountable, through their terms and conditions of employment or study for meeting professional requirements where applicable, especially those associated with clinical governance. This will achieved through the Trust new student record system developments. Staff and students who see patients in the Trust are required to comply with all Trust policies and procedures, particularly those relating to the statutory requirements for health, safety and welfare.

In particular staff and students must:

- take steps to avoid injury and risk to patients (where relevant), staff

and visitors;

- be alert to, identify and report risks especially those relating to patient care(where relevant), safety and welfare;
- being aware of any emergency procedures relevant to their role and place of work or study;
- manage risk within their sphere of responsibility. It is a statutory duty to take reasonable care of their own safety and the safety of others who may be affected by their acts or omissions.

7　　Risk Management Strategy

7.1　　Overview of the Process

The management of risks has a well-established approach. All staff must be competent at identifying risks in their own areas. Risks identified in an area other than where the person who identifies it works should be escalated to the relevant service line manager.

The risk process is designed to provide continuous identification, assessment, control, communication and monitoring of risk via defined timescales, reporting and escalation processes and supporting tools. It should be used to inform decision making.

Each directorate will maintain a risk register, having overall responsibility for keeping it up to date. The individual directorate risk registers together form the Trust Operational Risk Register.

Project risks are those risks to the objectives of a project and as such should be recorded on that projects risk register.   Should delivery of the project or any aspect of the project delivery e.g. running overtime, budget, not fulfilling full scope, not meeting expected levels of quality and not enabling expected benefits adversely impact on delivery of operational or strategic objectives then a risk should also be included on the directorate risk register or Board Assurance Framework as agreed by the relevant director or Management Team.

The risk assessment approach below as described by the former National Patient Safety Agency has been adopted by the Trust.
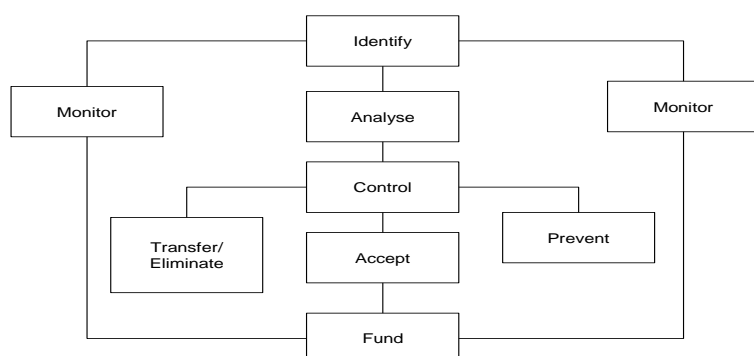
Figure 1: Risk Management Process

7.2   Using the Trust Risk Matrix

The Trust has developed a risk matrix to enable it to consider risks of all sorts against a common framework. The matrix enables a risk score to be ascribed to each identified risk and this score is used to determine the level of action and escalation for review that the risk should undergo. The Trust Risk Matrix is shown below and guidance on how this matrix is to be used is detailed within the 'Risk Management Procedure'.

			1	2	3	4	5
Likelihood	Almost certain to occur	5	5	10	15	20	25
	Likely to occur	4	4	8	12	16	20
	Could occur	3	3	6	9	12	15
	Unlikely to occur	2	2	4	6	8	10
	Very unlikely to occur	1	1	2	3	4	5
			1	2	3	4	5
			Negligible	Minor	Moderate	Severe	Extreme

Fig 2 Risk Matrix

Consequence

7.3   The Risk Register

Risk registers should be used to record all identified risks relating to an objective (or set of objectives). They should be useful as a day-to-day tool to help

managers achieve their objectives and drive and evidence risk management activities. They should also act as a source of information in risk reporting at all levels.

The Trust holds two registers which it uses to monitor risks:

Operational Risk Register: records risks to operational objectives. As new risks are identified they are added. It is formed of directorate risk registers. Risks of a level 9-25 (clinical and non clinical) are reviewed quarterly by the CQSG committee via workstream reports and the full risk register goes annually to the Board.

Strategic Risks are currently recorded on the Board Assurance Framework (BAF): This records risks which threaten successful delivery of the Trust's strategic objectives. It is the main tool used by the Board to monitor and evaluate the risks. It is reviewed at least three monthly by the Board where it will be considered alongside other key management tools, such as performance and quality dashboards and financial reports to give the Board a comprehensive picture of the organisational risk profile.

Both the BAF and Operational Risk Register are held centrally.

The registers serve as a record of current risks and enables risks to be quantified and ranked. They provide a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated.

Both registers will be held in the same format to support the move towards an integrated electronic risk management system in 2017.

7.4 Risk Ownership

See definition section 4.0 for details on Risk Owners and Action Owners.

7.5   Treating and Escalating Risks

The risk score is used for prioritising risks and determining where awareness, monitoring and decision-making should be escalated. The Trust has a scheme of escalation (shown at Figure 3 below). This scheme of delegation applies to an individual identified risk. Those risks which have been identified but as a low risk (level 1-4) that cannot be eliminated are added to the Trust risk register

Before a risk can be formally recorded on a risk register it must be reviewed and approved by the relevant accountable individual (see below).

Figure 3 Escalation levels and monitoring arrangements

Risk level	Authority / Ownership	Action	Escalation level
Low Risk 1-4	Individuals and Team /DET Managers	**Acceptable Risk** Managed through normal local control measures with annual monitoring at Team level to ensure they do not increase.	Consider for entry onto the Service Risk Register by Service/DET Manager.
Moderate Risk 5-8	Service /DET Managers	**Acceptable / Unacceptable Risk** Review control measures through formal risk assessment, ensuring that any further actions to reduce the risk are taken. Monitor six monthly at directorate level.	Risk to be raised with relevant Director and considered at Directorate level meeting for risk moderation. Record on Risk Register.
High Risk 9-12	Relevant Director	**Unacceptable Risk** As above plus: Action required to be taken. Monitored by CQSG Committee three monthly. Report annually to Board.	Risk to be raised with relevant Director and considered at Directorate level meeting for risk moderation. Record on Risk Register.
Extreme Risk 15-25	Executive director	**Unacceptable Risk** As above plus: Highly likely to be an intolerable level of risk **Immediate action** must be taken and the risk escalated to the relevant Director. EMT to review the risk and consider if it should be on the BAF. Board of Directors informed and receive assurance on progress on mitigating actions from the CQSG committee.	As above plus: Raise the risk with relevant Director and record on the Risk Register.

Risk registers will include actions plans with dates to mitigate the risk. Risk controls will be mapped against at least one source of assurance and assurances defined as (+) or (-). Meeting where risks are monitored will be asked to consider whether they have sufficient assurance that the risks are being adequately managed.

7.6   Risk Appetite

Risk Appetite is the term used to capture the levels and type of risk the Trust is prepared to accept, and not accept, in pursuance of its objectives.

7.7 How are the entries on the register reviewed?

Risk Owners will be asked to review entries on the register in line with the risk level. See the Risk Management Procedure. In addition, the Operational risk register and BAF will be reviewed via the Clinical Quality Safety and Governance Committee and Executive Management Committee for risks level 9-25.

The Board of Directors will receive the full Operational Risk Register for review and comment annually and the BAF quarterly. (See Appendix 1 chart)

As risks should relate directly to objectives they should t only exist during the lifetime of the related objective. Thus, if the objective is to be achieved over a two-year period, all risks relating to that objective should ordinarily be removed at the end of that two year period (sooner if the objective is achieved ahead of time, later if there is a delay in achieving the objective). For business-as-usual objectives, which essentially continue year after year, they should be revisited each year as part of the planning process and re-set. At the same time, the risks relating to that objective should be reviewed and updated/removed accordingly.

7.8 Risk Management Support

The Associate Director of Quality and Governance, Associate Medical Director (Patient Safety), Health and Safety Manager and Governance Manager are available to provide help and support on risk matters to individuals; teams and departments.

8 Training Requirements

8.1 Training

The Trust recognises that training of staff is an essential element of any successful risk management strategy. It has conducted a training needs analysis and full details of this are published in the Trust's Staff Training Policy.

The following table summarises the key training provided in relation to the Risk Strategy.

Target group	Training activity	Training aim	Frequency
Board of Directors and Executive Management Team	Overview of development of risk management systems and assurance framework , plus corporate risk assessment / review This course is tailored annually to needs of	Improve strategic management and understanding of risks to Trust,	Annual Delivered by: Risk expert (internal or external)

Target group	Training activity	Training aim	Frequency
	trust		
All staff	Risk update including risk assessment and incident reporting	To maintain risk awareness and activity throughout the organisation	At two yearly INSET delivered by Risk expert (internal or external)
All new staff, including students	Introduction to risk management and incident reporting	To raise awareness of Trust approach to risk management, policies and procedures	Once at induction delivered by Health and Safety Manager or online module

Fig 4: Summary of Risk Management Training from TNA

8.2 Managing attendance at mandatory risk training

Management of attendance and following up non-attenders of staff at induction and INSET risk training will be managed under the Staff Training Policy

In the event that a member of the Board of Directors or Executive Management Committee is unable to attend the annual risk update on request the Risk expert will provide a one to one session using the same materials

8.3 On-going information to staff on risk management

The Trust will provide information on risk management and risk reduction to its staff throughout the year through a variety of different ways which will include:

- Hazard notice circulation with obligatory feedback
- Policies and Procedures on the Intranet
- Health and Safety Information available by internet/intranet
- Updating at mandatory induction and INSET days
- Provision of specific training on different aspects of risk management, published in the Trust's training prospectus
- Provision of feedback to those who report/ are involved in specific incidents.
- Shared lessons learned from incidents and risks via the Quality News
- Risk Management information to be included on the digital learning platform, Moodle for students.

9   Process for monitoring compliance with this policy

The Trust will monitor the key components of this strategy and policy in the following way:

Key process for which compliance is being monitored	Monitoring method	Job title of person responsible for monitoring	Frequency of the monitoring activity	Workstream or Committee responsible for receiving the monitoring results	Committee responsible for ensuring that action plans are completed
Review of the Operational risk register by high level Committee	Receive operational register for review	Director of Finance	Annual	Board of Directors Executive Management Committee	CQSG reporting to the Board of Directors
Duties of key individuals	Audit of involvement in risk management	Associate Director Quality and Governance and Patient Safety workstream lead	by exception	Corporate Governance and Risk Workstream and Patient Safety workstream reporting to CQSG	CQSG reporting to the Board of Directors

10 References

- Care Quality Commission CQC.org.uk
- Department of Health and NHS Appointments Commission. (2003)
- Data Protection Act 1998
- Department of Health. (2002). Assurance: The Board Agenda. London: Department of Health. Available at: www.dh.gov.uk
- Department of Health. (2006). Integrated Governance Handbook. A handbook for executives and non-executives in healthcare organisations. London: Department of Health. Available at: www.dh.gov.uk
- Environmental Protection Act 1990
- Governing the NHS: A guide for NHS Boards. London: NHS Appointments Commission. Available at: www.dh.gov.uk
- Health and Safety Executive (HSE). (2010). Leading Health and Safety at Work: Leadership Actions for Directors and Board Members. London: HSE. Available at: www.hse.gov.uk
- Health and Safety at Work Act 1974
- NHS Improvement (formally MONITOR)

11 Associated documents[1]

Staff are referred to the following related procedures:

- Health and Safety Policy and Procedures
- Incident Reporting Policy and Procedure
- Information Governance Framework
- Policy and Procedure for the Management of Formal Complaints
- Procedure for Claims management
- Procedure for Investigation and Learning from Serious Incidents
- Procedure for Learning from Incidents Complaints and Claims to improve Patient Safety and Reduce Risk
- Staff Training Policy

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[1] For the current version of Trust policy /procedures listed above, please refer to the intranet.

12   Equality Impact Assessment

Completed by	Marion Shipman
Position	Associate Director Quality and Governance
Date	10 February 2017

The following questions determine whether analysis is needed	Yes	No
Is it likely to affect people with particular protected characteristics differently?		X
Is it a major policy, significantly affecting how Trust services are delivered?		X
Will the policy have a significant effect on how partner organisations operate in terms of equality?		X
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X
Does the policy relate to an area with known inequalities?		X
Does the policy relate to any equality objectives that have been set by the Trust?		X
Other?		X

If the answer to *all* of these questions was no, then the assessment is complete.

Reporting Quality, Safety, and Risk to Board of Directors

The Board of Directors

Clinical Quality, Safety & Governance Committee

Management Team

Assurance through accountability

Authority through delegation

Corporate Governance and Risk
Leads: Associate Director Quality + Gov

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

Information Governance
Lead: SIRO

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

Clinical Quality and Patient Experience
Lead: Director of Quality

- reports provide assurance that outcome data has improved outcomes at individual and patient group levels
- outcome results, where they can be benchmarked, compare favourably against those of other providers
- outcome monitoring methodology and practice best suits the Trust's patient population
- the annual audit programme is aligned with organisational priorities as set out in the annual operational plan
- the implementation of the recommendations of clinical audits leads to improvements in patient care
- information on outcomes facilitates patient choice and that any published information is of consistent good quality and is accessible and available to prospective patients and referrers
- the feedback from Experience of Service Questionnaires is dealt with effectively, both individually, and by analysing trends and common issues
- the Trust has prepared for inspections from the regulator of clinical services

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Patient Safety and Clinical Risk
Lead: Associate Medical Director

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

Board of Directors: February 2017

Item : 10

Title : Board Assurance Framework

Summary :

The Assurance Framework identifies key risks to achieving the Trust's strategic objectives as set out in the Medium Term Strategy.

It was presented in a new format in July 2015, and approved by the Board. It was updated in January, April, July and November 2016.

The BAF has been updated and is brought to the Board in February to coincide with the updated Risk Management Policy and Strategy. It will then revert to the usual quarterly timings – April, July, October and January. The current update includes additional requirements identified by the Trust Internal Auditors namely: mapping controls against at least one source of assurance (evidence); defining assurances as positive (+) or negative (-) and providing the consequence and likelihood detail that forms the **target risk**.

The **initial** risk has been reviewed and updated to reflect the risk level when first identified. Current risks within the BAF are also now presented on a Dashboard to provide a visual representation on a single page of all BAF risks.

If any major changes to the Trust's strategic risks are identified between these months, they will be reported to the Board at the next available opportunity.

The Framework was reviewed by the Management Team on 9th February 2017

BAF

For : Approval

From : Deputy Chief Executive & Finance Director; Associate Director of Quality and Risk.

BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

1.1. The Board Assurance Framework ("BAF") seeks to identify the key risks that could prevent the Trust from achieving its strategic objectives.

1.2. Following discussions with the Audit Committee and the Board the approach to the BAF has been amended and the new approach is outlined below.

1.3 Additional requirements identified by the Trust Internal Auditors have also been included. These are: mapping controls against at least one source of assurance (evidence); defining assurances as positive (+) or negative (-) and providing the consequence and likelihood detail that forms the **target risk**.

1.4 A BAF Heatmap is a new addition to this report, presenting all BAF risks on a single page overview of the current position. The direction of travel for each risk from last assessment is also included.

2. APPROACH TO RISK SCORING

2.1. Significant risks are identified by the Executive Management Team after discussion with each other, with their direct reports and with the Board. In identifying significant risks, various factors are taken into account including, amongst other factors, both the local and general environments for health and social care; the Trust's current and future operational performance; the current and future availability of resources.

2.2. Each significant risk is then given a score for the:

2.2.1. **initial risk:** the risk level assessed at the time of initial identification.

2.2.2. **current risk:** the risk at a point in time, taking in account completed actions / mitigating factors.

2.2.3. **target risk:** this is a new addition to the BAF and is the level of risk which the Board is expected / willing to accept after all necessary planned measures have been applied.

2.3. Scoring is based on the Trust's Risk Management Policy, as follows:

1 – 4	Green
5 – 8	Yellow
9 – 12	Amber
15 – 25	Red

2.4. The risks have been numbered for easier referencing (although the number does not imply a higher or lower level of inherent or residual risk).

2.5. The **initial risks** have been taken from the July 2015 BAF when the new BAF format was introduced.

2.6. Assurances have been defined as (+) or (-) as per internal audit recommendations and controls map against at least one source of assurance (evidence).

2.7. Directors have reviewed and updated their sections of the BAF including confirming the **target risk,** updating the **current risk** scores for each risk and updating the strategic objective(s) affected by the risk with the relevant 'Aim(s)'.

2.8. The BAF has also been reviewed by the Executive Management Team.

3. SUMMARY

3.1. Risks 5 and 10, national training contract and management capacity remain our most significant. Risk 3, Education and Training Failures, has increased from 8 to 9. The focus of risk 5 in respect of the national training contract is likely to change once Health Education England (HEE) funding and focus is confirmed.

3.2. Risk 2, clinical growth targets, Risks 12, reputation and Risk 13 relating to reputation and regulatory failure have all reduced.

3.3. All other risks have remained unchanged from the previous quarter.

4. CONCLUSION

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

BAF

CURRENT BAF HEAT MAP

Likelihood			Consequence				
Almost certain to occur	5						
Likely to occur	4				R10		
Could occur	3			R3, R4	R1, R2 R6, R8 R9, R13	R5	
Unlikely to occur	2				R7, R11		
Very unlikely to occur	1				R12		
Risk Matrix		1 Negligible	2 Minor	3 Moderate	4 Severe	5 Extreme	

OCTOBER 2016 BAF HEAT MAP

Likelihood			Consequence				
Almost certain to occur	5			R2			
Likely to occur	4				R10, R13		
Could occur	3			R4	R1, R6, R8, R9	R5	
Unlikely to occur	2				R3, R7, R11		
Very unlikely to occur	1					R12	
Risk Matrix		1 Negligible	2 Minor	3 Moderate	4 Severe	5 Extreme	

See next page for risk numbers and headings.

Risk headings, reference numbers.
Arrows denote direction of travel from risk level from last assessment

Risk 1	Clinical quality or governance failures	→
Risk 2	Clinical growth targets not achieved	↕
Risk 3	Education and training quality failures	↑
Risk 4	Training course numbers reduced	→
Risk 5	National training contract changes	→
Risk 6	Loss of workforce engagement and morale	→
Risk 7	Loss of workforce skills	→
Risk 8	Unable to agree or fund relocation/ redevelopment plans	→
Risk 9	Loss of access to critical systems (IT	→
Risk 10	Insufficient management capacity	→
Risk 11	Damage to Trust's reputation and brand	→
Risk 12	Regulatory failure	↓
Risk 13	Savings and growth contribution insufficient	↓

BAF

Board Assurance Framework 2016/17 - Summary

	Risk	Owner	Strategic Aim	**Current Risk Score**					Target Risk C= consequence L = likelihood Risk = C x L	Current v Target Risk Score
				Oct 16	Jan 17	*17	*17	*17		
10	Insufficient management capacity	Paul Jenkins	ALL	Red 16	Red 16				**Amber 4x3**	Adverse
5	Adverse impact of National Training contract changes	Brian Rock	3	Red 15	Red 15				**Amber 4x3**	Adverse
13	Savings and growth contribution insufficient	Terry Noys	5	Red 16	Amber 12				**Yellow 4x2**	Adverse
2	Clinical growth targets not achieved	Julia Smith	5	Red 15	Amber 12				**Amber 3x3**	Adverse
1	Clinical quality or governance failures in context of elevated risk of serious incidents	Rob Senior	2	Amber 12	Amber 12				**Yellow 4x2**	Adverse
6	Loss of workforce engagement / morale / commitment	Paul Jenkins	4	Amber 12	Amber 12				**Yellow 4x2**	Adverse
8	Unable to agree or fund relocation / redevelopment plans	Terry Noys	7	Amber 12	Amber 12				**Yellow 4 x 2**	Adverse
9	IT applications and hardware do not sufficiently support Trust objectives. Loss of access to critical systems	David Wyndham Lewis	7	Amber 12	Amber 12				**Yellow 4x2**	Adverse
4	Training course numbers reduced, or growth targets not achieved	Brian Rock	3	Amber 9	Amber 9				**Yellow 3x2**	Adverse

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BAF

Current Risk Score

	Risk	Owner	Strategic Aim	Oct 16	Jan 17	* 17	* 17	Target Risk C= consequence L = likelihood Risk = C x L	Current v Target Risk Score
3	Education and Training quality failures	Brian Rock	3	Yellow 8	Amber 9			Green 4x1	Adverse
7	Loss of workforce skills	Craig De Sousa	4	Yellow 8	Yellow 8			Green 4x1	Adverse
11	Damage to the Trust's reputation and brand	Paul Jenkins	6	Yellow 8	Yellow 8			Yellow 4x2	Meets
12	Regulatory failure	Paul Jenkins	2, 5	Yellow 5	Green 4			Green 4x1	Meets

STRATEGIC AIMS
1) Contributing to the development of new models of care (PJ /SH/ JSt /BR)   5) Delivering a sustainable financial future for the Trust (TN / JS)
2) Maintaining & developing the quality & reach of our clinical services (JSt/SH /LL)   6) Raising Trust's profile & its contribution to public debate & discourse (LT/BR /RS)
3) Growing and developing our training and education and delivering a remodelled National Training Contract (BR)
4) Supporting the wellbeing and engagement of our staff (CdS / LL / BR)   7) Develop our infrastructure to support our work (TN /DWL)

RISK 1): Clinical quality or governance failures – including the risk of serious incidents

Risk Owner: Medical Director	Date last reviewed: January 2017

Strategic Objective(s) affected by this risk:
Aim 2: Maintaining and developing the quality and reach for our clinical services

INITIAL risk rating (at identification):
Likelihood 2 x Consequence 4   8
CURRENT risk rating (after mitigation):
Likelihood 3 x Consequence 4   12

Rationale for current score:

The consequence of a serious clinical incident attributable to a failure to comply with appropriate standards of quality or safety is high and the likelihood of incidents has risen because of increased risk in some services and populations. There are well-embedded systems in place to provide governance and early warning of system failures. Evidence of learning from incidents has improved. New GIC contract to be taken up April 2017 with unknown risk level.

Controls/Influences *(what are we currently doing about this risk?)*:

Director of Quality and Patient Experience leads Quality work-stream reporting to CQSG Committee.
Continuing development of staff training programmes.
Associate Medical Director leads Patient Safety and Risk work-stream. CQC report discussed at MT, CQSGC and Board. Full action plan approved and being implemented.
CareNotes now more fully embedded in clinical practice.
Individual action plans arising from the investigation of incidents

Assurances received *(independent reports on processes; when; conclusions)*:

CQC inspection report published in May: Good rating overall and in 4/5 domains (+)
Quality Reports and Accounts externally audited: qualification on one of the indicators has led to an agreed action plan (+)
Risks attributable to reduced capacity of other providers including Social Care and Voluntary Sector are difficult to mitigate.
Investigations including SCR and coroner's inquest have not identified failures by Trust practitioners.
Clinical Governance Leads appointed CYAF and AFS (+)

Gaps in controls/influences:

Restructuring of Quality Team and Clinical Governance Office needed to meet enhanced requirement for integrated programme of quality improvement.

Action plans in response to gaps identified: *(with lead and target date)*

Recruitment and retention of suitable junior staff 31Mar 2017 (RS) Review safe sharing of information across organisations by Safeguarding Committee and Patient Safety Clinical Risk (PSCR) workstream 30 June 2017 (RS)
Review risk in light of new GIC contract 31 Mar 2017 (RS)

BAF

RISK 2): Clinical growth targets not achieved

Risk Owner: Commercial Director	Date last reviewed: January 2017

Strategic Objective(s) affected by this risk:
Aim 5: Delivering a sustainable financial future for the Trust

INITIAL risk rating (at identification):
Likelihood 4 x Consequence 3 **12**
CURRENT risk rating (after mitigation):
Likelihood 3 x Consequence 4 **12**

Rationale for current score:
Growth target is likely to be met for 2017/18. Targets for 2018/19 and beyond have yet to be finalised, but it is likely to be difficult to achieve significant growth.

Controls/Influences *(what are we currently doing about this risk?):*
Accurate list of contracts in place (OAF)
Quarterly forward look at income by contract in Commercial Report considered by Strategic and Commercial Committee
Plans updated, agreed and monitored by Strategic and Commercial Committee– most recently on 11 October. Regular liaison with commissioners. Continue the development and modernisation of existing services, including the Thrive model for CAMHS.
Demonstrate quality and outcomes. Action plan to address underperformance in place. Start and finish group in place to secure continued funding for FDAC. Development of new service models, including Thrive and TAP. Engaged in NCL STP.

Assurances received *(independent reports on processes; when; conclusions):*
OAF in place
Commercial Report considered by SCC.
Quality Reports for Commissioners.
Internal Audit of Board Assurance Framework, December 2014 confirmed that the BAF entries for clinical income maintenance and growth were correct; controls were appropriate and were functioning as stated. (+)

Gaps in controls/influences: External environment has changed, so patient services strategy needs to be refreshed. No systematic plan in place to manage relationships. No systematic approach with regard to horizon scanning.

Action plans in response to gaps identified: *(with lead and target date)*
Refresh patient services plan Feb 2017 (RS & JS)
Create relationship management plan Jan 2017 (JS)
Horizon scan plan in place January 2017 (JS and RS)

RISK 3): Education and Training quality failures

This includes failure to deliver a quality learning experience to students that is fundamental to our position in the sector.

Risk Owner: Director of Education and Training.	Date last reviewed: January 2017

Strategic Objective(s) affected by this risk:
Aim 3: Growing and developing our training and education and delivering a remodelled National Training Contract

INITIAL risk rating (at identification):
Likelihood 2 x Consequence 4   **8**

CURRENT risk rating (after mitigation):
Likelihood 3 x Consequence 3   **9**

Rationale for current score:
The Trust is a leading quality provider of education and training. Any actual or perceived loss of quality in delivery through the expansion of numbers, courses, sites of delivery and teaching formats would potentially have a serious impact. DET is negotiating a significant restructuring of its professional support services and implementing a new student information management system.

Controls/Influences *(what are we currently doing about this risk?)*:
Successful negotiation of transition arrangements with university partners. Robust Academic Governance and Quality Assurance arrangements in place, supported and monitored by university partners.
Curriculum Quality Group embedded to manage and oversee issues in the ongoing partnership arrangements reporting to the Partnership Management Board with Essex University.
Establishment of a Student Experience Committee as an additional conduit of communication between DET/Faculty and student group.
Learning & Teaching Committee now fully established with links to Higher Education Academy to foster staff development.
Portfolio Manager Group provides greater oversight and dissemination of governance & quality requirements across the portfolio
Establishment of Standard Operating Procedures to create clarity of roles and responsibilities to support students across DET functions and course teams.
Action plan developed for closer working relationships with Associate and Alternative Centres.
Development of complaints procedure in line with membership of OIA.
Implementation of new student information management system

Gaps in controls/influences:

Assurances received *(independent reports on processes; when; conclusions)*:
QAA inspection visit successfully completed with all four required expectations met. Report published August 2016 (+)
Annual student survey results in keeping with previous high levels of satisfaction (June 2016) (+)

Action plans in response to gaps identified: *(with lead and target date)*

Professional support services restructure undertaken alongside the development and embedding of clearer processes across roles.
1) New staffing arrangements in core administrative team.
2) Implementation of SITS involves sustained input from operational team.

1) Workshops established to work with professional support staff and faculty to further develop and embed SOPs (Nov 2016 – ongoing / Associate Deans).
2) Weekly Rapid Response Group established by Deputy Director to work closely with key operational staff members to monitor and address issues that impact student experience (Sept 2016 – ongoing).

RISK 4): Training course numbers reduced, or growth targets not achieved

Education & Training has been set an ambitious set of growth targets. Not achieving growth through reduced student numbers or reach will have an adverse effect on our standing and financial position.

Risk Owner: Director of Education and Training.	Date last reviewed: January 2017

Strategic Objective(s) affected by this risk:

Aim 3: Growing and developing our training and education and delivering a remodelled National Training Contract

INITIAL risk rating (at identification):

Likelihood 4 x Consequence 3   **12**

CURRENT risk rating (after mitigation):

Likelihood 3 x Consequence 3   **9**

Rationale for current score:

The Trust's primary learner group is postgraduate part time students. Although we are operating in a more constrained financial environment with greater demands on staff time within health and care, there has been a significant increase in our recruitment numbers when compared to previous two years. Many legacy issues are now being addressed with implementation of SITS system functionality with recruitment functionality successfully implemented and being adopted.

Controls/Influences (*what are we currently doing about this risk?*):

Student recruitment team more solidly established under leadership of Director of Marketing & Communications.

SITS Release 1 has been implemented on time and provides prospective students with a more responsive system for engagement with enquiries and for applications. Greater capability to identify needed actions to support recruitment.

SITS also provides recruitment team with more responsive data capture and tracking with greater links with faculty.

Recruitment cycle has been launched earlier than last year with the

Assurances received (*independent reports on processes; when; conclusions*):

Recruitment for AY 16/17, while below target, was an increase on AY 15/16 in a constrained and reducing market for postgraduate part-time education (+).

Monthly monitoring reports provided to the Training and Education Programme Management Board and the Board of Directors (+).

Analysis of previous recruitment cycle with specific recommendations for improvements (+).

publication of our Prospectus and our new website providing clearer information and better search functionality for learners.

Development of marketing strategy underway for completion in Dec 2016.

Learning from active review of past year's performance including learner surveys.

Achievement of being able to offer student loans from beginning of the cycle.

Greater responsiveness to application submitted and supporting reference acquisition to make offers earlier in the cycle.

Gaps in controls/influences:
1) Development of new long and short courses to expand portfolio of programmes
2) Technology Enhanced Learning unit is supporting a range of activities in the Trust and is unable to be as singularly focused on new product development
3) Operational / organisational constraints including room availability and staff to deliver expanded training

Action plans in response to gaps identified: (with lead and target date)
1) Portfolio review being led by Associate Dean (AGQA) underway and recruitment review should identify possible provision to address steps into existing programmes (Jan 2017 – Elisa Reyes-Simpson).
2) Review underway with Director of IM&T to address support for AV so that TEL resource can be more focused on expansion (March 2017 – Simon Kear).
3) More timely review of operational constraints being undertaken in a more timely manner linked to accommodation review (March 2017 – Fiona Hartnett).

RISK 5): Adverse impact of National Training Contract changes

Significant changes to HEE funding & focus with active review of our National Training Contract & expected change in its remit & value. Continuing to deliver and develop our existing portfolio alongside the development of new initiatives will be challenging but also presents opportunities.

Risk Owner: Director of Education and Training.	**Date last reviewed:** January 2017

Strategic Objective(s) affected by this risk:

Aim 3: Growing and developing our training and education and delivering a remodelled National Training Contract

INITIAL risk rating (at identification):

Likelihood 3 x Consequence 5   **15**

CURRENT risk rating (after mitigation):

Likelihood 3 x Consequence 5   **15**

Rationale for current score:

National Training Contract is under active review by HEE. Active engagement by Regional DEQs and National Programme Lead for MH and Learning Disabilities.

Controls/Influences *(what are we currently doing about this risk?)*:

Task & Finish group has actively supported development of proposals from three key work streams (portfolio review, educational consultancy, reporting and outcomes).

Engagement of external expert with relevant HEE experience as interim programme manager to support and inform preparation and presentation of proposals. Progress made in establishing national mental health training initiatives. Perinatal programme delivery supportive of future directions.

Assurances received *(independent reports on processes; when; conclusions)*:

Ongoing engagement with key HEE colleagues in an active process including presentation to key stakeholders at HEE (+).

Establishment of joint steering group to oversee the work of the educational consultancy (+).

Transition funding agreed (+).

Gaps in controls/influences:

External review.

Action plans in response to gaps identified: *(with lead and target date)*

Close dialogue with HEE commissioners at different levels and they are actively engaged in this transformation work and close alignment with 5 Year Forward View for Mental Health.

BAF

RISK 6): Loss of workforce engagement and morale

Risk Owner: Chief Executive	Date last reviewed: January 2017

<u>Strategic Objective(s) affected by this risk:</u>
Aim 4: Supporting the wellbeing and engagement of our staff

<u>INITIAL risk rating (at identification):</u>
Likelihood 2 x Consequence 4   **8**

<u>**CURRENT risk rating (after mitigation):**</u>
Likelihood 3 x Consequence 4   **12**

Rationale for current score:
Staff survey consistently shows strong commitment to the Trust and its work.
Evidence form a number of sources indicates growing pressure on staff as resources reduced and workload increases.

Controls/Influences *(what are we currently doing about this risk?)*:
Organisational Development and People Strategy to come to Board in January with important focus on staff engagement and wellbeing.

Continuing programmes of consultation and communication with staff including monthly CE Question Time.

Support development of team managers as a key level for staff support/engagement.

Assurances received *(independent reports on processes; when; conclusions)*:
2016 NHS Staff survey due to be completed by early December will provide important benchmark if state of issues.

Gaps in controls/influences:
Level of external pressure to generate financial savings.
Some particular issues in DET relating to level of change required in wake of external pressures.

Action plans in response to gaps identified: *(with lead and target date)*
OD and People Strategy will include specific recommendations on staff wellbeing and engagement.

New intranet to be launched by the end of the year with aim of improving staff communications.

RISK 7): Loss of workforce skills

Risk Owner: Director of HR

Strategic Objective(s) affected by this risk:
Aim 4: Supporting the wellbeing and engagement of our staff

Rationale for current score:
Skills and experience levels remain high within the organisation, however, there are signs of growing pressure. Results from the annual Staff Survey and from the Friends and Family Test remain generally good.

Controls/Influences *(what are we currently doing about this risk?)*:
Employee engagement and employee satisfaction is assessed annually through national survey and three times a year through the Staff Friends and Family Test. The findings of these surveys and any arising concerns are discussed and addressed with the management team and our trade union colleagues. For example, the helpline for staff to raise concerns helpline has been introduced. We have also implemented a localised action planning process and tasked managers to address hot spots within their directorates.
The current Trust HR Strategy includes a focus on effective partnership working and on exploring options (including flexibilities in pay structure) to attract and retain talented staff.
Up to date employment policies and best practice principles are invoked whilst consulting staff during changes and service re-design, to ensure continuous engagement and foster a sense of fairness and transparency in the process.
The Trust has developed a much more strategic approach to learning and development commissioning. Through the annual appraisal process a comprehensive development programme has been developed and approved by the Staff Training Committee. In addition to this the Trust also continues to make provision for flexible, multi-professional, continuous professional development funding.
The process for succession planning within Directorates is encouraged and a framework will be delivered in 2016/17 to support a consistent

Date last reviewed: January 2017

INITIAL risk rating (at identification):
Likelihood 3 x Consequence 4   **8**

CURRENT risk rating (after mitigation):
Likelihood 2 x Consequence 4   **8**

Assurances received *(independent reports on processes; when; conclusions)*:
Quarterly reports to the Board (+) (-)

BAF

approach.

Organisational values: Our Trust values have been developed and we are now embarking on a process of distilling these and creating a behavioural framework which will be applied to recruitment and appraisal processes.

Job Descriptions: Managers and trade union colleagues are engaged by HR to assess the future skills requirements in job descriptions that cater to the current and future Trust needs.

Gaps in controls/influences:

The current time to hire is higher than other London Trusts.

Increasing levels of sickness absence.

Action plans in response to gaps identified: *(with lead and target date)*

The Strategic HR Business Plan sets out a number of activities to improve our recruitment and transactional process.

The plan also sets out a number of organisational development interventions which will seek to increase management and leadership capability.

RISK 8): Unable to agree or fund relocation / redevelopment plans.

Risk Owner: Deputy Chief Executive	Date last reviewed: January 2017

Strategic Objectives affected by this risk:

Aim 7. Develop our infrastructure to support our work

INITIAL risk rating (at identification):

Likelihood 3 x Consequence 4 `12`

CURRENT risk rating (after mitigation):

Likelihood 3 x Consequence 4 `12`

Rationale for current score:

Cost of maintaining existing buildings places stress on profitability and will require disposal of assets. Alternative of Relocation also requires disposals. In terms of finances and degree of disruption, Relocation is better, whilst also providing better quality of accommodation and producing (potentially) additional space. In terms of the management challenge, not Relocating is probably slightly easier.

Controls/Influences *(what are we currently doing about this risk?)*:

Outline Business Case approved by the Board September 2015; approved by Council of Governors; and reviewed by Monitor.

Updated options appraisal undertaken in December 2016 which,

Assurances received *(independent reports on processes; when; conclusions)*:

Baker Tilly engaged to support production of the Outline Business Case, which ensured compliance with the Green Book issued by HM Treasury (+).

December 2016 report by Capita on costs of remaining together with

BAF

broadly, confirms original decision by the Board. Confirmation (or otherwise) of decision being taken to January Board and meeting of the Council of Governors

Gaps in controls/influences:
Future movements in property values (for both sale and purchase) uncertain
Spending Review has reduced overall NHS capital funding

updated valuations on potential asset disposals(+).
Updated conversations with Camden Council. (+)

Action plans in response to gaps identified: *(with lead and target date)*
Revised decision by the Board on 30 January and by the Council on 2 February 2017 to confirm / revise Relocation decision

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RISK 9): IT applications and hardware do not sufficiently support Trust objectives. Loss of access to critical systems

Risk Owner: Director of IM&T	Date last reviewed: January 2017

Strategic Objectives affected by this risk:
Aim 7: Develop our infrastructure to support our work

INITIAL risk rating (at identification):
Likelihood 3 x Consequence 4   **12**
CURRENT risk rating (after mitigation):
Likelihood 3 x Consequence 4   **12**

Rationale for current score:
IM&T strategy and plan agreed however implementation is only just commencing. Capacity and Capability review nearing completion will help the Trust understand our ability to deliver the remedial project work.

Controls/Influences *(what are we currently doing about this risk?):*
CareNotes Optimisation Work is nearing completion with positive feedback on improved reliability and performance. However some problems remain, particularly on remote sites, for us to address. These will be addressed in the main through the Network Replacement Project.

Network Replacement Project initiated with procurement specification in draft for issue in December. Procurement includes network replacement, network security and ongoing support contract that will collectively increase uptime and performance of network. Implementation expected in Q4 2016/17.

Assurances received *(independent reports on processes; when; conclusions):*
Capacity and Capability Review of IMT being undertaken which will confirm our ability to both operate IMT services in this area and to deliver the projects that will address this risk.

Improvements to electrical provision and security and physical environment for network cabinets has been started with levels 1, 3 and 4 complete. Rest to complete in Q3 2016/17. Gaps in controls/influences: Significant downtime over the summer has highlighted the fragility of the network and confirmed there are no opportunities for interim controls before the network replacement.	Action plans in response to gaps identified: (*with lead and target date*) Network replacement in procurement in Q3 2016/17 and implemented in Q4 2016/17. Action plans for security and continuity are being implemented alongside this. (DWL) New student records system in implementation during 2016/17. Email system replacement is underway with Phase 1 (upgrade to modern platform hosted onsite) and Phase 2 (move to Office365 Cloud) due in Q3 through to Q4 and Phase 3 (secure send of patient data without NHSMail) due in Q4.

RISK 10): Insufficient management capacity

Risk Owner: Chief Executive

Date last reviewed: January 2017

Strategic Objective(s) affected by this risk:

ALL

INITIAL risk rating (at identification):

Likelihood 3 x Consequence 4 `12`

CURRENT risk rating (after mitigation):

Likelihood 4 x Consequence 4 `16`

Rationale for current score:

As a small and diverse Trust management resources are spread thinly.

Need to support growth alongside savings agenda. Considerable growth in external pressure from STP and regulators.

Controls/Influences *(what are we currently doing about this risk?)*:

Use strategic plan to focus priorities and manage trade-offs.

Review opportunities to share resources across organisation through the Mental Health Alliance and National Mental Health Training Hub.

Assurances received *(independent reports on processes; when; conclusions)*:

Quarterly review of progress against strategy objectives by the Strategic and Commercial Committee (+)

Gaps in controls/influences

Uncertainty of external environment and impact on internal capacity.

Action plans in response to gaps identified: *(with lead and target date)*

Continue to use strategic plan on a quarterly basis to review pressures and resolve tensions over priorities. Develop opportunities to share resources through the Mental Health Alliance.

BAF

RISK 11): Damage to the Trust's reputation and brand.

Risk Owner: Chief Executive	Date last reviewed: January 2017

Strategic Objectives affected by this risk:

Aim 6: Raising the Trust's profile and its contribution to public debate and discourse

INITIAL risk rating (at identification):

Likelihood 2 x Consequence 4 `8`

CURRENT risk rating (after mitigation):

Likelihood 2 x Consequence 4 `8`

Rationale for current score:

Generally positive reputation in wider mental health world. Positive impact of Kids on the Edge.

Controls/Influences *(what are we currently doing about this risk?)*:

Communications and marketing team strengthened

Focus in strategic plan on building profile, developing links with alumni and developing thought leadership

Public Affairs Strategy

Assurances received *(independent reports on processes; when; conclusions)*:

Media monitoring (+)

Communications team fully staffed (+)

Gaps in controls/influences:

Change in external environment

Action plans in response to gaps identified: *(with lead and target date)*

Public Affairs Strategy due to the Board in February 2017.

Follow up to Century Films

RISK 12): Regulatory failure.

Risk Owner: Chief Executive	Date last reviewed: January 2017
Strategic Objectives affected by this risk: Aim 2: Maintaining and developing the quality and reach of our clinical services	**INITIAL risk rating (at identification):** Likelihood 1 x Consequence 5 <mark style="background:yellow">**5**</mark> **CURRENT risk rating (after mitigation):** Likelihood 1 x Consequence 4 <mark style="background:lime">**4**</mark>
Rationale for current score: Strong current performance but needs to keep under review. Positive rating for CQC and QAA in the last year. Currently in top rating for NHS Improvement	
Controls/Influences *(what are we currently doing about this risk?)*: Range of governance processes in place. CQC Good rating with positive reinspection report published in February with Trust now good in all domains QAA Fully meet UK requirement Trust in receipt of rating of 1 for NHS Improvement Single Oversight Framework	**Assurances received** *(independent reports on processes; when; conclusions)*: CQC rating (+) QAA rating (+) Clean external audit opinion, May 2016 (+) NHS Improvement Single oversight framework (+)
Gaps in controls/influences: Ongoing pressure for efficiency savings impact on management capacity.	**Action plans in response to gaps identified:** *(with lead and target date)* CQC action plan agreed and being implemented. QAA action plan developed and being implemented.

BAF

RISK 13): Savings and growth contribution insufficient.

Risk Owner: Deputy Chief Executive	Date last reviewed: January 2017

Strategic Objectives affected by this risk:
Aim 5. Delivering a sustainable financial future for the Trust

INITIAL risk rating (at identification):
Likelihood 4 x Consequence 4 — **16**

CURRENT risk rating (after mitigation):
Likelihood 3 x Consequence 4 — **12**

Rationale for current score: It is likely required savings and growth targets will be met for 2017/18. Whilst not all efficiencies have yet been identified, it is probable that the current gap of around £500k will be filled, if not by the start of the financial year then certainly by its conclusion. The major risk relates to 2018/19, where achievability of the Control Target is currently less certain and not yet supported by detailed delivery plans

Controls/Influences *(what are we currently doing about this risk?)*:
Active and regular Executive Management Team consideration of the issues (including monthly management accounts)

Projections and targets (including Directorate-specific plans) for 2017-18 partly agreed. Growth targets and action plans reviewed regularly by Strategic and Commercial Committee (SCC), Trust Board and Training programme Board

Assurances received *(independent reports on processes; when; conclusions)*:
2017/18 and 2018/19 Operating / Financial Plans submitted to NHSI. Feedback on initial submission positive. Feedback on final submission awaited (+)
Initial Directorate Plans in place (+)

Gaps in controls/influences:
Directorate targets need to be agreed for 2017/18 and 2018/19
Challenge of delivering on new National Training Contract

Action plans in response to gaps identified: *(with lead and target date)*
Savings / growth targets for 2017/18 supported by Directorate plans to be agreed by no later than 31/3/17 (PJ/JS/TN/BR)
Delivery of targets monitored on a month by month basis
DET commercial strategy to be completed by 28/2/17 (JS/TN/BR). Pt services commercial strategy refresh 31/3/17 (JS/SH/Jst)

Board of Directors: February 2017

Item : 11

Title : Refresh of Mission and Values Statement

Summary:

Following consultation with the Council of Governors and staff this paper seeks the agreement of the Board of Directors to our refreshed Mission and Values statement.

For : Approval

From : Chief Executive

Misson & Values

<u>Refreshing our statement of Mission and Values</u>

1.   Introduction

1.1   At its meeting in November 2016 the Board of Directors considered a refreshed draft statement of Mission and Values for the Trust.   This reflected discussions with the Council of Governors where a number of Governors had raised concerns that the previous version did not sufficiently describe the unique identity of the Trust.

1.2   We agreed to respond to these concerns and refresh the statement in a way which addressed this point while also describing our desire to make our work relevant to contemporary challenges and issues in health and care.

1.3   Following consideration of the revised statement by the Board of Directors we have discussed it with the Council of Governors at its meeting on 1st December. Subject to some small proposed amendments the revised document was supported and felt to address the issues raised by Governors.

1.4   We have subsequently consulted with staff on the proposed statement. The proposed changes have, again, been welcomed. Staff suggested a number of small drafting changes which have been incorporated in the revised version.

2   Recommendation

2.1   The Board of Directors are invited to:

- Agree the revised statement of mission and values set out at **Annex A.**

Paul Jenkins
Chief Executive
February 2017

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Annex A

Tavistock and Portman NHS Foundation Trust - Statement of Mission and Values

Mission

For almost 100 years, the Tavistock and Portman clinics have embodied a distinctive way of thinking about and understanding mental distress, mental health and emotional wellbeing. Working with children and families and adults our approach brings together psychoanalytic, psychodynamic and systemic theory and practice and other approaches and seeks to understand the unconscious as well as conscious aspects of a person's experience and places the person, their relationships and social context at the centre of our practice.

Our creative and skilled staff continue to build on these approaches, welcoming new ideas and developing innovative interventions, services and models of care which respond to contemporary challenges.

Our goal is that more people should have the opportunity to benefit from our approach. We seek to spread our thinking and practice through devising and delivering high quality clinical services, the provision of training and education, research, organisational consulting and influencing public debate.

Aims

The Tavistock and Portman will:

- Continue to deliver and develop high quality and high impact patient services.

- Offer training and education which meets the evolving needs of individuals and employers and helps transform the workforce in health, care and other sectors.

- Develop its presence as a centre of excellence in research.

- Lead the development and evaluation of new models of care and innovative approaches to addressing systemic issues in the delivery of care and other services.

- Use its insights and expertise to contribute to the development of national debate and public policy.

Misson & Values

Values

As an organisation:

- We work with people with lived experience of mental distress to co-create and improve our services and inform our decision making.

- We are caring and compassionate.

- We are passionate about the quality of our work and committed to openness, the use of evidence and the application of improvement science.

- We value all our staff, are concerned for their wellbeing and seek to foster leadership, innovation and excellence in our workforce.

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

- We work with others, in the UK and internationally, who share our values and can enable us to achieve our mission.

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

Board of Directors : February 2017

Item : 12

Title : Finance And Performance Report
Period ended January 2017

Summary:

Year To Date	
Surplus	GREEN
Cash flow	GREEN
Supplier payments	AMBER
Agency spend	AMBER
SOF rating for Finance and Resources	GREEN
Full Year Forecast	
Surplus	GREEN
Cash flow	GREEN
Agency spend	AMBER
SOF rating for Finance and Resources	GREEN
Vacancies	

For : Discussion

From : Carl Doherty, Deputy Director of Finance

FINANCE AND PERFORMANCE REPORT

1. OVERVIEW

Year To Date

1.1. YTD surplus, at £1m is £0.1m favourable to Budget.

Full Year Forecast

1.2. The current FYF is showing net surplus of £810k, £10k favourable to the Budget and agreed NHSI Control Total.

Use of Resources / Single Oversight Framework ("SOF")

1.3. The new SOF has five reportable metrics for finance. Currently, one of these 5 metrics is forecast to show as '2', being agency costs. Agency costs are discussed below in 5.10. Notwithstanding this, our overall rating is still expected to be a 1.

2. INCOME AND EXPENDITURE: 10 MONTHS ENDED JANUARY 2017

Summary

2.1. After ten months, the Year To Date ("YTD") surplus is ahead of Budget by £135k.

£'000	YTD Bud	YTD Act	YTD Var
Income	40,897	40,470	(427)
Staff costs	(28,084)	(26,974)	1,110
Non-staff costs	(10,851)	(11,302)	(451)
Expenditure	(38,936)	(38,276)	660
EBITDA	1,961	2,194	232
Margin	4.8%	5.4%	
Interest receivable	7	9	2
Depreciation / Amortisation	(654)	(613)	42
Dividend	(483)	(483)	-
Surplus before restructuring costs	831	1,107	276
Restructuring costs	-	(141)	(141)
Net surplus	831	966	135
Margin	2.0%	2.4%	

EBITDA – Earnings before interest, tax, depreciation and amortisation

Agency Costs	607	623
Percentage variance against Cap		3%
Staff numbers (WTE)	620	598

2.2. Although income is 1% adverse to Budget, operating costs are 2% favourable to Budget, resulting in an overall net over performance.

2.3. The rating of the Finance and Resources element of the Single Oversight Framework ("SOF") for January was submitted on 15 February with a Use of Resources metric of 1, which is the best possible rating.

Income

2.4. The adverse performance against Budget is due, primarily, to income shortfalls in the Education Portfolio, Tavistock Consulting and Adult & Forensic Services ("AFS").

2.5. Education income is down as student recruitment did not meet the, in retrospect, over ambitious target and this trend will continue through the remainder of the year.

2.6. AFS income is down primarily due to a shortfall on named patient agreements and miscellaneous other income being short.

Expenditure

2.7. YTD operational expenditure is favourable to Budget due, primarily, to under spends in staffing in AFS, Tavistock Consulting and the Education Portfolio (as a result of lower income). The under spend in GIDS staffing has been largely accounted for in the cost of office refurbishment (and associated) costs required to house the new GIDS team.

2.8. There are over spends in Estates and visiting lecturers ("VLs").

2.9. Estates overspend reflects the Relocation Project, for which there was not a revenue budget.

2.10. YTD agency staff costs are 3% adverse to the Trust's agency cap.

3. FULL YEAR OUTLOOK – 2016/17

3.1. The Trust expects to meet its control total with a Budget Full Year Forecast surplus of £810k for the year.

3.2. The current full year forecast out-turn shows the Trust achieving £10k above its Budget net surplus (of £800k). Continued prudent management of expenditure must be maintained to achieve this.

3.3. Income is forecast to be 0.4% adverse to Budget, that is, by £190k. The main areas of over / (under) performance are those noted in 2.4 – 2.6 above. Full year operational expenditure is forecast to be £421k favourable to Budget due, primarily, to the under / (over) spends identified in 2.7 – 2.9 above.

3.4. The forecast assumes agency expenditure of £803k (versus a cap of £728k), a variance of 10%.

3.5. Restructuring costs are expected to increase to at least £259k from £141k at month 10.

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£'000	YTD Bud	YTD Act	YTD Var
Income	48,518	48,328	(190)
Staff costs	(33,761)	(32,258)	1,503
Non-staff costs	(12,604)	(13,686)	(1,081)
Expenditure	(46,365)	(45,944)	421
EBITDA	2,153	2,384	231
Margin	4.44%	4.93%	
Interest receivable	8	10	2
Depreciation / Amortisation	(781)	(746)	35
Dividend	(580)	(580)	0
Surplus before restructuring costs	800	1,069	269
Restructuring costs	0	(259)	(259)
Net surplus	800	810	10
Margin	1.65%	1.68%	

EBITDA – Earnings before interest, tax, depreciation and amortisation

Agency costs	803
Percentage variance against Cap of £728k	10.3%

4. CASH FLOW AND CAPITAL EXPENDITURE

4.1. As at 31 January 2017, the Trust had cash balances of £5.8m. This is £1m favourable to Budget primarily due to the quarterly payment in advance of the national training contract.

Capital Expenditure

4.2. The 2016/17 Budget for capital expenditure was £2.5m, including £1.1m on the Relocation Project and £1.4m on other items.

4.3. As at the end of January, capital expenditure was £0.8m and is forecast to be £1.2m by the end of the financial year. None of this expenditure relates to the Relocation Project.

5. BETTER PAYMENT PRACTICE CODE

5.1. The Trust has a target of 95% of invoices being paid within the agreed terms.

	YTD Actual	Target
Number of invoices	90%	95%
Value of invoices	93%	95%

5.2. In line with previous Board discussions, this performance is considered to be satisfactory.

Carl Doherty
Deputy Director of Finance
20 February 2017

Finance & Performance Report

Board of Directors : February 2017

Item : 13

Title : Clinical, Quality, Safety and Governance Committee Board Report

Summary:

This paper has been prepared to provide the Board with assurance of achievements and progress towards meeting the Directorate and Trust wide objectives of the Clinical Quality, Governance and Safety Committee.

The report was reviewed by the Management Team on the 14th February.

For : Information

From : Medical Director

CQSGC MINUTES FROM A MEETING
HELD AT 11:00, TUESDAY 7th February 2017, BOARDROOM

Members	Present?
Rob Senior, Medical Director (& CQSGC Chair) (RS)	Y
Paul Jenkins, Chief Executive (PJ)	Y
Paul Burstow, Trust Chair – Non-Executive Ex-officio (PB)	Y
George Wilkinson, Public Governor (GW)	Y
Anthony Levy, Public Governor (AL)	Y
Jane Gizbert, Non-Executive Director	N
Edna Murphy, Non-Executive Director (EM)	N
Dinesh Bhugra, Non-Executive Director (DB)	N
Terry Noys, Deputy Chief Executive and Finance Director & SIRO (TN)	Y
David Wyndham Lewis, Director of IMT (in part)	Y
Caroline McKenna, Associate Medical Director (CMK)	Y
Louise Lyon, Director of Quality and Patient Experience (LL)	Y
Liz Searle, Consultant Psychiatrist, deputising for Sally Hodges, CYAF Director (LS)	Y
Julian Stern, Director (CQC) of Adult and Forensic Services (JS)	Y
Marion Shipman, Associate Director Quality and Governance (MS)	Y
Elisa Reyes Simpson, Associate Dean for Academic Governance and Quality Assurance (ERS)	N
Irene Henderson, Clinical Governance & Quality Manager & CQSGC Secretary (IH)	Y

		SUMMARY OF ACTION POINTS		
AP	Item	Action	By	Deadline
4	M/A	MS agreed to seek assurance from Paul Waterman that the Trust is fully compliant in relation to legionella precautions.	**MS**	Complete
6		There was also a discussion around the possible under reporting in the CYAF against the national figures and CMK agreed to audit this area to interrogate whether patients felt sufficiently supported to make a comment or complaint or even to provide feedback.	**CMK**	02/05/2017
6		Health Service Ombudsman recommended that clinical trainees should make detailed clinical notes in the EPR. CMK confirmed she is taking this forward with teams across the Trust to ensure all clinical trainees are aware of what's required in terms of recording patient information accurately and timely.	**CMK**	02/05/2017
7	a	PB asked if the lack of uptake for the flu vaccination has had any impact on Q3 sickness returns among staff. LL agreed to check with the HR director, staff sickness rates during the season flu	**LL**	02/05/2017

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		period.		
7	a	It was also noted that the Trust must ensure staff working off site have access to the vaccination. MS agreed to check the cohort of staff requiring the vaccination for next year's CQUIN and also to ensure staff working remotely are included in the cohort and have the service easily available to them.	**MS**	02/05/2017
7	b	LL also noted that there is increased emphasis on the well led domain. MS agreed to produce using a simple dashboard to show the high level rag rating for each domain.	**MS**	02/05/2017
8		MS confirmed she would seek assurance from Brian Rock in the Department of Education and Craig de Souza in HR that the risk of our tier 4 sponsorship status is being managed sufficiently.	**MS**	Complete

AP	Item		Action
1		**Chair's opening remarks** RS confirmed there are now three NEDs on the CQSGC membership and that the workstream reports being considered today were covering Q3 2016-17.	
2		**Apologies for Absence** Dinesh Bhugra, Edna Murphy, Jane Gizbert, Sally Hodges and Elisa Reyes-Simpson.	
3		**Notes from last meeting** The previous minutes were accepted as an accurate account of the last meeting with the following amendment to the Corporate Governance & Risk Workstream Report on page 11 to read: • NHS Improvement – there is a risk to our green rating if we continue to overspend on our Agency Cap.	
4		**Matters Arising** AL noted that the December 2016 Capita Report was predominantly looking at estates management especially in relation to Legionella. As an issue of governance he requested assurance that although the risk of legionella may be low here that it is still being managed. LL confirmed this was included in our CQC action plan. MS agreed to seek assurance from Paul Waterman that the Trust is fully compliant in relation to legionella precautions.	**MS**

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		REPORTS FROM WORK STREAM LEADS	
5		**Information Governance** *Terry Noys, Senior Information Risk Owner (SIRO)* DWL presented the IG report noting that although we were still rated red in Q3, much of the work has already been put in place to provide evidence and take this rating to Green for both Q3 and Q4. DWL confirmed that we will also be compliant for the secondary data assurances as meetings have been put in place and the minutes produced will provide the required evidence to achieve level 3. DWL highlighted two points in the report: • **Trainees taking patient sessions' recordings off site** DWL confirmed there was now a policy in place so trainees are aware that this is not acceptable but added for the next financial year further controls will be applied to ensure the data is fully encrypted prior to leaving the Trust. • **Data loss protection** DWL confirmed there have been challenges with the data leak software in relation to interdependencies with existing technology but confirmed that there is now a policy in place and that going forward a further technical mechanism will be in place to provide oversight. RS asked if the Trust does any form of self-assessment in relation to meeting these standards and DWL confirmed that we do self-assess our systems and that Jonathan McKee also bench marks us with other Trusts. RS asked whether this committee should be concerned in relation to the acquisition of the AGIC service and DWL confirmed: • We are ensuring all staff have undergone their mandatory IG training • There are probably going to be issues in relation to data migration and we will assess those when we have actually migrated the data. PB asked if there were issues in relation to scanning the paper records and how the paper based information on file would be stored/used in relation to Carenotes. DWL confirmed the plan is to migrate data from EPR to EPR which covers demographics and appointment information. Other areas of the patient file will be scanned as required, two weeks prior to a patient's appointment. RS also confirmed he was working with SH and LL to think this through further as time is so short. MS gave clarification that projects would not be added to the risk register unless they have a negative impact on the corporation, on the Trust strategy or are considered mission critical. These projects would go on a new Projects Risk Register. RS congratulated the team on moving their rating on from red to the predicted green for Q4 which was accepted by the committee.	
6		**Patient Safety and Clinical Risk (Sign Up to Safety Plan)**	

Caroline McKenna, Patient Safety and Clinical Risk Lead

CMK confirmed that the Board has now agreed the Sign Up to Safety plan and highlighted the following six areas of her report:

- **CQC Inspection**
  CMK reported that the further CQC inspection carried out at the end of Q3 had reversed our safety rating to GOOD, which was welcomed by the committee. LL also noted that the CQC have confirmed that our current rating will not be affected by the addition of the new AGIC service but that the Trust must remain in a state of readiness for further inspections and the focus may well be on the well led element of the KLOE.

- **Serious Incidents**
  CMK confirmed the two serious incidents reported did not involve a death, however, one was a young person who took an overdose and the other was in relation to an 11 year old child being held in police custody for an extended period whilst they looked to secure accommodation for her. Both cases are under internal investigation and NHS England has also launched an investigation regarding the 11 year old in police custody.

- **Incident Recording/Reporting**
  CMK confirmed there has been a sharp rise in the reporting of incidents, mostly in relation to Gloucester House pupils and violence against staff. CMK confirmed the increase in Q3 was predominantly for absconders, which again was mostly due to two specific pupils who have since both left. PJ noted that remedial building security work is being carried out at Gloucester House to address pupils absconding. There was some discussion around the paper based system at Gloucester House and whether the way incidents are now recorded had increased the reported numbers and CMK confirmed the system has been tightened up to receive incident reports in a more timely manner. There was also a discussion around the possible under reporting in the CYAF against the national figures and CMK agreed to audit this area to interrogate weather patients felt sufficiently supported to make a comment or complaint or even to provide feedback. RS suggested a dashboard be introduced to show trends and PJ agreed this would be the correct committee to review this information.

  CMK

- **Complaints**
  CMK confirmed that the Health Service Ombudsman were deciding on whether to fully investigate the three complaints referred to them, but in the interim they made a recommendation that clinical trainees should make detailed clinical notes in the EPR. CMK confirmed she is taking this forward with teams across the Trust to ensure all clinical trainees are aware of what's required in terms of recording accurate, timely patient information.

  CMK

- **Sign Up To Safety 2016-19**
  CMK confirmed that the Sign up to Safety plan has been approved by the

	Board and drew the committee attention to one of the key priorities; suicide prevention. CMK has now cascaded the relevant information across the Trust for dissemination to all clinical teams. • **Safeguarding Children** CMK confirmed there has been an increase in reported safeguarding alerts from 7 to 53. CMK met with the Sonia Appleby, children's safeguarding lead, who confirmed that it is a good sign that the Trust has a low threshold for reporting and confirmed that we are now working well with the local authority and receiving regular monthly updates on child protection status cases ensuring we have more timely and accurate information. RS confirmed that this is monitored via the Children's and Adults at Risk Safeguarding Committee. The committee accepted the assurance rating as Green for Q3 and Q4.	
7a	**Clinical Quality and Patient Experience** *Louise Lyon, Director of Quality* LL introduced her report highlighting the following five areas: • The completion rates for the physical health form have now exceeded the CQUIN requirement which is excellent. • Implementation of the Living Well Programme has highlighted some problems but the programme is being reviewed to find the best way to incorporate physical health with mental health. LL also confirmed a new CQUIN is due which promises room for innovation in its delivery. • The flu vaccination programme again had limited uptake so it has been decided to check the cohort of staff required to have the vaccination, e.g. all front facing staff, but it was also noted that all staff can attend the common facilities such as the café, so we should ensure as many staff are included in the cohort as possible. It was also noted that some staff have the vaccination at their GP surgery and we don't yet have a way of capturing that information. PB asked if the lack of uptake for the flu vaccination has had any impact on Q3 sickness returns among staff. LL agreed to check with the HR director, staff sickness rates during the season flu period, with the caveat that we don't log staff's reason for being off sick so it may be difficult to attribute sickness absence directly to flu sufferers. It was also noted that the Trust must ensure staff working off site have access to the vaccination. MS agreed to check the cohort of staff requiring the vaccination for next year's CQUIN and also to ensure staff working remotely are included in the cohort and have the service easily available to them. • LL stated that the lack of a clinical audit officer has negatively impacted on areas of work within this and other work streams. CMK explained that the previous staff member had resigned unexpectedly due to personal circumstances and that had left us with a four month backlog of work. IH updated that we now have a temp in place and hope to make a	 LL MS

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7b	permanent appointment as soon as possible.	

- LL informed the committee that a new piece of work is underway to "reduce the burden" on clinical staff in terms of their use of Carenotes. LL has tasked the CYAF and AFS clinical governance leads to ensure that we look into all areas of data capture on Carenotes and ensure it is as streamlined as possible for clinical use. There should be a firm plan in place to action this by the financial year.

LL confirmed she is recommending an amber rating for Q3 with a predicted rating of Green for Q4. The committee accepted this assurance.

CQC Action Plan Update

LL noted that we have done very well completing the action points so far and AL commented that this was a great achievement to date, but that the momentum to complete all areas of the plan must be maintained. PB accepted this and acknowledged the achievement was due to an exceptional input from staff but reminded the committee that in order to make a sustainable change, we will need to

LL confirmed this is the final time the CQC action plan will be looked at separately and in future all outstanding actions from the plan will be included in the relevant work streams for quarterly monitoring. PJ asked if we could also begin to look at a cultural change within the Trust and how this could be shown and monitored. LL confirmed that a cultural change could be achieved via the implementation of the KLOEs which are encompassed in each of the work streams as follows:

CARING, RESPONSIVE and EFFECTIVE	Clinical Quality & Patient Experience Work Stream
SAFETY	Patient Safety & Clinical Risk Work Stream
WELL LED	Clinical Quality Safety & Governance Committee

LL also noted that there is increased emphasis on the well led domain.
MS agreed to produce a simple dashboard to show the high level rag rating for each domain.

MS

| **8** | **Corporate Governance and Risk**
Marion Shipman, Associate Director of Quality and Governance

MS introduced her paper with an overall rating of amber for Q3 and confirmed there was nothing specific to highlight to the committee but confirmed that the performance rating on agency spend is predicted to be rated as green at the end of Q4 as they have a plan in place to reduce the spend.

There was some discussion around the Single Oversight Framework (SOF) and it was agreed this committee should retain that oversight with clear plans in place | |

		going forward. PJ agreed to confirm this in his next meeting with NHS England.	
		PB asked if the tier 4 sponsorship status was at risk of increasing and PJ requested an overall look at the full picture including the background and current issues in relation to students at the Trust. MS confirmed she would seek assurance from Brian Rock in the Department of Education and Craig de Souza in HR that the risk is being managed sufficiently.	**MS**
		The committee accepted an amber rating for Q3 with a predicted rating of green for Q4.	
9		**Any Other Business**	
		PJ noted that there was now an increased focus in the area of Well Led and there was a discussion about what could be considered further and where best it should sit to give us capacity to reflect on our issues and also retain oversight of all action points.	
		RS & PJ agreed this committee was a key meeting as part of our reflections and PJ noted the CQSGC is now running more smoothly, and although we cannot be complacent it is encouraging to know we are moving in the right direction. RS closed the meeting.	
10		**Notice of future meetings:** 11am, 2nd May 2017 New dates to be agreed to replace the below meetings: 11am, 5th September 2017 replaced by …………………………………. 11am, 7th November 2017 replaced by ………………………………….	

Board of Directors : 28th February 2017

Item : 14

Title : Physical Health Update

Summary:

In the past year we have developed a physical health programme and direct clinical service to improve the health of our patients, carers and staff.

The Trust signed up to two CQUINs for 2016/17 relevant to health and wellbeing: Living Well Programme and Staff Health and Wellbeing. In addition there was a contract performance metric around documenting smoking cessation and offering intervention e.g. brief advice. Physical Healthcare is also one of our Sign up to Safety goals.

Compliance against CQUIN metrics (London contracts) has been good with all targets met up to the end of Q3. The challenge will be for completion of the Physical Health Form (PHF) in Q4 which has an increased target from 60% to 70%.

The physical health key performance target (patients aged 14+) for recording smoking status has not been met the target of 80%. Details are within the report.

The physical health work undertaken over the past year is just the beginning; we have made a good start, learned a lot about delivering a physical health programme and increasing patient, user and staff knowledge about physical health issues. We have developed an increased awareness of the importance of physical health across the Trust and will work with clinicians to further develop and embed a culture of integrated physical and mental health and wellbeing across the Trust.

The Trust has signed up to developing the Living Well and Staff Health and Wellbeing CQUINs over 2017-19 and the recently updated Smoke Free Policy will help support this work.

 This report has been reviewed by the following Committees:

* EMT, (14th February 2017)

Physical Health

Page 1 of 10

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

For : Discussion

From: Tim Quinn, Physical Health Specialist Nurse
Marion Shipman, Associate Director Quality and Governance

1. **Introduction**

We understand that good mental health is associated with good physical health and there is evidence that links the two. Current Public health messages and evidence relate to four central health and wellbeing goals: Smoking, alcohol consumption, healthy diet/weight management, and managing stress. We believe physical health should be included within the holistic management of patients at the Tavistock and Portman NHS Foundation Trust. During the year we have set out to provide a collaborative evidence -based service designed in response to patient's, carers and our staff in order to help improve their physical health and wellbeing.

A structure to support the delivery of physical health work across the organisation was set up during 2016/17 which will need developing. This includes two physical health clinical leads, one for CYAF and one for AF services. A Physical Health Specialist Nurse appointed on 2 days per week to lead on developing and delivering the Living Well Programme. Service level physical health champions were sought in-year and these currently number six.

Over the year 2016 -17, we have been delivering a programme of initiatives related to improving physical health and wellbeing across both user, carer and staff groups, guided by the Public Health agenda for England.

1.1 Developing Our Approach

The last year has given us the opportunity to develop our approach and start to learn what works well and less well for our patients, carers and staff. We have made good progress in implementing physical health assessments and are seeing a growing number of referrals to our Physical Health Specialist Nurse, but there are lessons to be learned in terms of the most effective ways of supporting our vision for a holistic approach.

Providing a programme of lectures for example, however individually excellent, is unlikely to engage effectively with staff unless it is more closely linked to clinical work and the concerns of our patients and carers. For effective engagement and progress in these domains we need an approach which places at its centre the twin elements of the psychological meaning of attending to physical health and the impact of physical well-being on mental health. 'Top down' approaches alone are unlikely to be effective in this sensitive and complex area where a first step to physical well-being may be a patient's developing sense of self-worth. Awareness of the interrelationship of the mental and physical is highly congruent with our main clinical approaches. Further progress may best be achieved through providing relevant training, interventions and information to address concerns as they arise from acknowledging the difficulties with which patients, carers and staff are struggling.

We need also to make best use of the resources available in our staff group, for example within the nursing discipline, to help support the multidisciplinary team develop its capacity.

1.2 <u>What We Did In Brief</u>

- In consultation with users, carers and staff we designed and delivered a six-week Living Well Programme to improve patient and carer physical health and wellbeing.
- We established use of physical health assessments for all clients aged 14 and over and a referral process from across the trust to the Physical Health Specialist Nurse to provide a one to one physical health service to clients with problems relating to: smoking, alcohol, diet and exercise, stress, sleep disturbance and substance misuse. This service has also been available to staff.
- We undertook to increase staff knowledge of physical health matters in running a 'Mind-body Lecture Series' and making Very Brief Advice (VBA) training available for staff.
- We have recruited service level physical health champions to help support this work
- We have gathered physical health resources which will be available on the Trust internet and intranet.
- We established weekly staff mindfulness sessions

2. Delivery and Outcomes

2.1 Living Well Programme

The Living Well programme was designed as a six week programme with the aim to cover a key topic at each session: alcohol, smoking, healthy nutrition, exercise, weight management and managing stress. Two adult patients attended consistently throughout the process with positive feedback about impact on their health.

> (1) 'the group really helped me to reduce my alcohol use and my blood pressure went down. Now I can do more at the gym and eat healthier.' JL

> (2) 'by closing my kitchen/bar earlier and developing new strategies for coping with stress, I reduced my alcohol use and my sleep pattern improved.' VT

There were no attendees at the adolescent 'drop in' sessions.

2.2 Physical Health Assessments

The CareNotes Physical Health Form (PHF) for all patients 14+ years allows for smoking and alcohol screening and referral of clients to the Physical Health Specialist Nurse. Targets set by commissioners for completion of the forms for all new patients from 1 April 2016 were met for all three quarters. The quarter 4 target will be harder to meet.

PHYSICAL HEALTH FORM COMPLETION	
	Data run 23 Jan 2017
Q1 (Target 35%)	42.20%
Q2 (Target 45%)	52.00%
Q3 (Target 60%)	60.00%
Q4 (Target 70%)	

2.3 Recording Smoking Status

One of the Trust key performance indicators for this year relates to the recording of smoking status with an 80% target. This information is collected from both the Physical Health Form and also the Social Inclusion Start Form. Data relates to London contracts only.

Target >80% Smoking Assessment for patients 14+	Q1	Q2	Q3	Q4 (Report run 9.2.17)
Adolescent	81%	89%	95%	47%
Adults	52%	79%	50%	47%
Camden CAMHS	72%	69%	50%	36%

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City and Hackney	84%	81%	83%	59%
Other CAMHS	37%	39%	41%	13%
Portman	65%	38%	22%	0%
Total	63%	62%	53%	40%

Monthly team level physical health and smoking information will be provided from February to raise the profile of physical health with staff.

2.4   One to one Referrals

The activity table below gives a flavour of the service provided in response to a range of physical health issues referred to the Physical Health Specialist Nurse for quarter 3.

2016-17¤	Alcohol¤	Alcohol & Drugs ¤	Drugs¤	Smoking¤	Smoking & Alcohol¤	Smoking & Drugs¤	Smoking, Alcohol & Drugs¤	Total¤	Quarterly Total¤	¤
October¤	3¤	°¤	°¤	°1¤	°¤	°¤	°¤	4¤	°¤	¤
November¤	7¤	°¤	1¤	8¤	°¤	°¤	°¤	16¤	°¤	¤
December¤	3¤	°¤	°¤	°1¤	1°¤	2°¤	°¤	7¤	¤	¤
Total¤	13¤	¤	1¤	9¤	1¤	1¤	¤	27¤	27¤	¤

2.5   Physical Health Awareness Raising

- We have developed staff skills in giving Very Brief Advice (to smokers).
- In partnership with UCL Partners Breaking Down the Barriers, we provided a 'Mind and Body Lecture Service' for all Trust clinicians. Lectures covered physical health awareness training, diabetes and smoking and were delivered by external experts. There was generally poor attendance and whilst the discussions were excellent, with the exception of the diabetes lecture, information had not been tailored enough to the Tavistock patient population.
- We are developing the Trust intranet and website physical health information for users and staff.
- Service level physical health champions self- nominated. Currently there are some services without a lead in this 'role'. The Champions were involved in consultation about Trust physical health developments and offered support from the Physical Health Specialist Nurse and Physical Health Clinical Leads. There was limited training specific to this group.

2.6   Policy Development

We have developed a comprehensive Trust Smoke Free Policy. This update encompasses the broad smoke-free position of the Trust. This is in line with what other Trust have in place and is aligned to the national strategy. It is proposed that the updated policy will go to the February Board for approval.

2.7   Staff Wellbeing

Weekly lunchtime mindfulness courses were established during the year and have been well attended by 6-10 members of staff.

2.8   External links

We have worked closely with other NHS Trusts across London including the Smoking Cessation Nurse Consultant at SLaM and the Physical Health Community Matron at LB Islington NHS Foundation Trust. The Trust is a member of London Physical Health Leads Network undertaking benchmarking audit information on our Trust's Physical Health Care provision and the Physical Health Specialist Nurse is the nominated British Thoracic Society (BTS) member.

3.   Summary

In the past year we have developed a physical health programme and front line clinical service to our patients' carers and staff. During this time there has been many opportunities for reflection and learning through the collaborative process we have adopted.

From the beginning of this programme we identified that improving the physical health of mental health patients would be a challenge requiring a significant culture shift in the organisation. There has been some resistance to change, uncertainty, some lack of clarity around the new referral system and the process of physical health form completion. Some clinicians and teams have voiced concerns relating to risk, confidentiality, governance and dilution of the therapeutic process. But alongside this there have been a number of teams and senior clinicians expressing clear support via their referrals and communications around accessing physical health treatment.

There has been a positive shift with a regular channel of referrals for one to one physical health interventions and the increasing completion rate of the Physical Health Form.

We will only increase awareness and support for integrating physical health needs with the mental health services we provide by working together and building the confidence of patients, carers, staff and our more senior clinicians towards this end. This is the beginning of a journey that may take time and will require all the collaborative and reflective skills that are central to the Trust way of working.

We will continue with a collaborative approach to underpin this work in going forward. Key objectives for the next year will be to:

- Provide improved/integrated physical health assessment information reducing the age for assessment to 13 years;
- Develop the Trust intranet and website physical health information for users and staff;
- Work with staff to identify how best to provide information on physical health;
- Implement the Trust Smoke Free Policy and training recommendations;
- Develop the Physical Health Champions role;
- Develop a robust communications strategy to engage with staff, patients and carers;
- Consult widely on the Living Well Programme to further amend and deliver programmes for adults and adolescents;
- Evaluate the programme(s) and provide feedback to participants;
- Use the evaluation to further develop and deliver ongoing programmes including group work for 2018-19;
- Consider with services and users how best to address physical health needs of those under 13 years of age.

Tim Quinn, Physical Health Specialist Nurse
Marion Shipman, Associate Director Quality and Governance
20th February 2017

Appendix 1

Background: Physical Health and Wellbeing Evidence

1. The following summarises the evidential base for the physical health work – Living Well Programme within the Trust.

1.1 Smoking and drugs

Helping people to stop smoking is among the most effective and cost-effective of all interventions the NHS can offer patients. The Mental Health and Smoking Action Report by Action on Smoking and Health (ASH April 2016), informs us that: People with mental health conditions die on average 10-20 year earlier than the general population and smoking is the single largest factor accounting for this difference. Around one third of adult tobacco consumption is by people with a current mental health condition with smoking rates more than double that of the general population.

'The Stolen Years', a report by ASH, endorsed by 27 health and mental health organisations, sets out recommendations for how smoking rates for people with a mental health condition could be dramatically reduced. These include improved training of healthcare staff, better access to stop smoking medication and a move towards smokefree mental health settings. (ASH April 2016) Action on Smoking and Health.

1.2 Alcohol

Drinking more than 14 units of alcohol per week can damage a person's health (Chief Medical Officer CMO 8th January 2016). For example, alcohol is one of the biggest behavioural risks for disease and death (as well as smoking, obesity and lack of physical activity). In England in 2010 to 2011 there were 1.2 million alcohol-related hospital admissions and around 15,000 deaths caused by alcohol. Alcohol CQUINs have been in place for two years, but there is still much to be done to achieve full compliance with NICE guidance.

1.3 Promoting Health Diet and Exercise

Both overweight and obesity are associated with an increased risk of numerous chronic and severe health problems which contribute to a reduced life expectancy and impact negatively upon quality of life (WHO, 2003) and has a high associated cost. NICE guidance on Obesity (CG 189: Nov '2014) recommends steps for people with a BMI over 30.

New commissioning guidance, 'Commissioning Excellent Nutrition and Hydration' NHSE (October 2015) highlights the risks of malnutrition. 'Around 1 in 3 patients admitted to acute care will be malnourished or at risk of becoming so (NICE, 2011). The excess annual health costs associated with malnutrition alone are estimated to exceed £19billion (BAPEN, 2015).

Therefore it is essential that malnutrition and dehydration problems are better recognised and treated.

1.4 Reducing Stress

High levels of stress can lead to emotional and physical health problems. (NHS Choices 2017). If you're stressed, whether by your job or by something more personal, the first step to feeling better is to identify the cause.

The most unhelpful thing you can do is turn to something unhealthy to help you cope, such as smoking or drinking.

> "In life, there's always a solution to a problem," says Professor Cary Cooper, an occupational health expert at the University of Lancaster. "Not taking control of the situation and doing nothing will only make your problems worse."

He says the keys to good stress management are building emotional strength, being in control of your situation, having a good social network and adopting a positive outlook.

www.nhs.uk/Conditions/stress-anxiety-depression/Pages/understanding-stress.aspx

Board of Directors: February 2017

Item : 15

Title : Waiting Time Analysis by Team

Purpose:

The purpose of this report is to provide analysis and narrative commentary for waiting times by Team. The waiting time definition is from receipt of referral to first appointment. Data is presented on a quarterly basis in order to show whether the waiting time trajectory is improving or worsening. Actions taken to address identified issues are included.

This report has been reviewed by the following Committees:
- Executive Management Team, 14th February 2017

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

For : Discussion

From : Marion Shipman, Associate Director Quality and Governance. Report drafted by Kerri Johnson-Walker, Data Quality Manager

Waiting Times

Waiting Times Analysis by Team

1. Introduction

1.1   As requested by the October Board of Directors the following paper provides an analysis and narrative for waiting times by Team on a quarterly basis in order to show whether the waiting time trajectory is improving or worsening. Actions being taken to address identified issues are included. Data is provided for the period 1 April 2016 to 31 December 2016.

1.2   The following services and the relevant waiting time targets have been included:
1.2.1   Adults = 11 weeks
1.2.2   City and Hackney = 18 weeks (from 1 April 2017)
1.2.3   Portman Clinic = 11 weeks
1.2.4   Camden CAMHS = 8 weeks
1.2.5   Other CAMHS = 8 weeks
1.2.6   Adolescent = 8 weeks
1.2.7   GIDS = 18 weeks
1.2.8   Westminster = 6 weeks
*Please note that adolescent over 18s are included in 'Adolescent' target time of 8 weeks

1.3   This report shows the amount of seen waiters by team across services offered in the Trust. The data is for patients Trustwide including NHS England contracts for GIDS and Portman.

1.4   Waiting time information is taken from the date the referral was received to the first appointment. Service Leads and Team Administrators have provided commentary on where these are not well met and what action plans are in place to improve waiting times and meet the target.

1.5   Please note First Step has been excluded from the analysis.

2. Summary

2.1 Table 1 shows the number of patients that that have been seen in the quarter and how long their wait was, on a team level. The numbers in green indicate the number of people within their targeted waiting time and those in red have not met the target waiting time.

2.2 Adult teams: Overall Adults has maintained their waiting times, with the Adult Trauma Unit improving towards their target.

2.3 City and Hackney have performed well over Quarter 1 and Quarter 2 decreasing their waiting times; however they have risen slightly in Quarter.

2.4 Increases in waiting times leading to breaches are noted in specific Other CAMHS overall, the GIDS service overall and Westminster FAS Family Assessment Team.

2.5 Adolescent Camden Team have seen an increase in waiting times from 77.% of patients being seen with in the target waiting time in Q2 to only 55.2% in Q3.

3. Detailed analysis and commentary

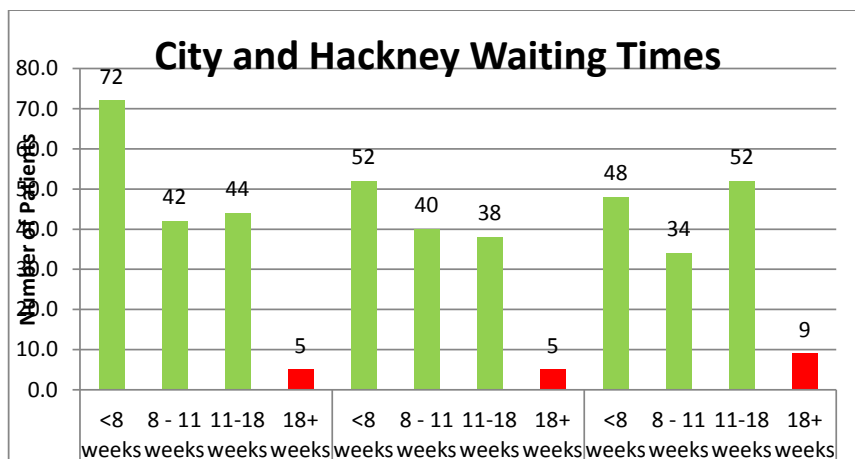### 3.1 Adults Service (All Teams included in analysis)

Adult - Waiting Times
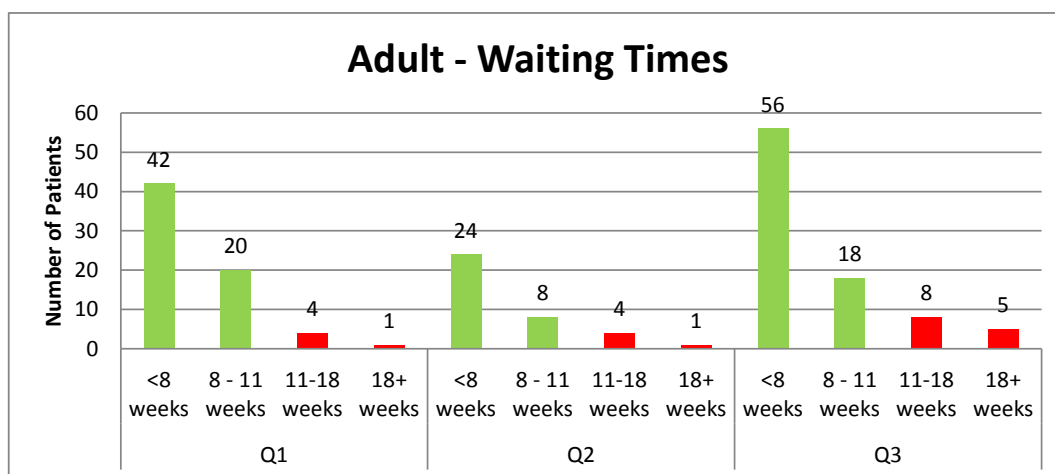
by the Service Lead, Michael Mercer.
The number of patients waiting at the end of Quarter 3 was 53.

The report has been confirmed

Waiting Times

3.2 City and Hackney Service (PCPCS)

City and Hackney Waiting Times

The waiting time target for City and Hackney is 18 weeks with 93.7% meeting this target in Q3, equating to 91 patients waiting at the end of Q3. Commentary has been provided by the Tim Kent, Service Lead.

The PCPCPS treatment waiting list has reduced from 12 months to 7–8 months. This remains our highest priority although it will be hard to sustain without considerable further service changes or resource investment. The three additional staff to help combat waiting times are due to leave by the end of this financial year and their dwindling capacity to take on anything other than very brief treatments as they get close to the end of contract makes it harder to allocate them the casework we need to get through (i.e. if they start a case at the end of Jan they only have a maximum of 8 weeks work.)

Our Q3 commissioner report showed some encouraging signs that service plans to manage intake differently is working. We no longer accept referrals from around 30 different agencies and have returned to a primarily GP only intake system with some two-way exchange of cases with IAPT where appropriate. Our working relationships with local services are excellent and we continue to have a presence at local forums, inter-trust meetings, GP quadrant meetings etc that allows us to discuss changes with our referrers in person and consider their wishes and expectations alongside reductions in NHS funding. The service is taking in 25% less referrals, excluding more that are inappropriate and helping other services to manage their own capacity by referring to us. This means that the service are now regulating their intake more strictly and therefore should see less patients moving into treatment. This will be a gradual process over the next 6 months.

3.3 Portman Clinic

Portman Waiting Times
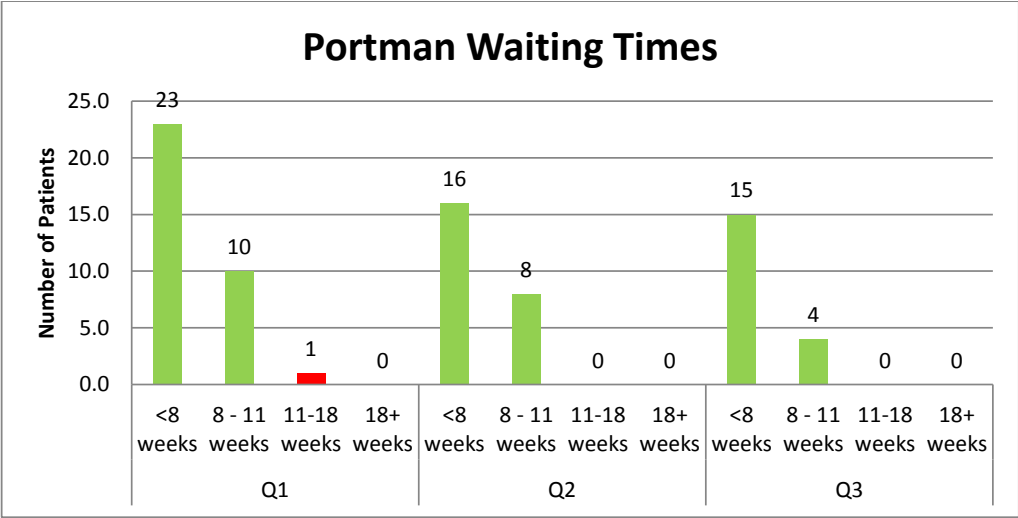
Portman have only breached on 1 patient in this financial year, with 13 patients waiting at the end on Q3.

Jessica Yakeley, Portman Clinic Clinical Director, commented:

'These are well within the waiting time limit (or actually much lower), so I don't think there is anything to be concerned about, and presently no action needed. There is no evidence that our times are increasing, being steady around 5-6 weeks. We have a lot of contact with referrers on the telephone to facilitate the referral process, and are flexible in our approach with patients in offering them days and times that are most convenient for them.'

Waiting Times

3.4 CYAF (Camden CAMHS – All Teams Selected)

CYAF - Camden CAMHS waiting times
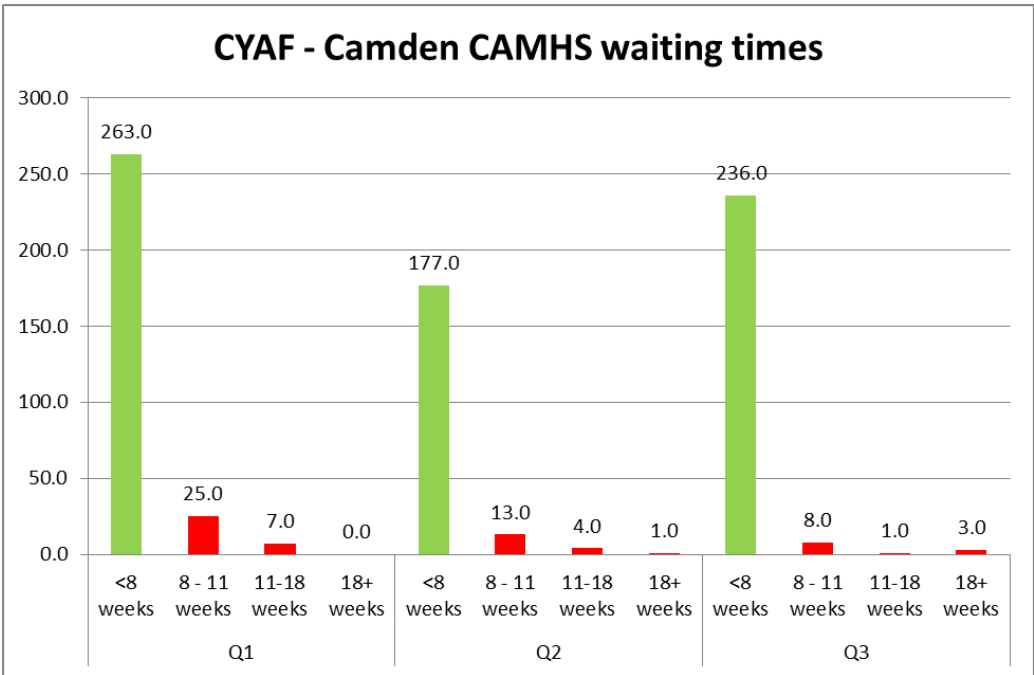
Performance on the whole is good. Sally Hodges,

CYAF Director commented:

'In Camden we have negotiated a band 7 to back fill senior staff in the intake system, who will be telephone triaging cases and directing to services more swiftly to meet our target of getting advice and appropriate redirection. This is likely to have a significant impact on our waiting times.'

3.5 CYAF (Other CAMHS – First Step excluded from analysis)

CYAF -Other CAMHS Waiting Times
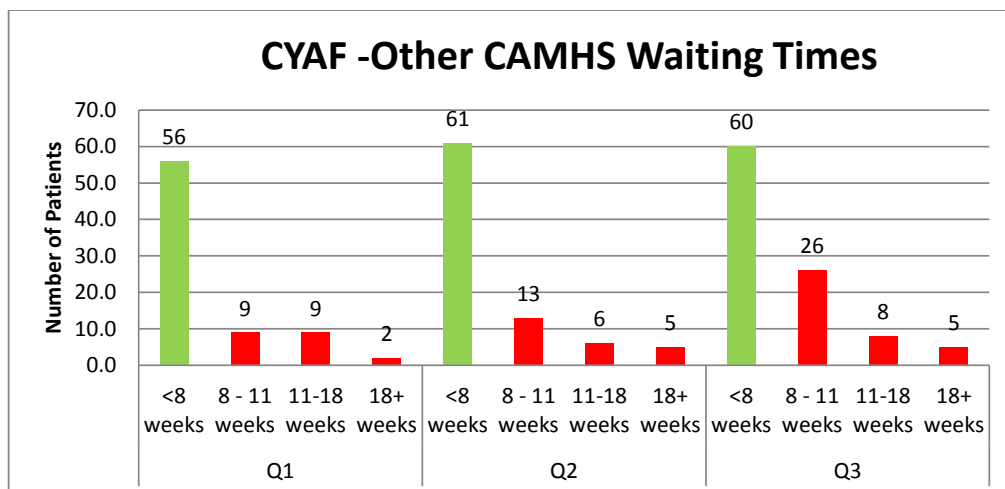
The waiting time target for Other CAMHS is 8 weeks, this was met in 73.7% cases in Q1, however only 60.6% in Q3.

3.6 Adolescent Service

Adolescent -Waiting Times
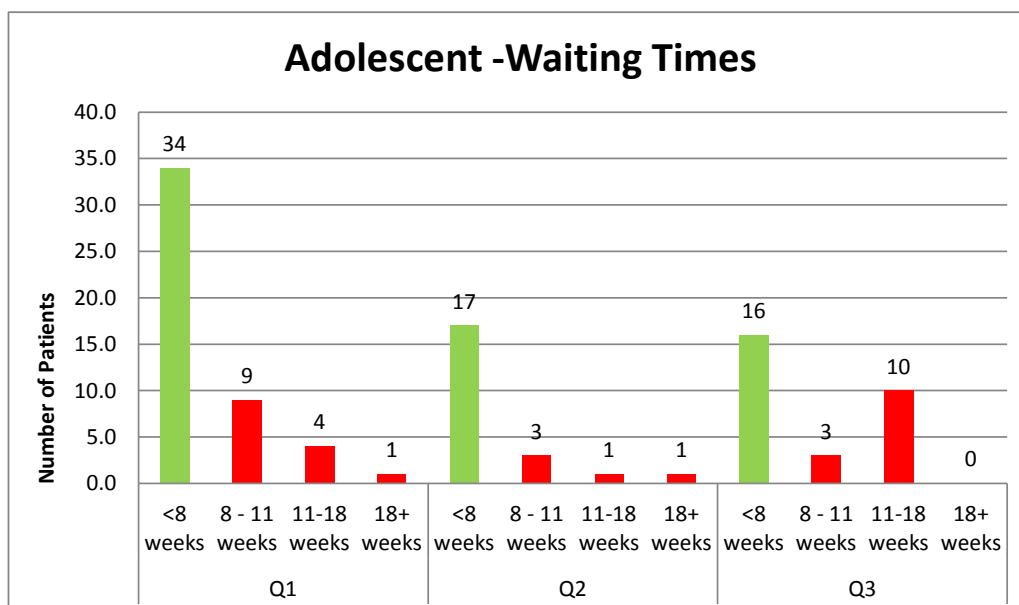
*Please note that adolescent over 18s are included in 'Adolescent' target time of 8 weeks, even though their

waiting time target it is 11 weeks, this may be the reasoning for some of the adolescent patient appearing to break the 8 week target.

29% of patients didn't meet the 8 week waiting time target for Q1 compared to 45% in Quarter 3. There were 33 patient waiting at the end of Q3.

Waiting Times

3.7 Gender Identity Development Service
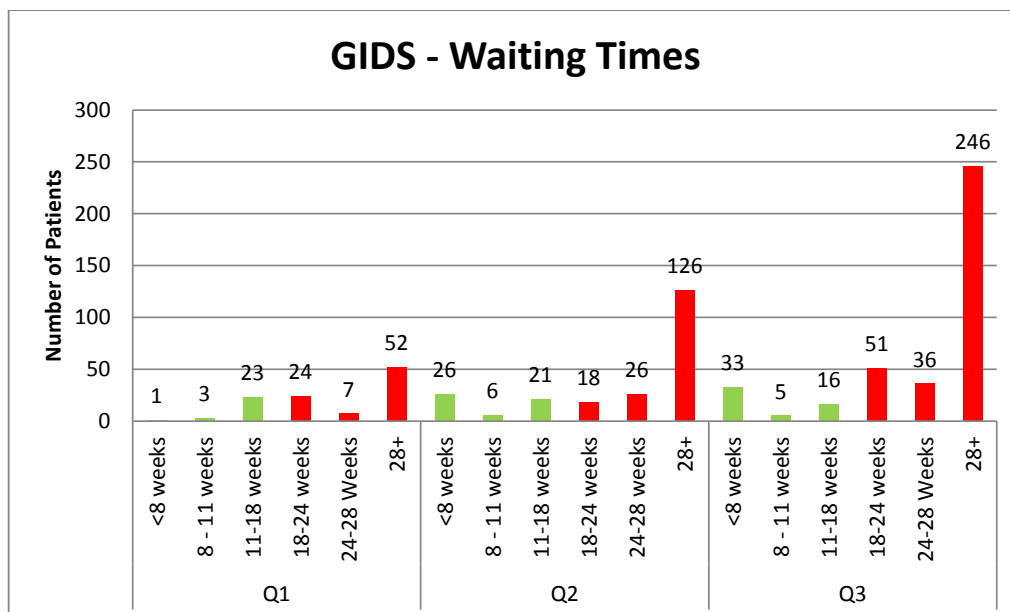
GIDS - Waiting Times

GIDS have a significant number of breaches for their 18 week target, with 1002 patients waiting at the end of Q3. In Appendix 1 detailed waiting time numbers for those over 18 weeks have been included in a separate table for more information.

The plan is to bring the waiting time back in line with the 18 week referral to treatment requirement by the end of September 2017. Clinical and administrator recruitment is on track to enable the service to meet requirements. Details of GIDS waiting lists initiatives follow:

i) 17 year plus group pilot

Background
Increase in referrals last year has led to an increase in RTT times.
Depending at what age young people are referred they may not have an appointment offered in GIDS before they reach the age of 18 years. They then face a second wait to see adult services. There may not be time to complete an assessment and go to endocrine clinic, if appropriate, before they reach 18 years.

Adult services have different length waiting lists, waiting lists times change, follow different protocols, and accept referrals from the GIDS at different ages.
Aim and benefits of group first appointment
To offer timely appointments to over 17 year olds and facilitate appropriate, informed choices regarding transition to adult services. A number of group appointments have been undertaken. Feedback has overall been excellent.

ii) Assessment Clinics

The aim of this clinic is to manage waiting list and offer assessment appointments in an equitable framework. With this in mind changes need to be introduced carefully and audited. Clinicians fill their diaries in a long time ahead and so it is not straight forward to move to new pathways as a whole clinical group. Rather, groups of clinicians have begun to pilot the assessment clinics and others will join as they have space freed up in their diaries. For this and the need to develop a flexible framework in which individual needs can be met it is not immediately possible to predict the impact on the waiting list. These challenges include:

- Less frequent follow up assessment appointments for younger clients not approaching puberty
- Speed up assessment, as appropriate, for pre-pubertal or early stage puberty clients who may be appropriate for or wish to attend the early physical intervention clinic
- Respond in a timely manner to need in more complex cases that require extensive liaison or local network meetings

iii)   Case load

Clinicians carry large caseloads therefore new initiatives to offer appointments need to be carefully monitored in terms of the impact on caseload and the impact of appointments available for existing caseload.

iv)   New specifications identify

Input agreed on case by case basis. Needs may change. Commissioned to deliver tailored treatment packages e.g. young people with little complexity; transition patients; patients needing additional support i.e. complex client

Waiting Times

3.8 Westminster Service

Westminster Waiting Times
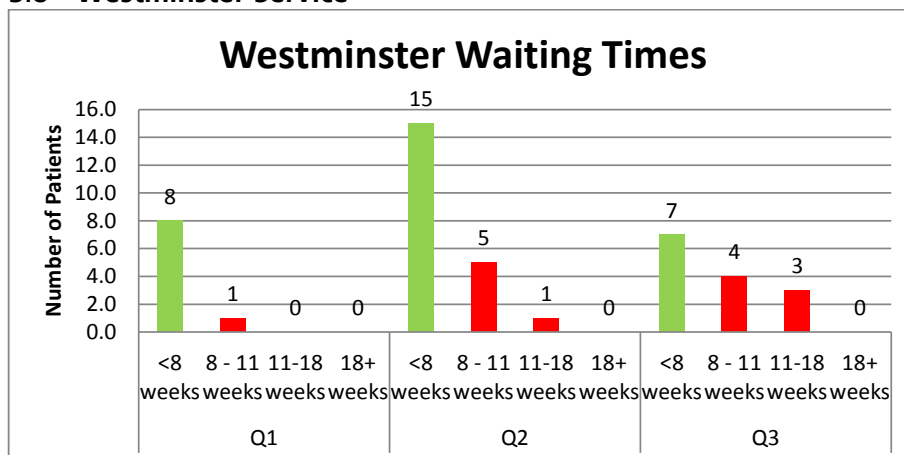
The waiting time target for Westminster is 6 weeks. This has decreased from 88.9% in Q1 to 50% in Q3, there are 7 patients waiting at the end of Q3.

Steve Bambrough, Associate Clinical Director at the service commented:
'Waiting times at Westminster are a complex picture and the variables are not all within our control. Cases can wait if the statutory social worker in the local authority (Westminster or Hammersmith & Fulham) doesn't supply all the required information at the point of referral. We have this clearly listed in our referral processes but this is not always adhered to by the local authority.

We have an unusually high number of referrals in the last two quarters which exceeds our capacity and also exceeds targets for the year. This has means cases have had to wait for clinicians to become available to carry out the work.
Since we are a multi-disciplinary team, some of the referrals state the need for adult or child psychiatric input. This usually has to be explored further by the service prior to allocating this very limited resource in the team. For example the child psychiatrist works half a day per week and if they are named as specifically required in too many assessments at any one time, this will alter the time the case has to wait before being assessed. This is done in consultation with the referrer.

We are in on-going discussions with the commissioners and referring teams to devise solutions to these issues, including better referral gatekeeping by the service leads in the children's services. However, the waiting times are largely a result of increased use of the service by the local authority, beyond the targets for which we were commissioned.'

Appendix 1 Table1.

		Q1				Q2				Q3				*n* Waiting at end of Q3
		<8 weeks	8 - 11 w	11-18 w	18+ wee	<8 week	8 - 11 w	11-18 w	18+ weeks	<8 week	8 - 11 w	11-18 w	18+ week	
ADOLESCENT Camden Team	Number Pts Referral to First Appointment	6	5	1	1	5	1	1	1	4	2	6	0	
	%	46.2%	38.5%	7.7%	7.7%	62.5%	12.5%	12.5%	12.5%	33.3%	16.7%	50.0%	0.0%	
ADOLESCENT Central and East Team	Number Pts Referral to First Appointment	2	1	1	0	1	1	0	0	2	0	2	0	
	%	50.0%	25.0%	25.0%	0.0%	50.0%	50.0%	0.0%	0.0%	50.0%	0.0%	50.0%	0.0%	
ADOLESCENT Family Therapy	Number Pts Referral to First Appointment	0	0	0	0	0	0	0	0	2	0	0	0	
	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	
ADOLESCENT North and West Team	Number Pts Referral to First Appointment	12	2	2	0	6	1	0	0	5	1	2	0	
	%	75.0%	12.5%	12.5%	0.0%	85.7%	14.3%	0.0%	0.0%	62.5%	12.5%	25.0%	0.0%	
ADOLESCENT Parents Consultation Service	Number Pts Referral to First Appointment	3	0	0	0	0	0	0	0	0	0	0	0	
	%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
ADOLESCENT Trauma Unit	Number Pts Referral to First Appointment	1	0	0	0	0	0	0	0	0	0	0	0	
	%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
ADOLESCENT YPCS	Number Pts Referral to First Appointment	10	1	0	0	5	0	0	0	3	0	0	0	
	%	90.9%	9.1%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	
Total		34.0	9.0	4.0	1.0	17.0	3.0	1.0	1.0	16.0	3.0	10.0	0.0	**33**
		70.8%	18.8%	8.3%	2.1%	77.3%	13.6%	4.5%	4.5%	55.2%	10.3%	34.5%	0.0%	
ADULTS Belsize	Number Pts Referral to First Appointment	5	5	1	0	6	3	1	0	15	5	4	0	
	%	45.5%	45.5%	9.1%	0.0%	60.0%	30.0%	10.0%	0.0%	62.5%	20.8%	16.7%	0.0%	
ADULTS Couple Waiting Team	Number Pts Referral to First Appointment	3	0	0	0	0	0	0	0	2	0	0	0	
	%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	
ADULTS Couples Unit	Number Pts Referral to First Appointment	2	1	0	0	1	0	0	0	6	3	0	2	
	%	66.7%	33.3%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	54.5%	27.3%	0.0%	18.2%	
ADULTS Fitzjohn	Number Pts Referral to First Appointment	1	2	0	0	0	0	0	0	1	0	0	1	
	%	33.3%	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%	50.0%	
ADULTS Fitzjohn Waiting	Number Pts Referral to First Appointment	1	2	0	0	1	0	0	0	0	0	0	0	
	%	33.3%	66.7%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
ADULTS Group Waiting Team	Number Pts Referral to First Appointment	1	0	0	0	2	0	0	0	1	0	0	0	
	%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	
ADULTS Hemel Team	Number Pts Referral to First Appointment	2	0	0	0	1	1	0	0	3	0	0	0	
	%	100.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	
ADULTS Individual Intensive Waiting Team	Number Pts Referral to First Appointment	4	1	0	0	0	0	0	0	1	0	0	0	
	%	80.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	
ADULTS Individual Once Week Waiting Team	Number Pts Referral to First Appointment	5	2	0	0	4	0	1	1	4	3	2	0	
	%	71.4%	28.6%	0.0%	0.0%	66.7%	0.0%	16.7%	16.7%	44.4%	33.3%	22.2%	0.0%	
ADULTS Lyndhurst	Number Pts Referral to First Appointment	4	4	3	0	3	2	1	0	16	6	1	2	
	%	36.4%	36.4%	27.3%	0.0%	50.0%	33.3%	16.7%	0.0%	64.0%	24.0%	4.0%	8.0%	
ADULTS Maresfield	Number Pts Referral to First Appointment	7	3	0	0	1	0	0	0	1	0	0	0	
	%	70.0%	30.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	
ADULTS Trauma Unit	Number Pts Referral to First Appointment	6	0	0	1	5	2	1	0	6	1	1	0	
	%	85.7%	0.0%	0.0%	14.3%	62.5%	25.0%	12.5%	0.0%	75.0%	12.5%	12.5%	0.0%	
ADULTS Watford	Number Pts Referral to First Appointment	1	0	0	0	0	0	0	0	0	0	0	0	
	%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Total		42.0	20.0	4.0	1.0	24.0	8.0	4.0	1.0	56.0	18.0	8.0	5.0	**53**
		62.7%	29.9%	6.0%	1.5%	64.9%	21.6%	10.8%	2.7%	64.4%	20.7%	9.2%	5.7%	

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Camden CAMHS	Camden Adolescent Intensive Support Service	Number Pts Referral to First Appointment	24	1	1	0	4	0	0	0	8	0	0	0
		%	92.3%	3.8%	3.8%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	CAMHS LAC	Number Pts Referral to First Appointment	8	1	0	0	5	1	0	0	6	2	0	0
		%	88.9%	11.1%	0.0%	0.0%	83.3%	16.7%	0.0%	0.0%	75.0%	25.0%	0.0%	0.0%
	Complex Assessment	Number Pts Referral to First Appointment	2	0	0	0	0	0	0	0	3	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	Complex Needs Outreach	Number Pts Referral to First Appointment	2	0	1	0	2	0	0	0	0	0	0	0
		%	66.7%	0.0%	33.3%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	NORTH Primary Care	Number Pts Referral to First Appointment	5	1	0	0	2	0	0	0	5	0	0	0
		%	83.3%	16.7%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	NORTH Primary School Service	Number Pts Referral to First Appointment	24	1	0	0	3	0	0	0	14	0	0	0
		%	96.0%	4.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	NORTH Secondary School	Number Pts Referral to First Appointment	13	0	0	0	5	1	0	0	8	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	83.3%	16.7%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	NORTH Service	Number Pts Referral to First Appointment	51	12	1	0	53	1	1	0	64	1	0	1
		%	79.7%	18.8%	1.6%	0.0%	96.4%	1.8%	1.8%	0.0%	97.0%	1.5%	0.0%	1.5%
	Refugee Service	Number Pts Referral to First Appointment	13	1	0	0	12	2	0	0	15	0	0	0
		%	92.9%	7.1%	0.0%	0.0%	85.7%	14.3%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	SOUTH Primary Care	Number Pts Referral to First Appointment	4	2	1	0	3	0	0	0	7	0	0	0
		%	57.1%	28.6%	14.3%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	SOUTH Primary School Service	Number Pts Referral to First Appointment	13	0	0	0	2	0	0	0	12	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	SOUTH Secondary School	Number Pts Referral to First Appointment	2	0	0	0	2	0	0	0	6	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	SOUTH Service	Number Pts Referral to First Appointment	62	5	3	0	46	5	3	1	41	1	1	0
		%	88.6%	7.1%	4.3%	0.0%	83.6%	9.1%	5.5%	1.8%	95.3%	2.3%	2.3%	0.0%
	TOPS	Number Pts Referral to First Appointment	1	0	0	0	7	0	0	0	12	1	0	0
		%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	92.3%	7.7%	0.0%	0.0%
	WFPerinatal - Camden	Number Pts Referral to First Appointment	0	0	0	0	1	0	0	0	0	0	0	0
		%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	WF Perinatal - Euston	Number Pts Referral to First Appointment	4	0	0	0	3	1	0	0	5	1	0	0
		%	100.0%	0.0%	0.0%	0.0%	75.0%	25.0%	0.0%	0.0%	83.3%	16.7%	0.0%	0.0%
	WF Perinatal - Kentish Town East	Number Pts Referral to First Appointment	4	0	0	0	5	0	0	0	3	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	WF Perinatal - Kentish Town West	Number Pts Referral to First Appointment	2	0	0	0	0	1	0	0	0	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	WF Perinatal - Kilburn	Number Pts Referral to First Appointment	2	0	0	0	0	0	0	0	0	0	0	1
		%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0	0.0%	0.0%	0
	WF Perinatal - Kings Cross and Holborn	Number Pts Referral to First Appointment	0	1	0	0	4	0	0	0	1	1	0	0
		%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%
	WF Perinatal - YPS	Number Pts Referral to First Appointment	13	0	0	0	7	0	0	0	2	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	Whole Family	Number Pts Referral to First Appointment	13	0	0	0	11	1	0	0	24	1	0	1
		%	100.0%	0.0%	0.0%	0.0%	91.7%	8.3%	0.0%	0.0%	92.3%	3.8%	0.0%	3.8%
	YPS	Number Pts Referral to First Appointment	1	0	0	0	0	0	0	0	0	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total			**263.0**	**25.0**	**7.0**	**0.0**	**177.0**	**13.0**	**4.0**	**1.0**	**236.0**	**8.0**	**1.0**	**3.0**	95
			89.2%	8.5%	2.4%	0.0%	90.8%	6.7%	2.1%	0.5%	95.2%	3.2%	0.4%	1.2%	

City and Hackney	CHPC Community Project Team	Number Pts Referral to First Appointment	3	1	0	0	4	0	0	0	0	0	0	0
		%	75.0%	25.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	CHPC Waiting Team	Number Pts Referral to First Appointment	1	3	1	0	0	0	0	0	0	0	0	0
		%	20.0%	60.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	CHPC A	Number Pts Referral to First Appointment	45	36	40	4	36	37	37	5	40	29	52	8
		%	36.0%	28.8%	32.0%	3.2%	31.3%	32.2%	32.2%	4.3%	31.0%	22.5%	40.3%	6.2%
	CHPC B	Number Pts Referral to First Appointment	1	0	1	1	0	0	0	0	0	0	0	0
		%	33.3%	0.0%	33.3%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	CHPC C	Number Pts Referral to First Appointment	0	0	2	0	0	0	0	0	0	0	0	1
		%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
	TCPS Care Planning Team	Number Pts Referral to First Appointment	22	2	0	0	12	3	1	0	8	5	0	0
		%	91.7%	8.3%	0.0%	0.0%	75.0%	18.8%	6.3%	0.0%	61.5%	38.5%	0.0%	0.0%
	Total		72.0	42.0	44.0	5.0	52.0	40.0	38.0	5.0	48.0	34.0	52.0	9.0	91
			44.2%	25.8%	27.0%	3.1%	38.5%	29.6%	28.1%	3.7%	33.6%	23.8%	36.4%	6.3%
GIDS	GIDS Leeds	Number Pts Referral to First Appointment	0	3	18	23	11	2	18	61	7	2	11	96
		%	0.0%	6.8%	40.9%	52.3%	12.0%	2.2%	19.6%	66.3%	6.0%	1.7%	9.5%	82.8%
	GIDS London	Number Pts Referral to First Appointment	0	0	5	58	15	4	3	101	26	3	5	230
		%	0.0%	0.0%	7.9%	92.1%	12.2%	3.3%	2.4%	82.1%	9.8%	1.1%	1.9%	87.1%
	GIDS South West	Number Pts Referral to First Appointment	1	0	0	2	0	0	0	8	0	0	0	7
		%	33.3%	0.0%	0.0%	66.7%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
	Total		1.0	3.0	23.0	83.0	26.0	6.0	21.0	170.0	33.0	5.0	16.0	333.0	1002
			0.9%	2.7%	20.9%	75.5%	11.7%	2.7%	9.4%	76.2%	8.5%	1.3%	4.1%	86.0%
Other CAMHS	Child Sex Abuse Hub	Number Pts Referral to First Appointment	0	0	0	0	2	0	0	0	5	0	0	0
		%					100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	Family Service	Number Pts Referral to First Appointment	20	2	1	0	25	4	1	0	17	10	0	0
		%	87.0%	8.7%	4.3%	0.0%	83.3%	13.3%	3.3%	0.0%	63.0%	37.0%	0.0%	0.0%
	FDAC-Kent	Number Pts Referral to First Appointment	6	0	0	0	2	2	0	0	7	0	0	1
		%	100.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%	87.5%	0.0%	0.0%	12.5%
	Fostering and Adoption	Number Pts Referral to First Appointment	5	1	1	1	13	2	2	1	9	2	3	3
		%	62.5%	12.5%	12.5%	12.5%	72.2%	11.1%	11.1%	5.6%	52.9%	11.8%	17.6%	17.6%
	Lifespan	Number Pts Referral to First Appointment	19	6	7	1	17	5	3	3	21	13	5	1
		%	57.6%	18.2%	21.2%	3.0%	60.7%	17.9%	10.7%	10.7%	52.5%	32.5%	12.5%	2.5%
	New Rush Hall School	Number Pts Referral to First Appointment	3	0	0	0	2	0	0	1	0	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	66.7%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%
	VIPP	Number Pts Referral to First Appointment	3	0	0	0	0	0	0	0	1	1	0	0
		%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%
	Total		56.0	9.0	9.0	2.0	61.0	13.0	6.0	5.0	60.0	26.0	8.0	5.0	82
			73.7%	11.8%	11.8%	2.6%	71.8%	15.3%	7.1%	5.9%	60.6%	26.3%	8.1%	5.1%

Waiting Times

Portman	Portman Glasser	Number Pts Referral to First Appointment	9	6	1	0	9	2	0	0	5	3	0	0	
		%	56.3%	37.5%	6.3%	0.0%	81.8%	18.2%	0.0%	0.0%	62.5%	37.5%	0.0%	0.0%	
	Portman Limentani	Number Pts Referral to First Appointment	14	4	0	0	7	6	0	0	10	1	0	0	
		%	77.8%	22.2%	0.0%	0.0%	53.8%	46.2%	0.0%	0.0%	90.9%	9.1%	0.0%	0.0%	
	Total		23.0	10.0	1.0	0.0	16.0	8.0	0.0	0.0	15.0	4.0	0.0	0.0	**13**
			67.6%	29.4%	2.9%	0.0%	66.7%	33.3%	0.0%	0.0%	78.9%	21.1%	0.0%	0.0%	
Westminster	FAS Family Assessment	Number Pts Referral to First Appointment	6	1	0	0	13	5	1	0	7	4	1	0	
		%	85.7%	14.3%	0.0%	0.0%	68.4%	26.3%	5.3%	0.0%	58.3%	33.3%	8.3%	0.0%	
	FAS Intervention	Number Pts Referral to First Appointment	0	0	0	0	2	0	0	0	0	0	1	0	
		%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	
	FAS Pre Birth Assessment	Number Pts Referral to First Appointment	2	0	0	0	0	0	0	0	0	0	1	0	
		%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	
	Total		8.0	1.0	0.0	0.0	15.0	5.0	1.0	0.0	7.0	4.0	3.0	0.0	**7**
			88.9%	11.1%	0.0%	0.0%	71.4%	23.8%	4.8%	0.0%	50.0%	28.6%	21.4%	0.0%	

			Q1						Q2						Q3						Waiting
			<8 weeks	8 - 11 week	11-18 week	18-24 week	24-28 Wed	28+	<8 weeks	8 - 11 week	11-18 week	18-24 week	24-28 wee	28+	<8 weeks	8 - 11 week	11-18 week	18-24 week	24-28 Wed	28+	
GIDS	GIDS Leeds	Number Pts Referral to First Appointment	0	3	18	19	2	2	11	2	18	17	22	22	7	2	11	49	32	15	
		%	0.0%	6.8%	40.9%	43.2%	4.5%	4.5%	12.0%	2.2%	19.6%	18.5%	23.9%	23.9%	6.0%	1.7%	9.5%	42.2%	27.6%	12.9%	
	GIDS London	Number Pts Referral to First Appointment	0	0	5	5	5	48	15	4	3	1	4	96	26	3	5	2	4	224	
		%	0.0%	0.0%	7.9%	7.9%	7.9%	76.2%	12.2%	3.3%	2.4%	0.8%	3.3%	78.0%	9.8%	1.1%	1.9%	0.8%	1.5%	84.8%	
	GIDS South West	Number Pts Referral to First Appointment	1	0	0	0	0	2	0	0	0	0	0	8	0	0	0	0	0	7	
		%	33.3%	0.0%	0.0%	0.0%	0.0%	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	
	Total		1	3	23	24	7	52	26	6	21	18	26	126	33	5	16	51	36	246	1002
			0.9%	2.7%	20.9%	21.8%	6.4%	47.3%	11.7%	2.7%	9.4%	8.1%	11.7%	56.5%	8.5%	1.3%	4.1%	13.2%	9.3%	63.6%	

Kerri Johnson-Walker, Data Quality Manager
Marion Shipman, Associate Director Quality and Governance
13 February 2017

Board of Directors : February 2017

Item : 16

Title : The Role of the Trust's Freedom to Speak Up Guardian

Summary:

This report is an overview of the work of the Trust's Freedom To Speak Up Guardian (FSUG) from the time of appointment in October 2015 to January 2017.

This report has been reviewed by the following Committees:
- Management Team, 14th February

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

- Quality
- Patient / User Safety
- Equality
- Risk

For : Discussion

From : Gill Rusbridger, Trust FSUG.

FTSU Guardian

An Overview of the Trust's Freedom To Speak Up Guardian, One Year In Post.

1. Introduction

1.1.1 The Francis Report in 2013 (Francis 2013) looked into failings that came to light at Staffordshire hospital. They were truly shocking. The report told a disturbing story of terrible neglect of many patients that happened in a culture of secrecy and defensiveness. There were accounts of nursing staff failing to perform basic tasks, and of inadequate care and treatment of patients.

1.1.2 Two years later, Robert Francis QC carried out a review (Francis 2015) into whistleblowing in the NHS. Staff in NHS Trusts were reporting continuing fears that speaking out about poor patient care was not welcome and indeed that individuals would find themselves in trouble for doing so.

1.1.3 In addition, the report commented on a pervasive culture that stopped staff from raising concerns and encouraged them to turn a blind eye to what was going on. The inquiry highlighted failures throughout the system. Checks and balances should be in place to make sure that patients were not at risk, but this failed to happen.

1.4 The review recommended that all NHS Trusts should appoint FSUGs as an additional, confidential person available for staff to turn to if they wanted to raise concerns. The hope was for a FSUG to be in place in all NHS Trusts in England by October 2016.

1.5 Our Trust Board responded proactively and appointed a staff member to this role in October 2015, very soon after the Review's recommendation. By appointing a FSUG the Trust was acknowledging that staff might be anxious about speaking out and was giving a message that we support a culture that listens to and welcomes the raising of concerns.

2. Staff Contact with the FSUG.

2.1 No formal complaints have been raised, either before or since my appointment. Staff members have contacted me on average 2-4 times each month. Staff have approached me from all service lines. Some have travelled in from other services based in community settings, and I have offered to visit other sites. Staff who

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have contacted me have been both women and men, white and from BME backgrounds, and all staff groups have been represented.

2.2 Although no concerns have been raised directly to do with patient safety, staff have expressed anxiety and anger about a culture in the organisation in which excessive pressures are placed on them or on others, often by managers who appear not to listen. Sometimes bullying or harassment is also a factor. These staff members have been preoccupied with not being able to work well and have been concerned that this indirectly impacts on patients. Usually staff are dismayed about breakdowns in communication and wish to find a solution rather than to escalate the problem.

2.3 See Appendix 1 for a summarised account of contact with staff during my time in office. The National Guardian's Office have recently circulated guidance for the recording of concerns and I will be using this from February 2017.

3.   Broader culture

3.1 The lack of formal complaints may give rise to some level of reassurance about the way in which patients and their families are looked after in the Trust. Nevertheless, the issues referred to in para 2.2 indicate that staff have broader concerns about the organisation's culture. Staff are working longer hours than previously, and feel increasing stress from the work pressures on them. Some staff have spoken out in staff surveys about feeling bullied and harassed. In general, we know that staff from black or minority ethnic backgrounds find it particularly hard to speak up for fear of discrimination by white managers. Currently our Trust has few BME staff at a senior management level so this could cause some added reluctance to speak out and an unspoken belief that concerns will at best be ignored, or at worst, used against them.

4.   Raising and maintaining awareness of the FSUG.

4.1 I displayed one poster in common areas and notice boards in the Trust soon after taking up the role. This has been revised recently. Posters and leaflets have been sent to other sites. A leaflet was attached to the payslip of all staff last year. Regular messages are sent via the trust Intranet. I speak at Inset days and arrange to speak with managers. I keep in touch with Paul Jenkins, CEO and with Craig De Sousa, head of HR. I arrange regular meetings with Edna Murphy as the FSUG link on the Board and with Louise Lyon as both Director of Quality and Patient Experience and in her role as Chair of the Equalities Committee. It is also helpful to link with other staff in the Trust who have responsibilities for staff wellbeing and/or patient safety. Sharing information about what is currently being raised by staff as concerns is, I think, one of the most helpful ways to monitor organisational anxiety, and its impact on patient safety. I meet with Angela Haselton from Staffside and with Lisa Tucker and the Trust's Mental Health First Aiders. I have also recently made contact with Sheva Habel in her role as the newly appointed Trust Guardian of Safer Working Hours for junior doctors and

FTSU Guardian

Caroline McKenna as the Trust's Caldicott Guardian. I make a point of attending staff wellbeing and thinking space events and any Chief Executive question time meetings that Paul Jenkins arranges that relate to hearing about staff concerns. We have been updating the Trust's Whistleblowing Policy to reflect the new NHS guidelines.

5. Links with other FSUG's and the National Guardian.

5.1 Links with other FSUGs and the National Guardian's Office have only recently begun. Dr Henrietta Hughes, the National Guardian, only came into office in October 2016. I have attended one FSUG workshop arranged in London in March 2016, and the first FSUG national conference which was held in October last year. A local London FSUG group was formed at the conference and I attended the first meeting in December 2016. It has been helpful to share experiences with other FSUGs and think about peer supervision and consultation. Many FSUGs are the only Guardian in their Trust, and there is some recognition that we need support that is independent of one's Trust in order to remain neutral. This has the backing of the National Guardian. There is also a specialist group forming of FSUGs from mental health Trusts, but I was unable to attend the first meeting. Interestingly, my impression from speaking with other Guardians is that in all Trusts, including those providing inpatient and physical treatment, it is issues of bullying and harassment that are being raised by staff. This indicates again the importance of having a culture of openness and responsiveness to reports from staff of tension and disaffection. Facing and speaking up about difficult and uncomfortable matters is often avoided, but is necessary to avoid a culture of neglect and acting out which could begin to impact on patients and service users.

5.2 Dr Hughes has asked to visit the Trust and will be meeting with myself, Paul Jenkins and other staff on 21 February 2017. I have been asked to write a short piece on my role which will be included in the National Guardian's publicity leaflets.

6. Discussion.

6.1 I welcome hearing from the Board members and having an opportunity to discuss this report.

Gill Rusbridger, Trust Freedom To Speak up Guardian

References

Francis 2013   Mid Staffordshire NHS Foundation Trust Public Inquiry
http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report

Francis 2015   Sir Robert Francis' Freedom to Speak Up Review.
https://www.gov.uk/government/publications/sir-robert-francis-freedom-to-speak-up-review

Staff contact 2015/17

FREEDOM TO SPEAK UP CONSULTATIONS NOVEMBER 2015 – JANUARY 2017

November – December 2015.

TOTAL - 5 staff making contact. 1 of whom recently employed, 1 BME staff, both reporting stress, bullying, not being listened to by their managers.3 were more junior staff, non clinicians. None wished to take up a second meeting.

January – April 2016.

TOTAL - 9 staff making contact. 3 were less qualified, not long in post. 5 clinicians (2 BME staffmembers) raising similar concerns about feeling managers are unavailable to listen or are under pressure themselves and unable to turn their attention to concerns. 1 middle manager, newly appointed, feeling pressure from a senior manager. 1 wished to arrange a follow up meeting.

May – July 2016.

Total - 5 staff making contact. (1 BME staff member) - concerns as before, 7 meetings arranged, including one follow up.1 senior clinical staff member arranged several meetings to discuss feeling pressure that bullying from a line manager and within the discipline was affecting their capacity to think about their patients and affecting their capacity to work in a way that maintained a high level of patient care.

September – December 2016.

TOTAL – 12 staff making contact. 1 staff member contacting in August and wanting to meet but not following up in September.1 meeting in September with central services staff member re concerns about a manager not responding to requests for help in managing a junior member of staff. No further action requested and matter resolved.1 meeting with another staff member re feeling bullied and ignored by line manager in October /November (BME staff member) A follow up meeting arranged.
1 meeting with another staff member in October - concern re management behaviour being reported but nothing happening. Follow up not taken up as matter resolved.1 email contact in October re staff progression and favouritism. Issue seemed resolved. Informal discussion following another meeting re staff experiencing possible racial discrimination.
Two further informal conversations re a staff member not acknowledging significant health issues and concerns that the staff member was unable to work effectively clinically/a clinical risk. This was taken up formally.1 meeting November involving an experienced staff member feeling belittled by a middle manager. (BME staff member).

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FTSU Guardian

1 meeting December – consultation about a senior staff member seen to be bullying and seeming unable to change attitude. Followed up with a second appointment.1 follow up meeting in December - member of staff remaining unhappy about line manager's failing to address concerns of the staff member feeling unappreciated and belittled.

Other staff contacting me in November and December to express concern about bullying and harassment in general.

At the end of the year, much stress and pressure on staff, in particular DET staff, expressions of concern raised by staff not directly involved but aware of the impact. This picture is confirmed by conversations with staff side.

January 2017.

TOTAL - 2 staff making contact. 1 request made for a meeting but not taken up. 1 meeting arranged for February. Following up on those who contacted in December with no further action requested.

To date, all consultations seemed to result in a lowering of tension and increased capacity to find ways to seek help to resolve difficulties. There has been one case where tensions remained high and further support has been requested. All issues were raised confidentially, none anonymously. All required only 1-3 meetings.

Gill Rusbridger.

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

Board of Directors : February 2017

Item : 17

Title : Directorate of Education and Training Board Report

Purpose:

To update on issues in the Education & Training Directorate. To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 6th February 2017.

This report focuses on the following areas:

• Quality
• Equality
• Risk
• Finance
• Productivity
• Communications

For : Noting

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

Page 1

Directorate of Education and Training Board Report

1. Introduction

1.1 This paper provides and update on the issues discussed at the Training and Education Programme Management Board held on Monday 6th February.

2. SITS Project

2.1 Brian Rock, Director of Education and Training/Dean of Postgraduate Studies presented a written update on this item.

2.2 The project has been renamed MyTAP by the project team in consultation with faculty.

2.3 SITS is progressing well and the first process has been launched. Applications is now operational and in use by the recruitment team for 2017/18.

2.4 The initial release of functionality to support applicants and the application process has been successful and is being used by a growing number of course teams as the recruitment cycle gains impetus. Early indications show that better data is available to the recruitment team to manage and support applicants in this process.

2.5 Student finance release is set for March, assessments and registrations are planned for June 2017 and the remaining functionality for October 2017.

2.6 The programme board considered the progress of the project and agreed that it was currently on schedule although the deadlines for delivery were tight.

2.7 The Board is asked to note that there has been an increase in the costs associated with the project to the quantum of an additional £439k. The Programme Board has been sighted on this. There are various factors including the baseline level of technical resourcing for DET within systems and project functions; the procurement (with some additional functionality required beyond initial specification), and subsequent engagement from the supplier requiring the acquisition of additional in-house development expertise.

2.8 The Project Board in conjunction with the Education and Training Executive and the DET Operations Managers Group continue to monitor the operational impact of this project and monitor use of resources and staff capacity.

3. Student Recruitment and Alumni

3.1 Laure Thomas, Director of Marketing and Communications presented a paper on this item.

3.2 To date 109 applications have been received (with a further 248 incomplete), 8 offers made and 2 accepted.

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3.3 An open day took place on 28th January and was well attended. 50 applications have been started since the open day.

3.4 It was agreed that consideration would be given to how we communicate with students after they apply until term starts and also the possibility of taking deposits for fees.

3.5 It was also agreed that future reports would include last year's numbers for comparison and be more explicitly linked to financial data.

4. Complaints

4.1 Fiona Hartnett, Dean's Office Manager, presented a paper on this item.

4.2 She explained that a total of 10 informal and 9 formal complaints had been received in the 2016 calendar year. This represented a significant increase on the previous year, however this is thought to be largely due to better recording and monitoring of complaints.

4.3 She advised that we had received some complex complaints this year that had required financial settlements being made to the complainants.

4.4 Subjects of complaints included:
    4.4.1   Accusations of discrimination
    4.4.2   Not being able to get information required
    4.4.3   Poor communication
    4.4.4   Lack of information regarding deferrals and results
    4.4.5   A week's notice being given to submit an essay

4.5 In some cases it is thought that complaints would be less likely to have escalated if they had been managed more actively from the start.

4.6 With this in mind all DET professional support staff will be attending training on customer service and complaints before the end of April 2017.

4.7 Consideration needs to be given as to how this training is provided to teaching staff.

4.8 Proposals are being developed for ensuring that the learning from complaints is shared more widely and where possible learning from near misses or informal complaints can enable a more proactive approach to addressing possible issues.

5. Portfolio Review and Target Setting

5.1 Elisa Reyes-Simpson explained that the portfolio review was now well underway.

5.2 This work began to review our portfolio in relation to the fit with HEE's strategic mandate. It is considering a range of options for both growth and efficiency savings. Portfolio managers are now considering these in greater detail.

5.3 A number of courses are being examined more closely to ensure greater consistency between the quality outcomes required and the

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level of input to achieve those outcomes, especially for those programmes that require professional accreditation.

5.4 Paul Jenkins and Brian Rock agreed to send a communication to Portfolio Managers highlighting the importance of this work and emphasising the need for a prompt turnaround of data to aid financial planning.

5.5 This data will be completed in time for the March programme board and discussed in greater detail.

Brian Rock
Director of Education and Training/Dean of Postgraduate Studies
15th February 2017

Board of Directors : February 2017

Item : 18

Title : CareNotes Optimisation Project Closure Report

Summary:

The purpose of the CareNotes Optimization Project ("COP") closure report is to assess the success of the project, if it achieved its objectives, confirm the transfer of any remaining pertinent project risks to the appropriate operational risk registers and to document any output lessons learned for future reference. Approval of this document will formally close the COP. In addition the COP closure report will highlight a number of projects initiated to follow COP.

The report recommends the closure of the project following partial delivery of the original objectives.

This report has been reviewed by the following Committees:

- Executive Management Team, 21st February 2017

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

- Quality

For : Noting

From : Director of IMT

CareNotes Optimisation

COP Project Closure Report   Tavistock and Portman NHS Trust

CareNotes Optimisation Project (COP)

Closure Report

Project Name: CareNotes Optimisation Project

Department: Informatics, IM&T Directorate

Project Mandate: To improve user engagement, provide training, fix technical issues, improve outcome monitoring data/graphs and further deployment of CareNotes at remote sites.

Product/Process: CareNotes

Prepared By: Abrar Shah, IMT Project Manager

Document Owner(s)	Project/Organization Role/Job Title
David Wyndham Lewis	Director of IM&T
Myooran Canagaratnam	CCIO

Project Closure Report Version Control

Version	Date	Author	Change Description
1	16/01/2017	Abrar Shah	First draft
2	14/02/2017	David Wyndham Lewis	Final draft

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CareNotes Optimisation

1   PROJECT CLOSURE REPORT PURPOSE

The purpose of the CareNotes Optimization Project ("COP") closure report is to assess the success of the project, if it achieved its objectives, confirm the transfer of any remaining pertinent project risks to the appropriate operational risk registers and to document any output lessons learned for future reference. Approval of this document will formally close the COP. In addition the COP closure report will highlight a number of projects initiated to follow COP.

2   PROJECT CLOSURE REPORT GOALS

This COP Project Closure Report is created to accomplish the following goals:

- Review and validate the success of the project.
- Confirm outstanding issues and recommendations for setting up new separate projects

3   PROJECT CLOSURE REPORT SUMMARY

3.1   Project Background Overview

Following the implementation of CareNotes throughout the Trust in July 2015, a number of performance issues and complications arose with regard to both user engagement and with the configuration of the system itself. In May 2016, the COP was initiated to resolve the above issues alongside a number of performance issues and to optimize the system and so achieve the following project objectives:

- Fixing remaining technical issues
- Outcome monitoring collection improvement
- To provide training to the end users
- Improve staff engagement
- Achieve further deployment

3.2   Project Closure Synopsis

The COP Project Board have reviewed the completed actions against the originally defined objectives and have deemed the achievable outputs to have been delivered. The COP Project Board noted that a number of the objectives were only understood and defined at a very high level. These objectives have since been understood to be of a much greater scale than initially proposed and so have recommended the initiation of separate follow on projects for each respective objective. These follow on projects are set out in more detail below.

4 PROJECT PERFORMANCE

4.1 Original Goals and Objectives

Technical: Improve functionality, connectivity and efficiency of the system; develop mobile solution and fix any technical bugs

Reporting/Outcome Monitoring: Improve the quality and reliability and robustness of OM data collected

Clinical Usability / Staff Engagement: Improve staff engagement and confidence through feedback and implementation of the solution of staff issues.

Training: Standardise and re-draft training package ahead of new trainees starting in the fall and re-train sites or clinicians as needed

Further Deployment: Rollout of Carenotes system to satellite sites and sites not yet, or not fully, using Carenotes.

4.2 Achieved Objectives and Performance

Technical

The CN Questionnaire function which allows patient to complete outcome measures on iPads, was reported to be very slow. It was fixed and is now available for clinical use in sessions with patients.

General performance of the core system was variable and particularly poor on remote sites. The Informatics team worked closely with the supplier and were able to suggest a series of coding changes to the CareNotes product to enhance performance. These changes have been accepted and implemented by the CareNotes supplier, Advanced Healthcare.

All performance issues identified have been remedied. In addition feedback received through both the CareNotes User Group ("CUG") and Wider Management Team have confirmed that this is reflected in the end user experience of the system.

Reporting/Outcome Monitoring

The CareNotes system does not provide comprehensive reporting function to generate outcome monitoring graphs out of the box. Following extensive investigation into the available technical options and an options appraisal, the Informatics team has been able to create this function through a converged technical solution that generates the graphs on the Trust data warehouse and seamlessly presents them to clinicians through the CareNotes front end. Using the mechanism it has proved possible to generate these graphs using real time data. It should be noted that this is a particularly innovative and creative approach and that no other engaged Trust has achieved this objective. We have shared the details with other local Mental Health Trusts to benefit from our work. In addition the Informatics team has since implemented further checks and constraints to ensure quality data is collected when completing OM forms on CareNotes system.

Clinical Usability / Staff Engagement

At the start of the project staff were invited to complete an online survey regarding experiences of CareNotes. This survey highlighted technical issues around connectivity particularly in remote sites, since partially remedied to the extent possible in advance of the Network Replacement Project.

Monthly CUG meetings were held between December 2015 and October 2016. All Trust staff were invited to these meetings. These meetings proved a useful forum for clinicians and administrative staff using the system to provide feedback, and receive updates from the COP team regarding optimization. Issues discussed included:

- Changes on CareNotes related to CAMHS Transformation
- Clinicians wish for Outcome Monitoring Graphs
- Issues around connectivity in community services
- The need to facilitate mobile working

The discussions in the CUG meetings helped the COP team to focus on issues of most importance to users, and assure users that any concerns were being addressed in a coordinated manner. Clinical Directors were also provided regular COP updates at the IM&T Steering group. Overall the CUG improved staff engagement and confidence through feedback and resolution of the highlighted staff issues.

Training

The training manual was updated with additional material including Thrive category, care plan and recording of non-patient activity. The training material was standardized.

The CAMHS Department was retrained on IAPT measures and the use of it. Also around 200 students who enrolled onto a course taking up clinical placement at the Trust were successfully trained on CareNotes using the new material and measures. All of the above are now reflected in the standard training practices for CareNotes.

Further Deployment

With a very small set of exceptions all clinical activity is now recorded on CareNotes. The remaining exceptions are reliant on a number of upstream dependencies and so are to be addressed as separate projects in the 17/18 IMT Programme. The exceptions include :

- Portman Clinic – activity is now recorded on CareNotes. Migration of the paper record remains.
- Family Drugs and Alcohol Court – activity is frequently not recorded on CareNotes but is captured through other means. This work is reliant on better provision of IMT infrastructure to the sites, such as the Coram charity, where service staff are trying to operate on the Charity network. This will be handled alongside an upcoming service reconfiguration for FDAC.
- MALT / CAMHS LAC – activity is recorded on CareNotes however migration of the record from Camden to the Trust has never been completed following that service reconfiguration.

5 PROJECT CLOSURE TASKS

5.1 Lessons Learned

Governance Model

The project governance model and reporting processes to the IMT Steering Committee were unclear and inadequately documented. This contributed to some delays in decision making in the early stages of the project. While oversight and assurance of the project was achieved through the Project Board this was achieved through ad hoc processes that would not be replicable for future projects.

The IMT Project Manager is undertaking a schedule of work, overseen by the Director of IMT, to develop a standard framework for programme and project management that will include standard Terms of Reference for Project Boards within the IMT Programme.

Needed clearer objectives and scope at start

The objectives of the project were poorly defined. There were no metrics against which to measure delivery of project outputs and no initial baseline assessed. This contributed to significant risk of scope creep and a lack of understanding of what the project would deliver and when it could be deemed complete.

As part of the new framework for IMT programme and project management, a Project Brief template has been developed. This will enforce a more rigorous assessment of project objectives, the project outputs and the metrics to be tracked to measure success. The iterative development of these measures during project initiation fall within the remit of the Project Board as part of their Terms of Reference. More formal sign off of project initiation will be required.

Clinical and Administrative Engagement

While the CUG proved very successful in its outputs attendance was variable and not representative of all stakeholder groups within the Trust. The group evolved from its intended purpose as a group that would lead the configuration of CareNotes from a clinical and administrative perspective to become a very tactical group that reported immediate problems.

Further consideration is required in this area as to how the CCIO can be supported in engaging broadly across all stakeholder groups within the Trust. The requirement is twofold; to provide a conduit for clinical and administrative staff to feed into the developing strategy for the electronic patient record and to offer a mechanism for championing of cultural and process change, enabled by IMT change, back into the organization.

Competition for same resource pool against other Trust projects

At the time of initiation of the project there was limited formal understanding of the other project and operational workload falling on the same named resources that were required to deliver the COP work. This led to unrealistic expectations of when work generated by the COP would be delivered.

The Director of IMT has already undertaken a capacity review of the IMT Directorate and project work is now prioritized against the limited resource pool. Future projects will be commissioned with better understanding of the organization's capacity to deliver the work. Prioritization of projects for the 2017/18 IMT Programme is underway.

<div style="writing-mode: vertical">CareNotes Optimisation</div>

Lack of understanding of interdependencies

A number of challenges to the evolving deliverables of this project related to deliverables of other project proposed by the IMT Strategy, in particular related to the "Building the Infrastructure Platform" theme, the Network Replacement project and its extension to cover all remote sites. Related to the lack of clear understanding of the COP objectives, this further exacerbated problems limiting scope creep. This highlighted limitations in the capacity of the IMT Steering Committee as it attempts to be both a strategic group and a programme board.

Handling of project interdependencies is best undertaken at programme level. Programme management is currently in an immature state for the IMT Programme. The Director of IMT will produce a paper for Wider Management Team in Q4 2016/17 that discusses the governance structure for delivery of the IMT Strategy and sets out proposals to mature both programme and project management to provide better assurance on delivery.

Cultural change – perception that IMT are telling clinical staff what to do

As part of the CUG it became apparent that some resistance to change resulted from a feeling that IMT were imposing the new structures of CareNotes upon the clinical practice of the Trust. This is a common issue in change projects that have a significant IMT enabler. The COP was led by the Chief Clinical Information Officer, which is entirely correct and in line with best practice. The challenge does highlight, in line with the need for improved Clinical and Administrative Engagement above, that the CCIO will need the support of a broader array of clinical and administrative stakeholder representatives to both define future changes, lead the projects and champion the change into the rest of the organization.

In addition to developing the supporting structures for the CCIO, it is also seen as critical that, with few exception related to pure infrastructure replacement, all projects that form part of the IMT Strategy are chaired and led by an appropriate business representative and not by IMT.

Training profile

As part of COP it has become apparent that the increasing level of regular training required for CareNotes as well as the training overhead created by any future changes to CareNotes configuration has been underestimated in the original CareNotes FBC. Additional interim resource was requested by the previous Director of IMT which has allowed IMT to provide training over a series of peaks during 2016/17, during which time improvements have been made to training materials and processes, however this has not fully addressed the underlying defecit.

The Director of IMT is aware of this issue and is addressing as part of broader considerations of IMT resource planning and IMT service maturity.

Evolving environment – STP and changing contracts

The project has been influenced by evolving requirements impacting the Trust as a whole. This has included changes to service requirements, such as for FDAC, as well as changes to our understanding of future requirements for the EPR driven by the North Central London Sustainability and Transformation plan.

The Project Board has managed to contain any scope creep that may have been generated by this changing context for the project. Issues identified have been highlighted to the Director of IMT for consideration as part of the 2017/18 IMT Programme.

5.2 Post Project Tasks

As noted above a number of the objectives initially set out for COP have been demonstrated to be of broader scale than originally foreseen. Where this has proven to be the case the COP Project Board has recommended that separate projects be initiated giving the opportunity for more detailed workup and definition of the project objectives and benefits. This will also allow for a better understanding of the cost of delivery against benefits for these projects.

SMS Appointment Reminders

CareNotes offered limited functionality for SMS appointments reminders. This is now setup as a separate project and registered on the project register. An alternate mechanism for provision of this service separate from CareNotes will be developed.

The approach for this project will be to run a pilot for two months with City & Hackney and one of CAMHS service. A successful pilot will help refine understanding of the cost to services of a Trustwide deployment as well as providing metrics on DNA rate and patient experience currently lacking. The project is included in the IMT Programme plans for 2017/18.

CareNotes Mobile Application

Technical issues prevented the deployment of this application within the COP timeframe. While the technical issues have now been overcome the project was able to highlight that use cases for this application were poorly defined with more work required by clinicians to provide a specification for the applications use. In addition should the pilot be successful there were no plans or allocated funding for the procurement of suitable devices for the clinicians to use (iPads). Finally there remains uncertainty on the viability of a business case for the functions deployment once the cost of the devices and their maintenance are taken into account. A project will be setup to run this pilot with the TOPS team as previously planned. Once this is complete and the specification and requirement is understood a further business case will be presented for any broader deployment.

This work also highlighted further interdependencies with the Network Replacement project particularly related to community services at remote sites where users are unable to access the community service site WiFi as a guest and where 4G signal is. Timing of any deployment will need to consider this dependency.

Further Deployments

Further detailed scoping work is required to understand the most effective approach to bringin the full set of activity data and documents onto CareNotes for each of the Portman Clinic, Camden LAC and FDAC. As noted above these will each be handled as separate projects in 2017/18.

Strategy Review

Feedback from the CUG has highlighted a desire for further developments in the function of CareNotes. These high level requirements are already encapsulated in the existing IMT Strategy under the banner of "patient engagement" and "patient portal", however again they are lacking detail.

The CCIO will lead a piece of work to support the prioritization of the IMT Programme for 2017/18 and then to develop a detailed brief, led by clinical and administrative staff, for each of the priority projects.

The Director of IMT has separately been asked to provide a refresh to the IMT Strategy for which we have already completed one of the planned two years.

5.3   Project Closure Recommendations

The Project Board has recommended that this project be closed as all of the achievable objectives have been completed as described above. The outstanding objectives have been initiated as a separate projects.

The project has partially fulfilled the requirements as documented in the project brief. The Project Sponsor, Project Board and heads of the various workstreams are satisfied that the majority of the objectives were addressed.

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 28th February 2017, 14.00 – 16.00
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES

1.	**Chair's Opening Remarks** Ms Edna Murphy, Deputy Trust Chair		Verbal	-
2.	**Apologies for absence and declarations of interest** Ms Edna Murphy, Deputy Trust Chair	To note	Verbal	-
3.	**Minutes of the previous meeting** Ms Edna Murphy, Deputy Trust Chair	To approve	Enc.	p.1
3a.	**Outstanding Actions** Ms Edna Murphy, Deputy Trust Chair	To note	Enc.	p.6
4.	**Matters arising** Ms Edna Murphy, Deputy Trust Chair	To note	Verbal	-

REPORTS

5.	**Service User Story** Student from the M34 Course, Psychological Therapies Portfolio	To note	Verbal	-
6.	**Service Line Report – Psychological Therapies Portfolio** Mr Peter Griffiths, Portfolio Manager	To discuss	Enc.	p.7
7.	**Trust Chair's and NEDs' Reports** Ms Edna Murphy, Deputy Trust Chair	To note	Verbal	-
8.	**Chief Executive's Report** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.25
9.	**Draft Risk Strategy and Policy** Ms Marion Shipman, Associate Director of Quality and Governance	To note	Enc.	p.28
10.	**Board Assurance Framework, BAF** Ms Marion Shipman, Associate Director of Quality and Governance	To approve	Enc.	p.56
11.	**Mission and Values Statement** Mr Paul Jenkins, Chief Executive	To approve	Enc.	p.78
12.	**Finance and Performance Report** Mr Terry Noys, Deputy Chief Executive and Finance Director	To note	Enc.	p.82
13.	**Q3 CQSG Report** Dr Rob Senior, Medical Director	To note	Enc.	p.87
14.	**Physical Health Report** Mr Tim Quinn, Physical Health Nurse	To note	Enc.	p.95
15.	**Waiting Times Analysis** Ms Marion Shipman, Associate Director of Quality and Governance	To note	Enc.	p.105

16.	**Freedom to Speak Up Guardian Report** Ms Gill Rusbridger, FTSU Guardian	To note	Enc.	p.119
17.	**Training and Education Report** Mr Brian Rock, Director of Education and Training	To note	Enc.	p.125
18.	**CareNotes Optimisation Report** Mr David Wyndham Lewis, Director of IMT	To note	Enc.	p. 129
CLOSE				
19.	**Notice of Future Meetings:** • Thursday 2nd March 2017: Council of Governors' Meeting, 2.00-5.00pm, Lecture Theatre • Tuesday 7th March 2017: Leadership Group, 2.00-5.00pm, Lecture Theatre. • Tuesday 28th March 2017: Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre			