The Tavistock and Portman NHS

NHS Foundation Trust

Board of Directors Part One

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

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 29th November 2016, 14.00 – 16.30
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

	PRELIMINARIES			
1.	**Chair's Opening Remarks** Prof Paul Burstow, Trust Chair		Verbal	-
2.	**Apologies for absence and declarations of interest** Prof Paul Burstow, Trust Chair	To note	Verbal	-
3.	**Minutes of the previous meeting** Prof Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	**Outstanding Actions** Prof Paul Burstow, Trust Chair	To note	Verbal	-
4.	**Matters arising** Prof Paul Burstow, Trust Chair	To note	Verbal	-
5.	**Trust Chair's and NEDs' Reports** Prof Paul Burstow, Trust Chair	To note	Verbal	p.9
	Strategy			
6.	**Trust Objectives – Success Criteria** Mr Paul Jenkins, Chief Executive	To approve	Enc.	p.10
7.	**Review of Board Assurance Framework** Mr Paul Jenkins, Chief Executive	To approve	Enc.	p.19
8.	**NCL Sustainability and Transformation Plan** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.42
9.	**Mission and Values Statement** Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.115
10.	**Draft Two Year Operational Plan** Mr Paul Jenkins, Chief Executive	To discuss	Late	-
	Reports			
11.	**Service Line Report – Gloucester House Day Unit** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.119
12.	**Chief Executive's Report** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.129
13.	**Waiting Times Analysis** Marion Shipman, Associate Director Quality and Governance	To discuss	Enc.	p.132
14.	**Finance and Performance Report** Mr Terry Noys, Deputy Chief Executive and Finance Director	To discuss	Enc.	p.147

Agenda

15.	**Training and Education Report** Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.156
16.	**Clinical Quality, Safety & Governance Committee Report** Dr Rob Senior, Medical Director	To approve	Enc.	p.159
	Governance			
17.	**Deputy Chair Appointment, Current NED Links and Committee Memberships** Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.171
18.	**Sign Up to Safety Plan** Ms Louise Lyon, Director of Quality and Patient Experience	To approve	Enc.	p.177
19.	**Single Oversight Framework** Mr Gervase Campbell, Trust Secretary	To note	Enc.	p.189
20.	**Data Quality Policy** Ms Louise Lyon, Director of Quality and Patient Experience	To approve	Enc.	p.197
21.	**Declarations of Interest** Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.210
	Close			
22.	**Notice of Future Meetings** • Thursday 1st December 2016: Council of Governor's Meeting, 2.00pm – 5.00pm, Lecture Theatre • Tuesday 6th December 2016: Leadership Conference, 9.45am – 1.45pm, Lecture Theatre • Tuesday 31st January 2017: Board of Director's Meeting, 2.00pm – 5.00pm, Lecture Theatre			

Board of Directors Meeting Minutes (Part One)
Tuesday 25th October 2016, 2.00 – 4.30pm

Present:			
Prof. Paul Burstow Trust Chair	Prof. Dinesh Bhugra NED	Mr David Holt NED	Dr Sally Hodges CYAF Director
Mr Paul Jenkins Chief Executive	Ms Lis Jones Nurse Director	Ms Louise Lyon Director of Q&PE	Dr Ian McPherson NED & Vice Chair of Trust
Ms Jane Gizbert NED	Mr Brian Rock Director of E&T/ Dean	Dr Rob Senior Medical Director	Dr Julian Stern, Director of Adult and Forensic Services
Attendees:			
Mr Gervase Campbell Trust Secretary (minutes)	Mr Carl Doherty, Deputy Director of Finance	Dr Stephen Blumenthal, Portfolio Lead Forensic (item 6)	Ms Yvonne Ayo, Portfolio Lead Systemic (item 7)
Mr Freddie Peel, Dashboards Lead (item 12)	Mr Carl Doherty, Deputy Director of Finance (item14)	Ms Edna O'Shaughnessy Governor	
Apologies:			
Ms Edna Murphy NED			

Actions

AP	Item	Action to be taken	Resp	By
1	3	Amendments to minutes	GC	Immd.
2	12	Report on physical health to come to next Board	LL	Nov.
3	12	Report on preparedness and risks for Quality Accounts for Board	MS	Jan.
4	13	Report on waiting times for the Board	MS	Nov.

1. Chair's Opening Remarks
Prof Burstow opened the meeting, and noted his link with ASH for item 12.

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

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

4. Matters Arising
Action points from previous meetings:
AP1 – (minutes) – completed

5. Service User Story – students from D59F & M6
Ms O explained that she had changed career after 20 years as a lawyer, completing a foundation course at the Institute of Psychiatry, then a post-foundation course at Parkside, before joining D58 at the Trust, and then D59F at

the Portman. On D58 she had found learning from other student's presentations in the small group supervisions very valuable. On D59F at the Portman she had found a collegiate atmosphere, with passionate clinicians.

Ms P explained that she had been working in marketing before becoming interested in organisational dynamics and starting a systemic training at KCC, in the third year of which she transferred to the Trust. The training at the Tavistock was less experiential and more clinical, and she had been one of the few on the course without clinical experience. She had found training here an excellent experience, with good tutors, resources, and a good balance of gender amongst the students. She had appreciated the opportunity to learn to teach on the course, and was now a visiting lecturer at the Trust as well as working in adult mental health. She noted some difficulties with coordination in the visiting lecturer model, commented that Moodle was well used and valuable, and suggested more support for other professionals in transition would be helpful.

Prof Burstow asked whether Ms O could expand on comments about differences between the Tavistock and the Portman for students. Ms O noted the crowding in the Tavistock centre on Wednesdays, and difference in size of the Portman, where there seemed to be time to talk to each other and maintain the collegiate atmosphere. She commented that there were some frustrations over the administration at the Portman, with delays in re-registration and a lack of clarity over who was responsible.

Dr McPherson asked whether the Trust promoted the possibilities of changing profession sufficiently. Ms P commented that there were a number of people on the systemic courses looking to change career, and it was actively supported. Dr Blumenthal commented that they did not do enough in forensic, and needed to think about using the P1 lectures as a route in. Ms O added that it was a daunting task to make the change, and could take from 3 to 6 years.

Mr Rock asked whether there was more scope for cross-fertilisation, or if courses benefitted from being more focussed. Ms P suggested that the depth of the courses should not be diluted, but offering opportunities to diversify on top might be helpful. Ms O commented that there was hardly enough time to do what they were in the most beneficial level of detail, and the luxury of allowing time for depth was important.

Mr Jenkins asked whether, given the pressures the Trust was under, there were any parts of the course that did not add value. Ms O and Ms P agreed that it was hard to see where costs could be cut, or elements reduced without loss.

Prof Burstow thanked the students for giving up their time to attend the board, and giving such a helpful window into their experience.

6. **Service Line Report – Forensic Portfolio**

Dr Blumenthal introduced his report by noting there was great potential in the forensic field, but to exploit it would require improving the relationship with the rest of the organisation in terms of the funding of posts to provide sufficient time to develop and expand the portfolio. There was a tension between

expanding training provision through the trust, or providing consultancy directly through the clinic.

It was agreed to discuss both portfolio reports together.

7.   Service Line Report – Systemic Portfolio

Ms Ayo introduced her report by noting that their course leads were new in post, and adjusting well given the loss of the most experienced tutor. The validation process had been a valuable opportunity to make changes and reshape courses. They were looking to embed systemic thinking more widely, and to introduce consultancy to M21 to give the course a unique selling point. Their long courses were core and essential, so they were looking to be innovative and contemporary in their CPD short courses.

Mr Holt asked whether teaching by video link preserved the collegiate atmosphere of small groups. Dr Blumenthal noted there were technical challenges with video links, but when they worked it was possible to do lectures and work discussion groups that way, although psychotherapy training was more difficult.

Prof Burstow noted the perverse incentives that were pitting Portman income generation against overall Trust growth, and asked how that was resolved equitably across the service lines. Mr Rock noted that Portman courses had a different organisational structure historically and elsewhere in the Trust differentiation between clinical and training roles were clearer. He added that the forensic portfolio was not synonymous with the Portman clinic, and whilst there existed a significant degree of complementarity, they also had different strategic objectives. Dr Senior noted the tension between the highly valued form of professional practice within the Portman, and the moral requirement to make what the Portman had to offer more widely available in other settings. Dr Blumenthal commented that they were already doing this, inspiring people to come in to the clinic or engage it for consultancy, and whilst they needed to think about a system for organising it better, that discussion should be held free of preconceptions.

Dr Stern commented that adult and forensic staff were aware of the challenges DET faced, but clinicians felt that bringing in money directly to the service was more beneficial than doing it via the rest of the organisation. Mr Rock noted that it had been agreed that a separate service line for E&T, with portfolios and portfolio manager roles, was the structure to use. Dr McPherson noted these issues had existed for a long time, but suggested that it was appropriate to review systems and recognise the knock-on effects of changes. Mr Holt commented that if the Trust was missing out on income as a result of the way its systems operated it was a tragedy and needed resolving quickly, as there was little time and growth in this area was critical for the Trust.

Ms Ayo commented that they needed to encourage those new in clinical posts to develop teaching as part of their careers to provide the next generation, but it was difficult as there was no capacity to do training in their current roles. Ms Hodges commented that the pressure of the changes to the national contract

were coming down to team level and having an effect, and with that tension reviewing courses, especially the shorter CPD ones, would be helpful.

Mr Jenkins noted that at the heart of the issue was the Trust's desire to develop what it did, but the difficulty of doing so when there was no income to underpin developments at the start. There was no easy solution to this with the increasing financial pressures, so it was important to get a clear shared vision of what the Trust wanted and then decide jointly how to achieve it. Clarity of vision and plan should come first. There was more that could be done on many portfolios, and the question was how to get the most from the unique clinical approach in the Portman and use it to reach the widest audience, by developing applications that were not dependent on a small number of staff.

Prof Burstow commented that it had been a useful discussion, and one that raised issues that would need to be resolved by the senior management team. In the context of the challenging financial outlook the Trust would be more successful if it acted as a whole. The message from the NEDs was that they wanted a resolution to the issue raised.

The Board noted the two reports.

8.   **Trust Chair's and NEDs' Reports**
Prof Burstow reported that the Sustainablility and Tranformatio Plan (STP) would be discussed in public at the November meeting of the Board. He expressed concern that the publication of the STP had been poorly handled with instructions from NHS England that draft STPs should not be published leading to negative media reporting and heightened suspicion about the goals of the process.

The Chair also reported that the Trust had jointly organised with Tavistock Relations an excellent policy seminar on relationships and life chances held at Westminster, which had been an example of the Trust at its best. On a recent visit to South Camden CAMHS he had witnessed the real issue they had with accommodation, and had flagged this to the chief executive. He had also made fascinating visits to Mosaic and First Steps and witnessed the exemplary clinical practice that is often discussed at the board.

Prof Bhugra had visited Abu Dhabi on mental health day, and seen the services that SLAM had set up there, which should be an inspiration for our own international ambitions. He noted that Prof Lamb from Hong Kong university, who was setting up a gender service there, would be visiting GIDS in January, and there were opportunities both in Hong Kong and on the mainland.

Ms Gizbert noted that Ms Lyon had attended the NICE stakeholder event, and it was good to see the connection between the organisations.

The Board **noted** the reports.

9. Chief Executive's Report

Mr Jenkins noted that this was the last meeting that Dr McPherson and Ms Jones would be attending, and thanked them both for their enormous contributions to the Trust.

He noted that the Century Films documentary would begin broadcast on the 17th November, and the episodes they had seen were excellent and told a powerful story.

Mr Jenkins reported that Mr Campbell would be starting to work for Camden and Islington NHS Foundation Trust as Trust Secretary, on a part-time secondment for a year, whilst continuing his role with the Tavistock and Portman.

The Board **noted** the report.

10. Strategic Objectives – review of progress

Mr Jenkins explained that the paper showed progress both for the quarter and for delivery overall. Prof Burstow noted that some of the indicators had moved from green to amber, and asked whether this was a question of capacity. Mr Holt commented that it was partly a result of harder deliverables becoming clearer as you approached the end point, combined with an evolution of the review process which meant that the Q2 scores were more robust.

The Board **noted** the report.

11. Refreshed Strategic Objectives for 2016-18

Mr Jenkins explained that given the changing external environment in which the Trust was operating and the north central London STP the opportunity had been taken to review the objectives, and make a call on prioritisation. Following the September Directors' Conference, they had grouped the objectives under seven aims to give a clearer focus on what was mission critical, and made the objectives more strategic. In November the finalised objectives would come to the board along with an updated BAF, for approval together.

Mr Holt reported that the Strategic and Commercial Committee had considered the objectives in the context where growth would be needed to balance the budget in the future, and they could not rely on the STP for growth as there was only a small margin available within the footprint. Therefore the refreshed objectives included an emphasis on growth outside London, and the necessity to use all contact points possible to increase income.

The Board **approved** the report.

12. Q2 Quality Report, commentary

Ms Shipman explained that this was the first attempt at a report which gave the background to gaps, and the learning to take from areas of good performance. It included commentary from service leads about the issues they had and what had

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been done to address them.

Prof Burstow noted the decrease in recording smoking status and that the number of interventions offered was still small, and asked what was behind this. Ms Shipman noted that there had been an increase in referrals following the appointment of Mr Tim Quinn, but completion of the form did not sit easily with some clinicians and work needed to be done on this. Mr Holt commented that recording the statistics should be easy, and asked whether the question couldn't be asked by administrative staff. Ms Hodges explained that it was a requirement for clinicians to ask the question in order to start a conversation, but that it got lost in the press of other things that needed to be discussed in the first session. Dr Senior added that there was also a cultural issue, with clinicians not trained to address public health issues, and the medical and nursing directorates had a role to play in promoting physical health. Ms Jones noted that the Trust was behind many others and it was an issue that could no longer be ignored. Whilst the staff training was well received, they needed to be more proactive in promoting it.

AP2 Prof Burstow requested that a report on physical health and the steps we were taking with our clinicians, but also on how education and training were including it in their courses, should be scheduled for a board meeting.

Mr Holt reminded the board of the problems with the last Quality Account, and how critical it was to get it right this year. Ms Shipman noted that the problem had been with waiting time data, and confirmed that they were working on validation and the data would be reliable by the year end. It was agreed that an update on preparedness and risks for the Quality Account should come to the

AP3 Board.

The Board **noted** the report.

13. Q2 Performance Dashboards

Mr Peel introduced the dashboards, explaining that they now included data on activity from EIS and TAP, and when Mosaic was included in the next quarter all non-Carenote services would be included. Data from these services on responsiveness was not yet included, the difficulty being in getting it from the organisations that held it in a timely way, and they were working on this. Further work on validation and to incorporate CYAF productivity would also be included in the next version. The waiting times were an area of concern, and the table had been enhanced to show the change over the preceding quarters.

Prof Bhugra commented that he had reviewed the Trust's complaints, and 2 out of 3 were concerned with GIDS waiting times, all of which had been handled very well. Dr McPherson commented that waiting times were likely to be increasingly used as a tool for judging performance in the future. Mr Jenkins noted that the increase in activity shown in the first table, and commented that this created an

AP4 increasing pressure on waiting times, which did seem to be getting worse. GIDS should improve with the increase in staffing, but overall there was best practice to be shared over practical measures that could be taken to see patients as soon as possible and support them during their wait. It was agreed that a report on waiting times, including both trajectories and granularity, should come to the next board.

The Board **noted** the report

14. Finance and Performance Report

Mr Doherty introduced the report, noting that the Trust was above plan with a surplus of £1.2M, which was predicted to reduce to £800k at year end, including the increased savings, in line with the revised control total. The Trust was currently ranked at level 1, the highest segment, under NHS Improvement's Single Oversight Framework. Discussions were proceeding with the auditors over whether the GIDS refurbishment expenditure should be categorised as capital.

Prof Burstow asked about the NHS debt in section 2.3.1, and Mr Doherty explained that this was money owed to the Trust by commissioners that had not yet been paid, but none of it was in dispute.

Mr Holt asked how the agency spend was being managed. Mr Doherty noted that the position had improved slightly over the previous month, and that they had agreed processes with HR to control the use of new agency staff, and to review the status of the 18 agency staff currently in admin posts across the Trust.

Prof Burstow asked whether it would be helpful to consider a central control over the current departmental underspends. Mr Jenkins commented that as the finances were critical, tighter central control was important, and an update on this should be included in the next report.

The Board **noted** the report.

15. Q2 IMT Report

Mr Jenkins noted that the report gave a comprehensive picture of the issues they faced, and highlighted the coming updates to infrastructure and email. Work on the network would be done on a managed service approach to insulate the Trust from the gaps in its skill set. He complemented Mr Rock and Mr Wyndham Lewis on the work they had done with the SITS project, which had reduced the risks from red to amber.

Ms Gizbert noted that she sat on the steering committee, and it was clear that it would not be possible to complete the full wish list of activities, and prioritisation would be necessary.

The Board **noted** the report.

16. Training and Education Report

Mr Rock introduced his report by noting that student numbers were up 16% on the previous year, and they had held a productive 'wash up' meeting which identified a number of changes that could be introduced to the recruitment system for the coming year. Fees had been reviewed, and an increase of 7% agreed after consideration of both costs and competitors' fees. Mr Rock tabled a

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brief summary of the breakdown of students: 68% were white, the next largest group was 'no data' at 10%, which should improve with the introduction of SITS, and then 7% recorded black or black British. He acknowledged that further work was needed on attracting students from different backgrounds. In the ICT project there had been real progress, especially in reviewing records, where 95% had been identified as ready for migration, which had been a major risk area for the project. Training had started with the faculty, and there would undoubtedly be a cultural challenge involved, but they expected SITS to be more immediately ready for use than had proved the case with Carenotes.

Mr Holt commented that it would be helpful to have more statistics on the makeup of students, especially a comparison of applicants to those accepted, and benchmarking, noting that it fed into the workforce makeup. Prof Burstow commented that he had requested the information following a BME staff meeting, and suggested they needed a more structured discussion of the issues at the Board.

The Board **noted** the report.

17.   Any Other Business
The Board noted its future meetings.

Part one of the meeting closed at 16.30

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

Outstanding Action Part 1

Action Point No.	Originating Meeting	Action Required	Director / Manager	Due Date	Progress Update / Comment
2	Feb-16	Monthly Optimisation Updates, and Quarterly IMT reports, to come to the Board	Toby Avery	April 2016	First update came in May, Quarterly report due in July. Completed.
3	Mar-16	3 to 5 year financial view to be drawn up	Simon Young	July 2016	Reviewed at Boad Away Day, Completed.
2	Oct-16	Report on Physical Health to come to the Board	Tim Quinn	Nov-16	Scheduled to come to the January meeting
3	Oct-16	Report on preparedness and risks for Quality Accounts for Board	Marion Shipman	Jan-16	Scheduled for January meeting.
1	Oct-16	Report on business plan of Tavistock Consulting to come to the Board.	Brian Rock	Mar-16	

Outstanding Actions

Board of Directors: November 2016

Item : 6

Title : Trust Objectives – Success Criteria and Q4 milestones

Summary :

The Board of Directors agreed the refreshed objectives at the October meeting.

Success criteria and Q4 milestones have now been included for review by Board. They have already been considered and agreed and the Management Team.

For :   Discussion

From : Chief Executive

Aim 1 – Contributing to the development of new models of care: Objectives and 2016-17 Q4 Milestones

1A. Work with partners in the NCL STP to transform mental health services and support the development of integrated care closer to home PJ

Success Criteria

Strengthened model for care close to home for mental health

Progress against STP objectives for improving quality outcomes

T&P secures recognition for system leadership in reshaping models of care including issues relating to staff recruitment and retention

Co-production embedded in approach to reshaping mental health services

Quarter 4 Milestones

1. STP plans embedded contracts for 2017/8 -2018/9

2. Implementation plans agreed for STP MH priorities for 2017/8

3. Experts by Experience Reference Group up and running

4. Effective contribution to development of thinking on new delivery models in NCL

1B. Establish a leadership role for the Trust in the field of children and young people's mental health including promoting Thrive as the leading model for the provision of CAMHS services PJ/SH

Success Criteria

Thrive is central to transformation plans and commissioning intentions for an increasing number of CCG's & STP's

Growth in Thrive Community of Practice and established evidence base for effectiveness of Thrive

Sustainable funding model for i-Thrive Programme Team
T&P leads introduction of local t4 commissioning across the STP area

T&P takes system leadership role in development of CAMHS acrosss NCL STP

Quarter 4 Milestones

1. Completion of commissioned modules for i-Thrive Academy including progress against HEE funded risk support workstream

2. Agreement of strategy for suststainable funding of –iThrive Programme

3. Agreed model for t4 commissioning in NCL ready for second wave bidding process

4. Active T&P involvement in all CAMHS workstreams in STP

Objectives

1C. Develop our contribution to models of problem solving justice and intervention for vulnerable children including securing sustainable funding model for FDAC and FNP PJ/SH

Success Criteria	**Quarter 4 Milestones**
Sustainable funding model for FDAC and FDAC National Unit	1. A programme of negotiations is in place with DfE & DoJ, aim to secure funding for the gap year
Develoment of FDAC model to other areas of problem solving justice and work with vulnerable families	2. To continue lining up interested LA's for the SIBs programme, and to ensure a structure for these relationships as well as a model for the funding
	3. To secure the south London FDAC contract
T&P secures reprocured contract for FNP National Unit	4. To continue negotiations and regular meetings with PHE
Evidence from ADAPT programme of effectiveness of planned changes to FNP interventions	5. To develop further the knowledge and skills exchange framework and collect feedback to ensure that it is well received
	6. That the ADAPT programme starts to generate positive data re outcomes and cost effectiveness

1D. Establish a leadership role for the Trust in the field of primary care mental health JSt/BR

Success Criteria	**Quarter 4 Milestones**
Establish a Primary Care MH programme within DET as part of the NTC national programmes, linked to the Primary care clinical service in AFS to develop relevant frameworks to support mental health developments and delivery in the sector	1. Further develop Primary Care Programme between DET & clinical services with key membership including staff and external advisers and establish programme requirements for staffing, scope and reach
Raise the profile of the distinctive work of the Trust in primary care and foster interest and engagement with our clinical model	2. Further development of successful MUS formats including regional meetings and contribution to relevant developments elsewhere, including the "Breaking down the barriers" conference in Jan 2017
Further develop research in primary care settings to develop best practice and foster innovation	3. Continue to scope relevant partnerships with organisations engaged in this area including UCLP (Developing Primary Care)

Aim 2 – Maintaining and developing the quality and reach of our clinical services. Objectives and 2016-17 Q4 Milestones

2A . To maintain and develop our existing portfolio of services for adults and children and support links with our work on education and training JSt/SH	
Success Criteria To ensure that our services maintain a distinctive quality that warrants them to be continued to be commissioned Ensure sustainability for our clinician trainer model To grow the clinical services from the current base via strong relationships with commissioners and local providers	**Quarter 4 Milestones** 1. To support contracts through the current commissioning round 2. To work with DET to ensure clinical staff are being used for training, that this is equitable and sustainable across clinical services 3. To engage with commissioners re CAMHS transformation plans locally (SH) 4. To engage with the STP mental health workstream where ever possible

2B. Agree and implement the Trust' clinical quality strategy including the delivery of current and future regulatory requirements LL	
Success Criteria Maintain Good rating with CQC awaiting visit before end of November 2016 Establish and implement a clinical quality improvement programme	**Quarter 4 Milestones** 1. Present clinical quality improvement strategy to the Board in January 2. Review progress on clinical quality strategy 3. Develop an agreed realistsic action plan to progress clinical quality objectives for remained of 2016-7 period of the strategy 4. Establish a plan for engaging all staff in quality improvement

2C. To develop systems for capturing, analysing, reflecting upon and acting upon qualitative and quantitative data to support the implementation of the clinical quality strategy with a particular focus on capturing the experience of people who use our services. LL	
Success Criteria Comprehensive, easy to assimilate data is available to internal and external stakeholders to provide assurance Monitor performance and show where improvement is required or has successfully been achieved Evidence that we have a good understanding of how our service users experience our services.	**Quarter 4 Milestones** 1. **Complete work with** dashboard project to ensure that dashboards cover main areas of data capture relevant both to external and internal reporting 2. Develop a proposal to share with Commissioners to reduce amount of data collected and to agree on which measures are most relevant to monitoring performance and providing assurance

Objectives

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

3A Agree and implement changes to our National Training Contract including the establishment of an Educational Consultancy BR

Success Criteria

Fully engage with the opportunity affored by the development of the NTC to extend the reach and the impact of our education and training offer for the development and transformation of the workforce

Establish successful partnerships and fully engage with collaborating organisations to develop, deliver and extend our contribution to mental health in line with the 5 year forward view

Quarter 4 Milestones

1. Establish the Educational Consultancy and governance arrangements (incl. with HEE)
2. Identify and establish new programmes (incl. links with clinical services)
3. Establish the National Mental Health Training Hub and agree priorities for 17/18
4. Continue with Portfolio Review for course development and expansion and

3B Deliver targets for growth in student numbers and educational income through local and/or Technology Enhanced Learning delivery on a national and international front BR

Success Criteria

Achieve growth in the reputation and relevance of our approach to learning and development through increase in reach geographically and across different levels of the workforce in related sectors

Develop and deliver a credible and stretching TEL strategy that underpins growth and an increase in capacity to extend our contribution

Quarter 4 Milestones

1. Setting targets for growth in student numbers (based on a better understanding of course level contribution and required national reach)
2. Appointment of interim TC Lead and implementation of TC review
3. Establish E&T commercial strategy and focus of TEL development opportunities
4. Draft strategy for international development

Aim 4 – Supporting the wellbeing and engagement of our staff

4A Agree and implement an Organisational Development and People Strategy that includes our commitment to enhancing staff health, wellbeing, diversity and inclusion. CdS

Success Criteria	Quarter 4 Milestones
To deliver a comprehensive organisational development and people strategy that sets out the workforce priorities for the next two years. Maintain and improve Trust performance against Trust survey Improve staff retention	**Quarter 4 Milestones** 1. Achieve Board approval of the organisational development and people strategy 2. Respond to the findings of the 2016 NHS Staff Survey 3. Review our recruitment, marketing and attraction processes 4. Launch the Trust's new management and leadership development programme

4B Progress towards seeing better implementation of diversity at all levels in the organisation. CdS / LL / BR

Success Criteria	Quarter 4 Milestones
Implement our four year diversity and inclusion objectives with a specific focus on recruiting, developing, retaining and providing promotional opportunities for our diverse staff and students. Ensure that we comply with our statutory obligations and deliver a comprehensive annual diversity and inclusion report with the appropriate equality delivery system (EDS) assessment.	**Quarter 4 Milestones** 1. Deliver the statutory diversity and inclusion annual report and objectives 2. Review and assess applications made to the management development programme 3. Finalise the scoping assessment of staff, service users and students with disabilities 4. Assess the impact of senior HR professionals on interview panels for roles graded 8 and above

Objectives

Aim 5 – Delivering a sustainable financial future for the Trust

5A To lead the development and updating of a Commercial Strategy for the Trust to generate growth in income across our activities including options for developments outside London and internationally. TN/JS	
Success Criteria Trust Income to increase by £500k in 2017/18 and £1m in 2018/19	**Quarter 4 Milestones** 1. Training Commercial strategy in place March 2017 2. Secure £4m contract for Adult GIC if awarded host arrangement Jan 2017 3. Conclude contract negotiations achieving a £0.5m increase in GIDS and £200k increase in CCG contracts 4. Refresh Patient Services Commercial Strategy February 2017
5B Deliver the Trust's agreed control total for 2016/7 TN	
Success Criteria Control total of £800k achieved	**Quarter 4 Milestones** 1. Monthly reforecasts reviewed by Management Team 2. Decision regarding capitalisation of office refurbishment for GIDS
5C To develop a 2017/8 budget for the Trust in line with our Control Total TN	
Success Criteria 2017/18 Budget set to deliver a surplus of £950k Efficiencies to achieve Budget identified and agreed with Budget holders	Quarter 4 Milestones 1. November 2016 Board agreement to confirm 2017/18 and 2018/19 Control Totals 2. Major contracts signed off by 23 December 2016 3. Budget holders 'sign off' agreed efficiencies necessary to achieve Budget 4. Budget approved by March 2017 Board

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

6A To agree and implement the Trust's Public Affairs Strategy LT	
Success Criteria Increased media profile and enhanced reputation as thought leader Increased reach of our communications	**Quarter 4 Milestones** 1. Maximise reach and positive coverage of Kids on the Edge and kick start next major documentary project (probably FDAC). 2. Successfully tender for an independent reputation audit. 3. Establish internal mechanisms to implement Public Affairs strategy. 4. Secure positive coverage (proactively) and online content for Trust projects and services which illustrate one of the three areas of focus identified in the Public Affairs Strategy. 5. Insightful and actionable reputation audit that informs our public affairs strategy

6B To develop, deliver and maintain an alumni function which creates a 'community of practice' and significantly reinforces the lifelong relationship between the Trust and its alumni. LT/BR	
Success Criteria Successful promotion campaign leading to a steady rise in alumni numbers Relevant and popular series of events and opportunities Creating a real sense of community and connection for past students Developing Tavi ambassadors	**Quarter 4 Milestones** 1 Continue to increase number of registered alumni and introduce cards. 2 Develop a suite of events across 2017 following on from initial first event. 3 Use alumni function to actively promote book launches, policy seminars and other activities that contribute to establishing the Trust as a thought leader. 4 Create an alumni newsletter and identify contributors and ambassadors for the Trust.

6C To secure further prestigious external grant funding for research, contributing to raising the Trust's profile as a leader nationally and internationally in the clinical and training domains RS		
Success Criteria Achieve further grant funding Contribute visibly to research where funding is held by other organisations	**Quarter 4 Milestones** 1. Deliver successful recruitment on NIHR programme grant 2. Develop relationships with potential co-applicants in HEIs, Trusts and Third sector 3. Hold workshops with potential partners to shape applications 4. Submit further research grant applications	

Aim 7 - Develop our infrastructure to support our work

7A To agree a Full Business Case for the best long term accommodation for the Trust's businesses TN	
Success Criteria Confirmation of preferred option New site identified (if appropriate) Required funding obtained Full Business Case approved by Board and NHS England Staff 'buy in' to preferred option	**Quarter 4 Milestones** 1. Revised costings / financial appraisal presented to the Council of Governors 2. If appropriate new site identified and Heads of Terms Agreed 3. If new site not appropriate, then outline plan for redevelopment agreed
7B To implement the IM&T strategy for the Trust which better supports our work and staff DW-L	
Success Criteria Delivery of projects related to the Infrastructure IMT strategy theme Delivery of projects related to the Information IMT strategy theme Delivery of projects related to the Services IMT strategy theme	**Quarter 4 Milestones** 1 Complete Network Refresh procurement and replace network hardware at the Tavistock Centre 2 Complete migration of Trust email to modern platform and Office365 3 Complete eReferral, Data Warehouse and Analystics (Phase 1) & GID Telemedicine projects 4 Implement new Service Desk and PPM systems

Objectives

Board of Directors: November 2016

Item : 7

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 November, January, April and July 2016.

As agreed, the BAF has now been completely revised and refreshed, at the same time as the review and revision of the two-year objectives.

As in previous years, the new BAF will be updated and brought to the Board quarterly – in January, April and July. 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 17 November.

For :   Approval

From : Chief Executive

BAF

Board Assurance Framework

1. **Introduction**

1.1 The Board Assurance Framework seeks to identify the key risks that could prevent the Trust from achieving its strategic objectives. For each risk, the framework sets out:

- the controls and processes that are in place to manage and mitigate the risk;
- the gaps;
- the independent[1] assurances received by the Board, that support these assessments;
- the current level of risk, taking into account all the above; and
- the action plans to reduce the risk further.

We do not formally re-score the likelihood after taking into account the action plans. See 2.1 below.

1.2 Directors have each reviewed and re-written their sections of the BAF; and assessed the scores for each risk.

2. **Conclusion**

2.1 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.

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[1] Where appropriate, this section may include non-independent reports that have given the Board assurance on the management of the risk.

The Tavistock and Portman **NHS**

NHS Foundation Trust

Board Assurance Framework 2016/17 - Summary

Risk	Owner	Related Aim	Current R/A/Y/G	Oct rating C x L = R			
Clinical quality or governance failures in context of elevated risk of serious incidents.	Rob Senior	2		4 x 3 = 12			
Clinical growth targets not achieved.	Julia Smith	5		3 x 5 = 15			
Education and Training quality failures.	Brian Rock	3		4 x 2 = 8			
Training course numbers reduced, or growth targets not achieved.	Brian Rock	3		3 x 3 = 9			
Adverse impact of National Training contract changes	Brian Rock	3		5 x 3 = 15			
Loss of workforce engagement / morale / commitment.	Paul Jenkins	4		4 x 3 = 12			
Loss of workforce skills.	Craig De Sousa	1, 2,3		4 x 2 = 8			
Unable to agree or fund relocation / redevelopment plans.	Terry Noys	2,3 4		4 x 3 = 12			
IT applications and hardware do not sufficiently support Trust objectives. Loss of access to critical systems.	David Wyndham Lewis	7		4 x 3 = 12			
Insufficient management capacity.	Paul Jenkins	all		4 x 4 = 16			

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The Tavistock and Portman **NHS**

NHS Foundation Trust

Damage to the Trust's reputation and brand.	Paul Jenkins	6		4 x 2 = 8
Regulatory failure.	Paul Jenkins	5		5 x 1= 5
Savings and growth contribution insufficient.	Terry Noys	5		4 x 4 = 16

Notes
(i)   C= consequence. L = likelihood *(allowing for the controls and assurances shown)*. R = C x L = risk rating.
(ii)   Rating 15+ = Red; 9 – 12 = Amber; 5 – 8 = Yellow; 1 – 4 = Green (in accordance with Trust risk management policy).
(iii)   Section 2 contains a separate table for each risk.

Board Assurance Framework

RISK: Clinical quality or governance failures – including the risk of serious incidents.	**Risk Owner:** Medical Director
	Date last reviewed: November 2016

Strategic Objectives affected by this risk:	Current risk rating:
Quality and patient experience.	Consequence 4 x Likelihood 3
Leadership in new models of care.	
Leadership in children's mental health and development.	**12**
Development of adult and forensic services.	

Controls/Influences *(what are we currently doing about this risk?)*:	Rationale for current score:
Director of Quality and Patient Experience leads Quality work-stream reporting to CQSG Committee.	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.
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.	

Gaps in controls/influences:	Action plans in response to gaps identified: *(with lead and target date)*
Restructuring of Quality Team and Clinical Governance Office needed to meet enhanced requirement for integrated programme of quality improvement.	Recruitment and retention of suitable junior staff continues to be challenging but all posts now appointed. Full team now operational.
Assurance received *(independent reports on processes; when; conclusions)*:	Shared systems being established across partner organisations where possible.
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	

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Board Assurance Framework

Voluntary Sector are difficult to mitigate.

Investigations including SCR and coroner's inquest have not identified failures by Trust practitioners.

Board Assurance Framework

RISK: Clinical growth targets not achieved.	Risk Owner: Commercial Director
	Date last reviewed: August 2016

Current risk rating:

Consequence 3 x Likelihood 5

15

Strategic Objectives affected by this risk:

Leadership in new models of care.

Leadership in children's mental health and development.

Development of adult and forensic services.

Finance – balanced budgets.

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.

Gaps in controls/influences:

External environment has changed, so patient services strategy needs to be refreshed.

Rationale for current score:

The growth target is very high. Currently the income we can secure through current prospects, after likely losses are factored in, falls short of the target.

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

Refresh patient services plan Feb 2017 (RS & JS)

BAF

Board Assurance Framework

No systematic plan in place to manage relationships. No systematic approach with regard to horizon scanning.	Create relationship management plan Dec 2017 (JS) Horizon scan plan in place January 2017 (JS and RS)
Assurance received (independent reports on processes; when; conclusions): 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.	

Board Assurance Framework

RISK: 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: November 2016
	Current risk rating: Consequence 4 x Likelihood 2 8
Strategic Objectives affected by this risk: Deliver growth in student numbers. Increase our national reach. Raise the profile of the Trust.	**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; but is being managed as set out here.
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 (SITS).	

BAF

Gaps in controls/influences:

1) Professional support services restructure undertaken alongside the development and embedding of clearer processes across roles.

2) New staffing arrangements in core administrative team.

3) Implementation of SITS involves sustained input from operational team.

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

QAA inspection visit successfully completed with all four required expectations met (April 2016 visit. 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)

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).

3) Review of requirements for project team for the period of the SITS project (Concluded by Dec 2016).

Board Assurance Framework

RISK: 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: November 2016
Strategic Objectives affected by this risk: Develop the scope of our training and education work. Increase numbers of students. Finance – balanced budgets.	**Current risk rating:** Consequence 3 x Likelihood 3 \[9\]
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 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.	**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.
Gaps in controls/influences: 1) Development of new long and short courses to expand portfolio of programmes	**Action plans in response to gaps identified:** (*with lead and target date*) 1) Portfolio review being led by

Board Assurance Framework

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	Associate Dean (AGQA) underway and recruitment review should identify possible provision to address steps into existing programmes (Jan 2017). 2) Review underway with Director of IM&T to address support for AV. 3) More timely review of operational constraints being undertaken in a more timely manner linked to accommodation review.
Assurance 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 reports provided to the Training and Education Programme Management Board and the Board of Directors.	

Board Assurance Framework

RISK: Adverse impact of National Training Contract changes With significant changes to HEE in its funding and focus, there is an active review of our National Training Contract with an expected change in its remit and 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: November 2016
Strategic Objectives affected by this risk: Develop the scope of our training and education work. Increase numbers of students.	Current risk rating: **15** Consequence 5 x Likelihood 3
Controls/Influences (*what are we currently doing about this risk?*): Task & Finish group has actively supported development of proposals from three key workstreams (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.	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.
Gaps in controls/influences: 1) External review. Assurance received *(independent reports on processes; when; conclusions)*: Ongoing engagement with key HEE colleagues in an active process.	Action plans in response to gaps identified: *(with lead and target date)* 1) 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

Board Assurance Framework

RISK: Loss of workforce engagement and morale	Risk <u>Owner</u>: Chief Executive Date last reviewed: November 2016
Strategic Objectives: Supporting the engagement and wellbeing of staff	Current risk rating: Consequence 4 x Likelihood 3 **12**
<u>Controls/Influences</u> (*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.	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.
<u>Gaps in controls/influences</u>: 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: 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.
Assurance 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.	

Board Assurance Framework

RISK: Loss of workforce skills.

Risk Owner: Director of HR

Date last reviewed: November 2016

Current risk rating:

Consequence 4 x Likelihood 2

8

Strategic Objectives affected by this risk:

Changing the way we work.

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

Action plans in response to gaps identified:

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.

BAF

Board Assurance Framework

framework will be delivered in 2016/17 to support a consistent 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.

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

Quarterly reports to the Board

Board Assurance Framework

RISK: Unable to agree or fund relocation / redevelopment plans.	**Risk Owner:** Deputy Chief Executive
	Date last reviewed: November 2016

Current risk rating:

12

Consequence 4 x Likelihood 3

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<u>Strategic Objectives affected by this risk:</u>

Changing the way we work. Maintaining and developing the Tavistock and Portman's psychosocial approaches to mental health.

<u>Controls/Influences (what are we currently doing about this risk?):</u>

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

Initial loan approved by ITFF and by Board in March, to cover £2m pre-FBC costs and possible £2m deposit to secure rights to a site.

Updated options appraisal being undertaken to confirm (or otherwise) original Board decision

<u>Gaps in controls/influences:</u>

Future movements in property values (for both sale and purchase) uncertain but appear to be moving adversely

Spending Review has reduced overall NHS capital funding; but our application is to be considered nonetheless, and alternatives are also being explored.

Timescale has slipped, mainly because a site has not yet been secured.

<u>Assurance received (independent reports on processes; when; conclusions):</u>

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

</td>
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<u>Rationale for current score:</u>

Current buildings deemed insufficient to cope with proposed expansion of activities. Cost of maintaining existing buildings excessive (compared with alternatives)

Some progress made but key elements of the plan not yet fixed.

Relocation is currently assessed as best option operationally and financially, but to be confirmed when specific options are available.

<u>Action plans in response to gaps identified:</u> (with lead and target date)

Board in June agreed action plan to secure a site before December, and update the key elements of the case, with issues and costs, to support the decision to agree heads of terms on this site.

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BAF

Board Assurance Framework

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

<u>Risk Owner</u>: Director of IM&T
Date last reviewed: November 2016

<u>Strategic Objectives affected by this risk</u>:
Changing the way we work.

<u>Current risk rating</u>:
Consequence 4 x Likelihood 3

12

<u>Controls/Influences</u> (*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.

<u>Rationale for current score</u>:
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.

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.

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.

<u>Action plans in response to gaps identified:</u>
(*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 is lead.

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.

<u>Gaps in controls/influences:</u>
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.

<u>Assurance received</u> (*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.

BAF

The Tavistock and Portman **NHS**

NHS Foundation Trust

Board Assurance Framework

RISK: Insufficient management capacity	Risk Owner: Chief Executive
	Date last reviewed: November 2016
Strategic Objectives:	Current risk rating: 16
	Consequence 4 x Likelihood 4
	Rationale for current score:
	As a small and diverse Trust management resources are spread thinly.
Controls/Influences (*what are we currently doing about this risk?*):	Need to support growth alongside savings agenda.
Refine strategic plan to focus priorities and manage trade offs	
Use in year surpluses to boost resources and review opportunities to share resources across organisation through the Mental Health Alliance and National Mental Health Training Hub.	
Gaps in controls/influences	

Board Assurance Framework

	Action plans in response to gaps identified:
Uncertainty of external environment and impact on internal capacity.	Continue to use strategic plan to review pressures and resolve tensions over priorities.
Assurance received
Quarterly review of progress against strategy objectives by the Strategic and Commercial Committee	

RISK: Damage to the Trust's reputation and brand.	Risk Owner: Chief Executive
Date last reviewed: November 2016
Strategic Objectives: Maintaining and developing the Tavistock and Portman's unique tradition of psychosocial approaches to mental health.	Current risk rating:
Consequence 4 x Likelihood 2   **8**
Controls/Influences (*what are we currently doing about this risk?*):
Strengthening communications and marketing team
Focus in strategic plan on building profile, developing links with alumni and developing thought leadership
Public Affairs Strategy
Developing links with stakeholders	Rationale for current score:
Generally positive reputation in wider mental health world but not necessarily contemporary. Need to raise profile of current work and relevance.
Gaps in controls/influences:
Significant change in external environment	Action plans in response to gaps identified:
Century Films documentary due to be broadcast in November.
Public Affairs Strategy due to the Board in February.
Assurance received
Media monitoring
External reputation audit	

BAF

Board Assurance Framework

RISK: Regulatory failure.	Risk Owner: Chief Executive
	Date last reviewed: November 2016
Strategic Objectives:	Current risk rating:
Regulatory requirements/Governance and leadership	Consequence 5 x Likelihood 1 **5**
Controls/Influences (*what are we currently doing about this risk?*):	Rationale for current score:
Range of governance processes in place.	Strong current performance but needs to keep under review.
CQC Good rating	
QAA Fully meet UK requirement	
Gaps in controls/influences:	Action plans in response to gaps identified:
Ongoing pressure for efficiency savings impact on management capacity	CQC action plan agreed and being implemented. Further inspection expected in November to look at one area requiring improvement.
Assurance received	
CQC rating	QAA action plan developed and being implemented.
QAA rating	
Clean external audit opinion, May 2016.	

Board Assurance Framework

BAF

RISK: Savings and growth contribution insufficient.	Risk Owner: Deputy Chief Executive Date last reviewed: November 2016
	16
Strategic Objectives affected by this risk: Finance – deliver balanced budgets through growth with contribution, and savings.	Current risk rating: Consequence 4 x Likelihood 4
Controls/Influences (*what are we currently doing about this risk?*): Projections and targets for 2017-18 agreed by Management Team. Growth targets and action plans reviewed by Strategic and Commercial Committee (SCC) and Board and Training programme Board. Draft Directorate savings plans in place. Draft income and savings targets in plan for 17-18 and 18-19 required by all NHS Trusts for NHS Improvement.	Rationale for current score: It is likely required savings and growth targets will be made for 2017/18. The Primary risk relates to 2018/19, where achievability of targets are currently less certain and are not yet supported by detailed delivery plans.
Gaps in controls/influences: Realistic growth target needs to be agreed for 2018/19. External environment has changed significantly and therefore there is a need to review both DET and clinical	Action plans in response to gaps identified: *(with lead and target date)* 2018/19 growth targets to be agreed by December in line with STP financial process. (PJ/JS/TN/BR) DET commercial strategy December 2016 (JS/TN/BR) Patient services commercial strategy refresh December 2016 (JS/SH/Jst)
Assurance received *(independent reports on processes; when; conclusions)*: Minutes and paper for SCC and MT. STP finance plan.	
	Draft delivery plans for 2018/19 and timetables produced February 2017 (TN)

Board of Directors : November 2016

Item : 8

Title : North Central London Sustainability and Transformation Plan

Summary:

This report provides an overview of the published North Central London (NCL) Sustainability and Transformation Plan (STP). The draft NCL STP strategic narrative was submitted to NHS England on 21 October 2016, appendix A.

Submission of the draft NCL Sustainability and Transformation Plan is supported by the development of workstream delivery plans. The workstreams focus on identified priorities for joint working across North Central London and focus on:

- Prevention
- Service Transformation
- Productivity
- Enablers
- Patient and Public engagement

The Trust has played a key role in the development of the plan with Paul Jenkins as Senior Responsible Officer for the mental health workstream. We believe this is the right direction of travel for the sector.

The Board is asked to **note** the plan;
Support the direction of travel; and
Comment on the next steps.

This report focuses on the following areas:

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

For : Noting

From : Paul Jenkins, Chief Executive

Page 1 of 6

<u>Sustainability and Transformation Plan</u>

1.   Introduction

The draft Sustainability and Transformation Plan (STP) has been produced by all the main healthcare organisations and local authorities within North Central London. It sets out plans to meet the challenges faced locally and to deliver high quality and sustainable services in the years to come.

The vision for the STP is for North Central London to be a place with the best possible health and wellbeing, where no one gets left behind.

The clinical case for change within the STP describes the changing health and care needs of local people and the key issues facing health and care services in North Central London. It will be used to guide the transformation of local services over the next five years.

The clinical case for change in the STP is aligned to address the gaps identified in the Five Year Forward Plan for health and wellbeing, care and quality, and finance.

To support delivery of the vision for the STP and address the clinical case for change a programme of transformation has been designed with four fundamental aspects:

- **Prevention:** We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population;
- **Service transformation:** To meet the changing needs of our population we will transform the way that we deliver services;
- **Productivity:** We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale;
- **Enablers:** We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation.

Delivering these plans will result in improved outcomes and experience for the local population, increased quality of services and significant savings.

The STP is still work in progress. Despite the development of the plans for prevention, service transformation, productivity and enablers the draft STP submitted on 21 October 2016 showed an overall £75m deficit in 2020/21 across NHS organisations. A number of areas for further work have been identified between now and Christmas where additional savings can be found to address this residual gap.

To ensure overall delivery as a system, a robust governance structure is being developed to enable NHS and local government partners to work together in new ways to drive implementation.

It is crucial that the whole system is aligned around delivery of the STP and work is underway to ensure that the development of the two-year health contracts that are being put in place for 2017/18 - 2018/19 are consistent with the STP strategic framework.

There is more work to do to finalise the granular detail of our delivery plans and address the residual challenge forecast. Development of plans in more detail will involve full engagement of people who use services and the public to ensure those plans are reflective of their needs. There is a commitment to being radical in approach, to focusing on improving population health and delivering the best care in London. Our population deserves this, and we are confident that we can deliver it.

The draft North Central London Sustainability and Transformation Plan therefore articulates:

- The health and social care landscape, and its complexity;
- The collective understanding of the challenges faced through the clinical case for change;
- The vision for health and care in NCL in 2020/21;
- The plans to deliver the vision and address the challenges, and the delivery framework that will enable implementation of those plans;
- The impact expect to be achieved through the delivery of the plans;
- Supporting governance arrangements;
- Plans for securing broader public support and engagement with the STP proposals;
- Next steps for further developing proposals and responding to our residual financial gap.

2.   Workstream delivery plans

Submission of the draft NCL Sustainability and Transformation Plan is supported by the development of workstream delivery plans. The workstreams focus on identified priorities for joint working across North Central London and focus on:

Prevention: We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population:
- This includes a focus on population health, particularly in areas that will support improved outcomes and reduced costs within the five-year period of the STP – smoking, alcohol ,obesity, falls and sexual health (use of long-term contraception and earlier diagnosis of HIV);

- A focus on a workforce for prevention including mental health first aid, dementia awareness, and the making every contact count programme;
- A focus on healthier environments including workplace wellbeing and an environment to help reduce childhood obesity.

Service transformation: To meet the changing needs of our population we will transform the way that we deliver services:
- A focus on developing out of hospital services and providing health and care closer to home. This includes the development of urgent care and primary care services;
- Development of mental health services for adults and children;
- Urgent and emergency care including an integrated urgent care system;
- Optimising elective care pathways including outpatient activity;
- Consolidation and/or networking of services following the previous template in London for stroke and trauma services;
- Cancer pathways including earlier diagnosis and improving patient experience.

Productivity: We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale through a focus on:
- Workforce (skill-mix; shared recruitment and bank functions, increase retention);
- Reducing operational and clinical variation including a response to recommendations in the Carter Report;
- Procurement efficiencies by acting at scale;
- Sharing back office functions;
- Reducing contract and transaction costs including new commissioning and contract models;
- Cost improvement schemes including theatre productivity.

Enablers: We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation. This will be dome through workstreams for:
- Workforce including the use of integrated employment models, developing new roles to support new models of care, and enabling productivity opportunities;
- Digital maturity including interoperability across providers as envisaged with the "Care My Way" programme in Islington;
- Estates including developing an overarching estates strategy, optimising the use and quality of estate across health and care services, supporting delivery of new models of care by delivering linked improvements to the health and care estate, and creating partnership working between commissioners and providers to align incentives for estate release and support delivery of devolved estates powers for the NHS and partners.

Patient & public engagement: We have a commitment to work in an open and transparent way. The STP summary has been produced to support

further engagement, in recognition that the full STP is a technical planning document. All organisations involved in the STP are asked to publish the full strategic narrative and summary on their websites to stimulate feedback and engagement with patients, the public, staff and other stakeholders. We recognise that engagement on the overall STP to date has been limited to the stakeholder meetings held in each borough in September, although individual STP workstreams such as mental health have also engaged users of service in the development of their plans. We will now develop an STP workstream on communications and engagement to ensure we build active and effective engagement into the further development and delivery of the STP.

3. Mental Health

The plan will give equal priority to physical and mental illness and aim to reduce demand on hospital care and mental health inpatient beds. Plans include increasing access to primary care mental health services and improving how we manage acute mental health problems, building community capacity to enable people to stay well; and investing in mental health liaison services – for example ensuring that more people in hospitals have their mental health needs supported. The plan will also look to strengthen perinatal and child and adolescent mental health services (CAMHS).

The transformation of services in mental health will be based on a stepped model of care (see below) supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs.

Details of the mental health initiatives can be found on page 27 of the plan:
- Improving community resilience
- Increasing access to primary care mental health services
- Improving the acute mental health pathway
- Developing a female psychiatric intensive care unit
- Investing in mental health liaison servicers
- CAMHS and perinatal
- Investing in a dementia friendly NCL

The Tavistock and Portman has played a key role in the development of the mental health strand of the plan, and I have been the Senior Responsible Officer (SRO) for that workstream. The workstream is now actively working to support development of implementation plans.

4.   Conclusion

As the Board has previously discussed, the Trust has supported the direction of travel for the STP and the case for developing a population health model which puts a greater focus on prevention, early intervention and managing care, where appropriate, in primary and community care.

The Mental Health workstream has followed a similar approach and has generated a very positive level of joint working between organisations across North Central London.

Delivering the plan will be challenging, recognising both the amount of change proposed and the overall financial pressures facing the sector. There will also be the need, which is recognised, for significant more work around patient and public engagement including the scope for meaningful co-production around the implementation of new service models.

The Board is asked:

- to **note** the plan;

- **Support** the direction of travel

- **Comment** on the proposed next steps

Paul Jenkins, CEO
November 2016

North Central London
Sustainability and Transformation Plan

21 October 2016

DRAFT

Key information
Name of footprint and number: North Central London, no. 28
Nominated lead of the footprint: David Sloman, Chief Executive, The Royal Free NHS FT
Organisations within footprint:
CCGs: Camden, Barnet, Islington, Haringey, Enfield
LAs: Camden, Barnet, Islington, Haringey, Enfield
Providers: Barnet, Enfield and Haringey Mental Health NHS Trust, Camden and Islington NHS FT, Central London Community Healthcare NHS Trust, Central and North West London NHS FT, Moorfields Eye Hospital NHS FT, North Middlesex University Hospital NHS Trust, Royal Free London NHS FT, Royal National Orthopaedic Hospital NHS Trust, Tavistock and Portman NHS FT, University College London Hospitals NHS FT, Whittington Health NHS Trust

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Contents

1 Foreword

Welcome to the Sustainability and Transformation Plan (STP) for the health and social care services that serve the population of North Central London (NCL). The aim of the STP is to ensure NCL is a place with the best possible health and wellbeing, where no one gets left behind.

This STP is a work in progress and we welcome your comments and input as we further develop the plans.

For the first time, we have come together as health and social care partners to plan how we will deliver excellent, future-proofed services for our local population over the next 5 years.

We know that the health and social care needs of our local people are changing, and that there are serious issues facing health and care services in NCL. People receive different care depending on where they go to obtain it: waiting times for services and health outcomes vary, and the quality of care and people's experience of health and social services is sometimes not as good as it could be.

On top of this, our financial situation remains challenging. Demand for health and social care continues to grow year on year and the growth in demand is running faster than the growth in funding. If we do nothing, we estimate that we would face an unprecedented financial gap in relation to health services alone of nearly £900m in NCL by 2020/21. In addition, as is well known, the trend is for people to live longer and in turn this is creating pressure on social care services and funding.

We believe the best approach to meeting these challenges is to work together to tackle them head on, working together to find solutions at scale and aligning as a system around the interests of local people rather than solely focusing on our individual organisations. It takes time to build relationships and trust in the context of a system that is fragmented and under increasing pressure, but we are committed to this joint endeavour across the whole partnership.

The STP sets out our commitment to transforming care to deliver the best possible health outcomes for our local population; shifting our model of care so that more people are cared for in out of hospital settings - through prevention, more proactive care, and new models of care delivery – and reducing reliance use of secondary care. We have made significant progress in developing our specific ideas for how we will achieve this. We have set up 13 different workstreams and have worked hard on these over the last few months to develop thinking, building on evidence and involving hundreds of members of staff drawn from every organisation in NCL. We have held public meetings in each of the boroughs to start to develop a dialogue with the local community, although we recognise there is much more to do on engagement in the months ahead.

The plan sets out a mixture of both radical service transformation and incremental improvements we believe we need to make in order to deliver real benefits for our population: increasing the emphasis on prevention; shifting care closer to home to reduce demand on hospitals; reducing variation in quality; improving productivity and reducing waste.

But the plan as it stands does not have all the answers. There are some parts of the plan which we have not had time to develop in detail that require significantly more work. We recognise the sheer scale of the changes that we set out currently in the plan will stretch our capacity to deliver, so we need to stress test the plan to ensure we focus on the most important improvement first. And fundamentally the plan does not yet balance the finances, either next year or by 2020/21. Unless we can do so, we will not be able to afford all of the investments and improvements we aspire to deliver. As a result we know that we may face some really tough decisions about where we can invest for improvement and where we will need to prioritise or make choices.

We need to resolve these questions between now and Christmas. We will ensure we are prioritising the areas which will add the most value (in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money) to focus our energies on achieving maximum benefit. This will include trying to attract as much investment into NCL as possible. We will continue to develop further ideas in the parts of the plan which are not fully developed. And we will review the phasing of our specific priorities for the first 2 years of our plan in the context of the significant financial challenge we face, seeking specifically to identify areas where we can go further and faster, and areas where we can defer our investment or effort.

We recognise there is much more work to do, and it is crucial that our local residents are involved in this. We are at the beginning of truly transforming care for our population, which will require significant input and contribution from the people who use services in NCL. We look forward to working with our local population to make designing and implementing the plan a success as it evolves.

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2 Executive summary

There are some excellent health and care services in North Central London (NCL). However, services are not consistent and there are examples of poor practice. We also face significant challenges over the next five years and need to shift our model of care so that more people are cared for in out of hospital settings. This Sustainability and Transformation Plan (STP) has been produced by all the main healthcare organisations and local authorities within NCL. It sets out how we are planning to meet the challenges we face and deliver high quality and sustainable services in the years to come.

We know from our track record that we have the capability to deliver excellent services and to deliver significant change. However, we are not currently able to deliver services across NCL consistently to the standards we would like. We also face a number of significant challenges around the health and wellbeing of local people; and the care and quality of our services. Our current system is focussed on dealing with illness, rather than orientated to prevention and helping people to live well. There is a substantial financial challenge facing health organisations in NCL; the health system is already in deficit and, if nothing changes, this will worsen over the next 5 years meaning that by 2020/21 we estimate we will be c.£900m in deficit. Local authorities are also facing significant financial pressures due to demographic changes and policy inflation: by 2020/21 the combinations of pressures and continued loss of funding will result in a combined social care budget gap of c.£300m.

Our vision is for NCL to be a place with the best possible health and wellbeing, where no one gets left behind. To deliver on our vision, we have designed a programme of transformation with 4 fundamental aspects:

1. **Prevention:** We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population.

2. **Service transformation:** To meet the changing needs of our population we will transform the way that we deliver services.

3. **Productivity:** We will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies, including working together across organisations to identify opportunities to deliver better productivity at scale.

4. **Enablers:** We will build capacity in digital, workforce, estates and new commissioning and delivery models to enable transformation.

Delivering these plans will result in improved outcomes and experience for our local population, increased quality of services and significant savings.

Despite this, we currently expect that the overall financial position of NHS organisations will be a £75m deficit in 2020/21. We have identified a number of areas for further work between now and Christmas where we believe there may be additional savings to be found that would address this residual gap.

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To ensure we are able to deliver as a system, building on the progress we have made to date we will develop a robust governance structure which enables NHS and local government partners to work together in new ways to drive implementation. We will put in place dedicated resources to support delivery. It is crucial that whole system is aligned around delivery of the STP and we will ensure that the development of the 2 year health contracts that are being put in place for 2017/18 - 2018/19 are consistent with the STP strategic framework.

We recognise there is more work to do to finalise the granular detail of our delivery plans and address the residual challenge we are forecasting. To develop our plans in more detail we want to fully engage people who use services and the public in our thinking to ensure they are reflective of their needs. We are committed to being radical in our approach, focusing on improving population health and delivering the best care in London. Our population deserves this, and we are confident that we can deliver it.

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3 Context

North Central London (NCL) comprises five Clinical Commissioning Groups (CCGs): Barnet, Camden, Enfield, Haringey and Islington, each of which is coterminous with the local London Boroughs. Approximately 1.45m[1] live in the 5 boroughs. We spend c.£2.5bn on health and c.£800m[2] on adult and children's social care and public health. The population is diverse and highly mobile, with a large number of people living in deprivation[3].

There are four acute trusts within NCL: The Royal Free London NHS Foundation Trust (sites include Barnet Hospital, Chase Farm Hospital and the Royal Free Hospital in Hampstead), University College London Hospitals NHS Foundation Trust, North Middlesex University Hospital NHS Trust, and Whittington Health NHS Trust. There are two single specialist hospitals: Moorfields Eye Hospital NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Trust. Great Ormond Street Hospital for Children NHS Foundation Trust is within the NCL geography, but currently out of the scope of the STP. Community services are provided by Central and North West London NHS Foundation Trust, the Whittington Health NHS Trust, and Central London Community Healthcare NHS Trust.

Mental health services are provided by the Tavistock and Portman NHS Foundation Trust, Camden and Islington NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust. There are 220[4] GP practices, and the out-of-hours services contract was recently awarded to the London Central and West Unscheduled Care Collaborative. There are 497 active social care sites registered across NCL, including 273 registered care homes (47 of which provide nursing)[5]. Care homes are particularly high in numbers in the north of NCL, for example in Enfield where there are 97 registered care homes (in contrast to the 12 care homes registered in Camden)[6]. In addition, there are 214 registered domiciliary care providers[7].

The organisation of services in NCL makes the area quite unique and this has ramifications for planning: there is a particularly high concentration of specialised services across multiple providers covering a small geographic area. This means many of the patients treated in NCL do not live in NCL and consequentially, a large proportion of the income paid to our providers comes from commissioners outside of the area.

As individual organisations in NCL, we have a history of working together in different ways to meet the needs of our population, and there are numerous excellent examples of collaboration as a result. However, working collectively across all organisations remains a relatively new endeavour and we continue to build the trust required to enable us to do so.

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[1] ONS, Mid-year population estimates, 2015
[2] 2015/16
[3] Office for national statistics, IMD 2015
[4] Latest figures from NHS England, updated since publication of the NCL case for change
[5] Local Authority Care Quality Commission reports, 2016
[6] Local Authority Care Quality Commission reports, 2016
[7] Local Authority Care Quality Commission reports, 2016

We are home to 4 national Vanguards: The Royal Free London NHS Foundation Trust is developing a provider chain model; University College London Hospitals NHS Foundation Trust Vanguard is focused on what can be done to improve the end-to-end experience for people with cancer; Moorfields Eye Hospital NHS Foundation Trust is developing an ophthalmology specialty chain; and, the Royal National Orthopaedic Hospital NHS Trust is one of 13 partners developing a UK-wide chain of orthopaedic providers. NCL is also home to two devolution pilots: one seeking to optimise the use of health and social care estate, and another focused on prevention in Haringey. In primary care, GP practices are already working together in a number of GP Federations to provide extended services to our residents.

In NCL, every borough has its own unique identity and local assets we can build on. Many people lead healthy lives, but if they do get sick we can offer some of the best care in the country. We have a reputation for world class performance in research and the application of innovation and best practice, and we can harness the intellectual capacity of our workforce to ensure the best outcomes are delivered. There are many examples of excellent practice across health and social care in our area, which we intend to use to help ensure that excellent practice can be offered to all our residents.

Our track record demonstrates that we have the capability to deliver excellent services and also to significantly change our services when needed. Our ambition is that everyone is able to get the care they need when they need it. This means ensuring people have the best start in life, and supporting them to live healthy lives. When people do need specialist care, we want them to be able to access it quickly and in the most appropriate setting, and to be fully supported to recover in the setting most suited to their needs.

However, we are not consistently delivering our ambition to the standards we would like. We face significant challenges around the health and wellbeing outcomes for our population, the quality of our services and the financial sustainability of the health and care system. These are outlined in this document and set out in more detail in our case for change[8].

The national requirement to produce an STP is an opportunity for the NCL system to address these challenges together and widen the scope of our collaborative working. This document articulates:

- our collective understanding of the challenges we face
- our vision for health and care in NCL in 2020/21
- the plans to deliver on our vision and address the challenges
- the delivery framework which will enable us to implement our plan
- the impact we expect to achieve through the delivery of our plans
- our plans for securing broader public support and engagement with our proposals
- our next steps for further developing proposals and responding to our residual financial gap.

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[8] https://www.uclh.nhs.uk/News/Documents/NCL%20case%20for%20change.September%202016.pdf

Exhibit 1: Overview of NCL
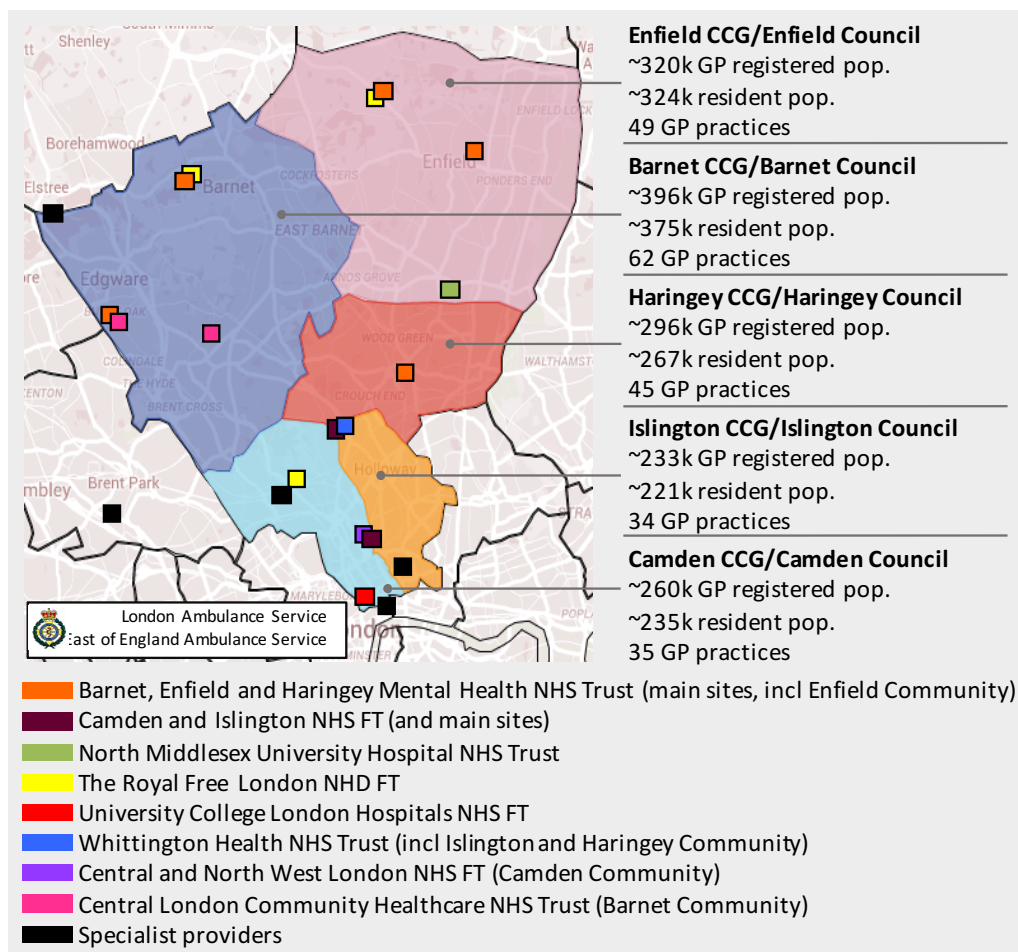
Source: Population figures from 2014 ONS data.

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4 Case for change: our challenges and priorities

In NCL we share many of the same challenges faced by health and care organisations across the UK (and indeed internationally). We have undertaken significant work to identify, articulate and quantify the specific gaps in health and wellbeing; care and quality; and our baseline financial position. Across the system we have aligned behind this work and we all agree on the nature and scale of the challenge, which we have described in our case for change which was published in September 2016.

4.1 Health and wellbeing gap

We have a diverse and highly mobile population. There are people from a range of Black and Minority Ethnic (BME) groups: these groups have differing health needs and health risks. A quarter of our local people do not have English as their main language[9], which creates challenges for the effective delivery of health and care services. The mobility of our population, with 8% of local people moving into or out of NCL each year[10], has a significant impact on access to services and delivery.

Poverty is a crucial determinant of health, and is widespread among both adults and children living in the boroughs that make up NCL[11]. Significant inequalities exist, which need to be addressed; for example, men in the most deprived areas of Camden live on average 10 years fewer than those in the least deprived areas[12]. We face challenges in addressing other wider determinants of health, for example, there are high levels of homelessness and households in temporary housing with all five boroughs in the top 10% for number of households in temporary accommodation[13]. Social isolation also remains a critical issue across the sub-region.

The children of NCL do not always get the best start to life. 30% of children grow up in child poverty and 6% live in households where no one works. 60 children take up smoking every day[14]. Although there have been some improvements recently, London as a whole has the highest rates of obesity nationally: 1 in 3 children are obese in Year 6 (age 11) and we need to do more to tackle this, particularly working with the schools in NCL[15]. Although many of our residents are healthy and people are living for longer, good health does not always persist into old age. Our older people are living the last 20 years of their life in worse health than the England average[16].

Almost half of people in NCL have at least one lifestyle-related clinical problem (e.g. high blood pressure) that is putting their health at risk[17]. However, they have not yet developed

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[9] NCL case for change, 2016
[10] ONS mid-year population estimates 2014
[11] Census 2011
[12] IMD 2015, ONS
[13] https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
[14] CENSUS 2011
[15] Public health outcomes framework tool, 2015
[16] Office for National Statistics, HSCIC CCG Indicators, 2014-15
[17] Camden and Islington GP Linked Dataset projected to NCL level

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a long term health condition. Many of these lifestyle-related clinical problems are risk factors for NCL's biggest killers - circulatory diseases and cancer. These diseases are also the biggest contributors to the differences which exist in life expectancy.

There are high rates of mental illness amongst both adults and children in NCL[18], and many conditions go undiagnosed[19]. 50% of all mental illness in adults begins before 14 years of age and 75% by 18[20]. Children with mothers with mental ill health are much more likely to develop mental health issues themselves. Three of our boroughs have the highest rates of child mental health admissions in London[21] There are high rates of early death amongst those with mental health conditions[22], particularly in Haringey and Islington, and the rate of inpatient admissions amongst this population is above the national average. A strong focus on mental health is central to our approach with a clear aim of treating mental and physical ill health in a joined up way and with "parity of esteem."

4.2 Care and quality gap

Currently, our system does not sufficiently invest in those people with a life-style related clinical problem, which would help stop them from developing the long term conditions which in aggregate are a huge burden on our health and care system. Only 3% of health and social care funding is spent on public health in NCL[23], and that is despite evidence showing that between 2012 and 2014 around 20% (4,628) of deaths in NCL could have been prevented[24]. There is a large opportunity in refocusing our efforts towards prevention and making every contact count. This focus should also address the wider determinants of health such as poverty, housing and employment, all of which have a significant impact on individuals' health and wellbeing.

Disease and illness could be detected and managed much earlier, and managed better in community. It is thought that there are around 20,000 people in NCL who do not know they have diabetes, while 13% of the population are thought to be living with hypertension[25]. It is likely that people are being treated in hospital for long term conditions (LTCs) when they could be better managed by individuals themselves with the support of professionals in the community. Many people with LTCs – over 40% in Barnet, Haringey and Enfield – do not feel supported to manage their condition[26]. This would help avoid the high levels of hospitalisation we experience for the elderly and those with chronic conditions.

One of the disease specific challenges we face is in the provision of cancer care. Late diagnosis of cancers is a particular issue, alongside low levels of screening for cancer and low awareness of the symptoms of cancer in some minority ethnic groups. Waiting times to

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[18] QOF data 2014/15
[19] NHS England Dementia Diagnosis Monthly Workbook, April 2016
[20] Dunedin Multidisciplinary Health & Development Research Unit. Welcome to the Dunedin Multidisciplinary Health and Development Research Unit (DMHDRU).
[21] Fingertips, 2014/15
[22] Healthy Lives, Healthy People 2010
[23] Based on 2015/16 public health budget of each NCL council
[24] Public Health Profiles Data Tool, PHE, 2012-14
[25] QOF 2014/15
[26] Office for National Statistics, HSCIC CCG Indicators, 2014-15

see a specialist are long, and so are waiting times for diagnostics. Additionally, referrals to specialists have almost doubled in five years. There is a huge shortfall in diagnostic equipment and workforce, and a lack of services in the community, particularly at weekends. A further issue is that some hospitals are seeing small numbers of patients with some types of cancer, in some cases less than two per week.

There are some challenges in primary care provision, however, this is a mixed picture which creates inequity. There are too few GPs in Barnet, Enfield and Haringey, and low numbers of registered practice nurses per person across all areas, but particularly in Camden and Haringey.

There are high levels of A&E attendances across NCL compared to national and peer averages[27], and very high levels of first outpatient attendances[28], which indicate potential gaps in primary care provision. Acute providers are not consistently meeting emergency standards.

In the acute setting there are differences in the way that planned care is delivered and this needs to be addressed, with variation based on differences in clinical practice rather than patient need. The number of people seen as outpatients in NCL is high and there is variation in the number of referrals between consultants in the same hospital, the number of follow-up outpatient appointments and the proportion of planned care that is done as a day case.

We are using hospital beds for people who could be cared for at home, or in alternative care settings. 59% of acute bed days are used by people with stays over 10 days, and the majority of these people are elderly. 85% of the mental health bed days in NCL are from patients staying over 30 days. Delayed discharges are also high in some hospitals. Staying longer than necessary in hospital is not good for people's health, especially the elderly whose health and wellbeing can deteriorate rapidly in an acute environment.[29]

We face challenges in mental health provision. People do not always have easy access to information and community based support, and community mental health services are under huge pressure. There is also no high quality health-based place of safety in NCL. Many people receive their first diagnosis of mental illness in Emergency Departments. High numbers of people are admitted to hospital – many under the Mental Health Act. There is variable access to liaison psychiatry, perinatal psychiatry and child and adolescent mental health services (CAMHS) within urgent care: most of the liaison psychiatry and CAMHS services in hospitals in NCL do not see children within one hour at weekends and overnight[30]. There is limited perinatal community service in NCL, in the northern boroughs there is no specialist team and in the southern boroughs the service does not meet national standards[31].

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[27] RightCare Atlas of Variation in Healthcare, September 2015
[28] NHS England Activity Data 2014-15
[29] Philip et al. (2013) Reducing hospital bed use by frail older people: results from a systematic review of the literature. International Journal of integrated care.
[30] Mental health crisis care ED audit, NHS England (London), 2015
[31] Maternal Mental Health Everyone's Business

Our use of information and technology does not currently support integrated health and social care across NCL. There is a variable level of digital maturity across providers and most being below the national average for digital capabilities, particularly their capability to share information with others.

Some of our buildings are not fit for purpose and there are opportunities to use our estates better. 11 sites in NCL have facilities management costs at least 10% more than the Carter benchmark (£319 p sq. m), with a further 3 sites within 10% of the benchmark. 8 sites have a higher proportion of unutilised space than the 2.5% benchmark contained within the Carter report, and over half of the sites analysed were found to have a higher proportion of non-clinical space than the Carter benchmark (35%).

We have significant workforce challenges across health and social care, including a high turnover across a range of professions, an over reliance on agency staff and HR policies which are not transferable across organisations.

There is consensus across the system that the current approach to commissioning and providing health and social care services across NCL could be better aligned to support the implementation of our emerging vision for the STP. In particular, the delivery of a population health approach and genuinely integrated care is significantly constrained by:

- the rigid separation of commissioning and providing responsibilities within the NHS
- the limited existing integration between health and social care
- the fragmentation of providers of health and care into many sovereign organisations
- increased financial risks across CCGs and providers
- stretched capacity and capability in the current organisational form.

We need to design new commissioning and delivery models that enable us to deliver transformed care in a way that is sustainable.

4.3 Baseline financial gap

Our population is growing and demand is rising: people access health care more often, and are – positively – living longer, but often with one or more long term conditions. Meanwhile, the NHS's costs are rising more than inflation across the UK economy (to which allocations are linked). The upshot of this is that not only is the system responding to greater demand, but also that the sum cost of activity is growing faster than allocations.

Put simply, funding increases in NCL of £269m over the next 5 years will not meet the likely increases in numbers of local people and growth in demand for health services of c.£483m, plus increases in the cost of delivering health care of c.£404m.

This means that there is a substantial financial challenge facing health organisations in NCL. Health commissioners and providers were already £121m in deficit in 2015/16 and, if nothing changes, this will grow to £876m in deficit by 2020/21.

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Exhibit 2: The 'do nothing' financial gap for NCL
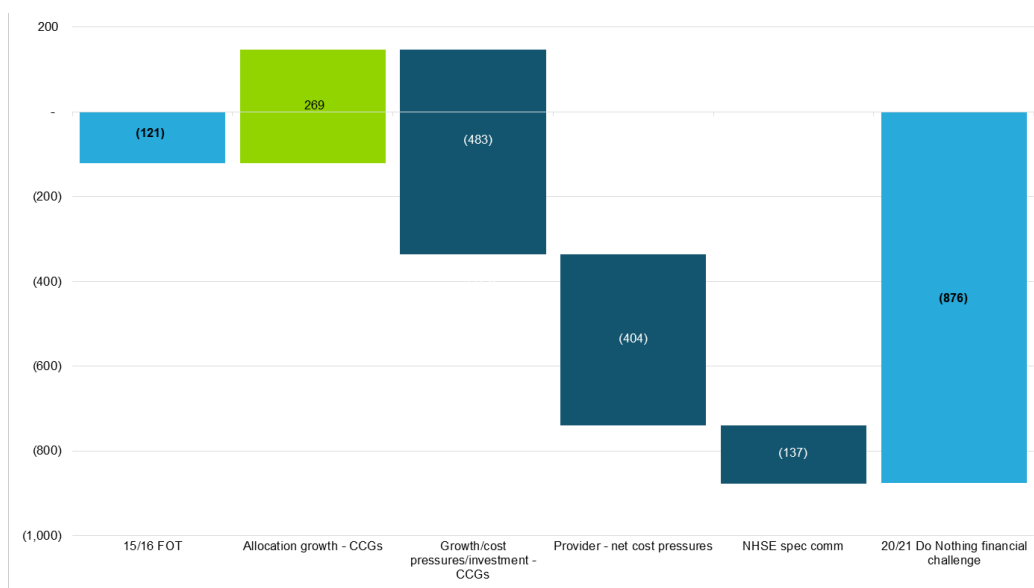
The 'do nothing' specialised commissioning financial challenge is estimated at £137m (this estimate is currently being validated). This excludes Great Ormond Street Hospital NHS Trust and the Royal National Orthopaedic Hospital NHS Foundation Trust which would add a further £49m and £10m respectively. The specialised commissioning challenge is driven by advances in science; an increasingly ageing population with LTCs; and rising public expectation and choice for specialised treatment. In addition there are increasing financial pressures for specialised services, including the increasing volume of expensive new drugs. Spending on specialised services has increased at much greater a rate than other parts of the NHS, and this is expected to continue.

The current combined net budgets for the 5 boroughs in NCL is £760m for Adults and Children's Social Care (CSC) and Public Health services. However, we know that between 2010/11 and 2020/21 the average reduction in borough spending power will be 35%. Adult Social Care (ASC) budget reductions during this period will total at least £154.5m. This reduction in funding requires that a significant savings programme be delivered.

The collective 2016/17 forecast budget pressures for the 5 boroughs in ASC and CSC is £39m (£26m ASC, £13m CSC). Both ASC and CSC will continue face considerable pressures from demographic growth, inflation and increasingly complex care needs. By 2020/21 the combinations of pressures and continued loss of funding will result in a combined social care budget gap of c.£308m, which is equivalent to a 28% reduction on the current Councils' total budget. Councils may have the option to raise a 2% precept for social care in future years, but this will be subject to political agreement and will not come close to closing the gap.

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5   Vision

> *Our vision is for North Central London to be a place with the best possible health and wellbeing, where no-one gets left behind.*

Developing our vision in NCL has taken time, and we have harnessed our high quality clinical and practitioner leadership at every stage of the process. The vision for NCL initially drew on existing local work which was underway before the STP process started. Leaders across the system then iterated the vision at an event in September 2016. This process, alongside the series of borough-based public engagement events in September and October, has ensured that our vision is collectively owned across the system. We are committed to fulfilling our vision through this plan, and have identified a set of core principles to support our ambition.

Our core principles

- We will work in a new way as a whole system; sharing risk, resources and reward.
- Health and social care will be integrated as a critical enabler to the delivery of seamless, joined up care.
- We will move from pilots and projects to interventions for whole populations built around communities, people and their needs. This will be underpinned by research based delivery models that move innovation in laboratories to frontline delivery as quickly as possible.
- We will make the best the standard for everyone, by reducing variation across NCL.
- In terms of health we will give children the best start in life, and work with people to help them remain independent and manage their own health and wellbeing.
- In terms of care we will work together to improve outcomes, provide care closer to home, and people will only need to go to hospital when it is clinically essential or economically sensible.
- We will ensure value for tax payers' money through increasing efficiency and productivity, and consolidating services where appropriate.
- To do all of this we will do things radically differently through optimising the use of technology.
- This will be delivered by a unified, high quality workforce for NCL.

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6 Strategic framework

To deliver on our vision and achieve the triple aim as set out in the Five Year Forward View (to increase health and wellbeing; meet the highest standards of care and quality; and improve productivity and efficiency), we have designed a programme of transformation with 4 aspects:

1. **Prevention:** Much of the burden of ill health, poor quality of life and health inequalities in NCL is preventable. We will increase our efforts on prevention and early intervention to improve health and wellbeing outcomes for our whole population, which will reduce health inequalities, and help prevent demand for more expensive health and care services in the longer term.

2. **Service transformation:** To meet the changing needs of our population we will transform the way that we deliver services. This involves taking a "population health" approach: giving children the best possible start in life; strengthening the offers and provision in the local community to ensure that where possible care can be provided out of hospital and closer to home – reducing pressure on hospital services; rethinking the relationships between physical and mental health to ensure that mental health care is holistic and person-centred; and, reducing variation in services provided in hospital. Social care plays a key role in service transformation.

3. **Productivity:** In order to ensure sustainability, we will focus on identifying areas to drive down unit costs, remove unnecessary costs and achieve efficiencies. For providers, this includes implementing recommendations from the Carter Review and working together across organisations to identify opportunities to deliver better productivity at scale.

4. **Enablers:** We will focus on delivering capacity in key areas that will support the delivery of transformed care across NCL. This includes digital, workforce, estates, and new commissioning and delivery models.

Exhibit 3: The NCL STP strategic framework
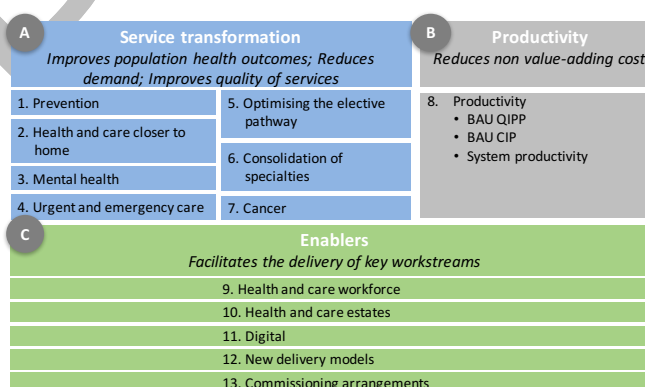
6.1 Prevention

We will embed prevention and early intervention across the whole health and care system and deliver effective preventative interventions at scale. As a result, we will improve population health outcomes and reduce health inequalities by harnessing assets within and across communities for example, from Council services, including social care and the voluntary and community sector. This will positively impacting on the lives of residents, their families, and our communities.

> Afrin lives in hostel accommodation and is dependent on alcohol. He experiences seizures almost daily. Afrin has in the past, with support from treatment, managed to gain abstinence but had a relapse which is due to depression brought on by unstable housing and economic circumstances. Afrin has had many unscheduled hospital admissions in the last 6 months. In future, on admission to hospital Afrin will be referred to an alcohol assertive outreach worker (AAOT) by the hospital alcohol liaison worker. This support will enable him to put in place foundations that will help him towards abstinence and recovery. Afrin will be supported to give up drinking, with input from an addictions doctor at a community alcohol service. A slow reduction plan, that is achievable and minimises the risk of seizures which in the past have led to hospital admission, will be put in place. Afrin will have regular 1-2-1 appointments with his AAOT, which will include psychological help.

Our prevention plans focus on interventions and system change across the whole spectrum of prevention (exhibit 4), where there is strong evidence of effectiveness and return on investment within the 5 year period of the STP[32]. In addition, we have identified opportunities where we could rapidly build upon successful local initiatives across NCL to achieve economies of scale.

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[32] Interventions have been identified from the Public Health England (PHE) Supporting Pack for STPs and the return on investment work undertaken for Healthy London Partnerships by Optimity.

Exhibit 4: Approach to prevention
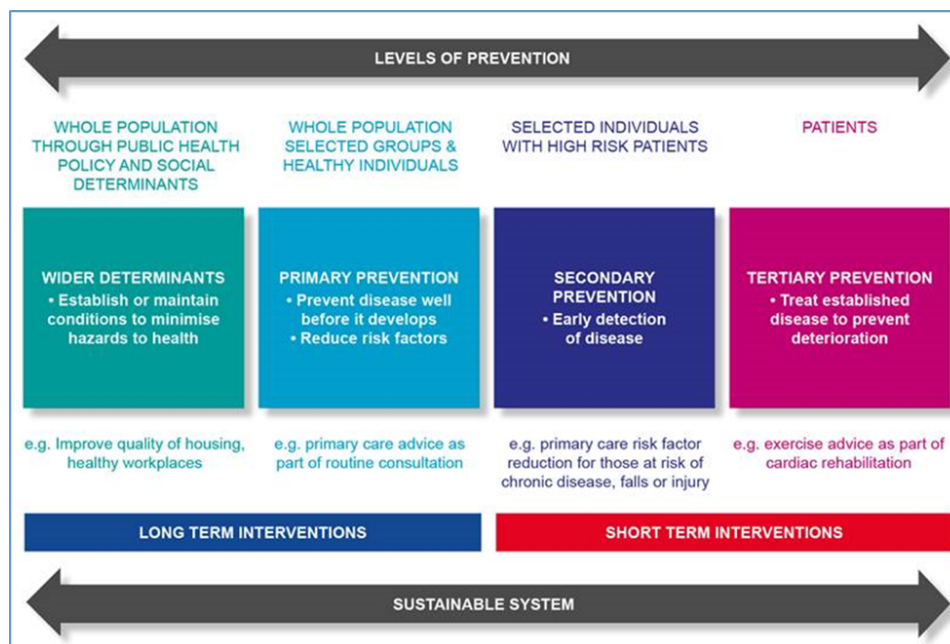
We will concentrate our efforts on:

- **Creating a 'workforce for prevention'** so that every member of the local public sector workforce in NCL is a champion for prevention.
  Specific interventions: Making Every Contact Count (MECC); Mental Health First Aid (MHFA); dementia awareness
- **Ensuring that the places where residents and employees live and work promote good health.** This will include: reversing the upwards trend in childhood obesity; supporting people with mental ill health and other long term conditions to stay in work; pioneering new approaches to tackling gambling, alcohol misuse and smoking; and supporting the workforce across NCL (including our own staff) to become healthier.
  Specific interventions: Haringey Devolution Pilot; improving employment opportunities for people with mental ill health through individual placement support (IPS); Healthy Workplace Charter; Healthy Early Years / Healthy Schools accreditation
- **Supporting residents, families and communities to look after their health: smoking and drinking less, eating more healthily, and being more active, as well as looking after their sexual health and mental health wellbeing.** This will all reduce hospital admissions from preventable causes such as smoking, alcohol, and falls, and reductions in associated ill health and early deaths. We will protect and ensure high quality universal services for vulnerable families by starting direct conversations with schools to proactively identify who these families are, and collaborating to map across primary care, social care, early years, therapies, paediatrics and secondary care. We will ensure that smoking cessation programmes are embedded across

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maternity services and services for children and young people, targeting parents and older children. Drawing on the experience of our local authorities in running large scale campaigns, we will design and deliver a campaign across NCL to address a variety of wellbeing or long term conditions through a single preventative message with common NCL branding.

Specific interventions: smoking cessation; alcohol screening, liaison and outreach teams; weight management programmes; diabetes prevention programme; multifactorial falls intervention; long-acting reversible contraception; community resilience; increased access to mental health services for children and new mothers; London's digital mental health programme.

- **Diagnosing residents with clinical risk factors and long term conditions much earlier to increase life expectancy.** Once diagnosed, empowering them to manage their own condition(s) alongside proactive management by health professionals to prevent the development of further conditions and complications.

  Specific interventions: increasing awareness and case finding (including national cancer screening and HIV testing) and appropriate medications to control conditions for people with high blood pressure, diabetes, atrial fibrillation; self-care and structured self-management for long term conditions; reablement offers in social care and care navigation.

We will build upon on the individual strengths that each part of the public sector in NCL can bring to preventing disease and ill health. As well as traditional 'health professionals' this also means working with local authority housing officers and the London Fire Brigade in, for example, preventing falls. We also recognise the key contribution that voluntary and community sector organisations can make in achieving disproportionately greater improvements in health for residents with mental ill health and learning disabilities, specific BME groups, and those in the most deprived communities, and we are committed to working more collaboratively with these organisations.

6.2 Service transformation

To meet the changing needs of our population we will transform the way that we deliver services, shifting the balance of care from reactive to proactive. This will be through ensuring people achieve the best start in life, developing our care closer to home model, creating a holistic approach to mental health services, improving urgent and emergency care, optimising the elective pathway, consolidating of specialties where appropriate and transforming cancer services to improve the end-to-end experience. Social care plays a key role in all aspects of service transformation.

6.2.1 Achieving the best start in life

Children make up between 25% and 30% of the population across the NCL footprint which means that service transformation must include a specific focus on our children and young people. We recognise that providing children with the best start in life is critical for their development and health long term. We have identified interventions across the pathway,

from prevention to acute care, that are focussed specifically on improving health and outcomes for children and young people.

In the context of a considerable body of research suggesting that fetal exposure to an adverse environment in-utero sets the trajectory for child and adult health in terms of congenital malformations, obesity, diabetes and cardiovascular disease, we will explore ways to link primary care, public health and maternity services to optimise maternal health before, during and after pregnancy. In particular, smoking cessation, weight reduction, optimisation of blood sugar control in diabetics and improvement of diet in women of reproductive age has the potential to reduce the health needs of children. We will leverage the work of our NCL Maternity Network to ensure that our local maternity system implements the findings of the national Maternity review: Better Births. We are keen to take part in the National Maternity Transformation programme as an Early Adopter.

We will promote active travel, sport and play for children in schools, for example involving schools to deliver the *Take 10, Active 15, Walk a daily mile* initiatives that other parts of the country have adopted to support this. By 2020/21, our aim is that 4 out of 5 early years' settings and schools in NCL will be accredited as part of the healthy schools, healthy early years or similarly accredited programme for promoting healthy lives.

> Tai, 14, suffers from severe depression. With the involvement of Tai, his family, and his CAMHS practitioners, Tai has been admitted into a Tier 4 unit on a planner basis. Previously, it was likely that Tai would have been placed far from home. In future, with the local commissioning of Tier 4 he will be able to be placed close to home. This will enable better linkage with the local CAMHS community team, which will have also been enhanced. Together, these factors will mean Tai has a better experience of care and stays in hospital for a shorter length of time. When Tai is discharged back into the community, he will have an enhanced care plan to support him to keep well.

We will address mental ill health in children as early as possible: developing antenatal and postnatal interventions for mothers with mental ill health; improving services for parenting support, health visiting, and signposting; and creating targeted services that focus on vulnerable high risk families. We will capitalise on the universal services of MIND, Place2Be and voluntary sector initiatives like *Hope Tottenham* that are already established and working directly with families and young people. As part of our Child and Adolescent Mental Health Services (CAMHS) and perinatal initiative led through the mental health workstream, we will:

1. **Develop a shared dataset for CAMHS** to enable comparison and shared learning across the 5 boroughs
2. **Tackle eating disorders** by establishing dedicated eating disorder teams in line with the waiting time standard, service model and guidance
3. **Upskill our workforce** to meet the mental health and psychological wellbeing needs of children and young people, including developing a children and young people's IAPT workforce capability programme

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4. **Build on our Transforming Care initiative** by supporting children and young people with challenging behaviour in the community in order to prevent the need for residential admission
5. **Improve perinatal mental health services** by developing a specialist community perinatal mental health team that serves the NCL population and the physical health acute trusts within NCL
6. **Implement a Child House model** following best practice to support abused children
7. **Create a 24/7 crisis pathway for children and young people**, including local commissioning of Tier 4 CAMHS to eliminate out of area placements for non-specialist acute care by 2020/21; and review of S136
8. **Develop a co-commissioning model for youth justice** working with NHS England.

The principles of THRIVE will be used as an overarching approach to our CAMHS work, with the aim that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019 as set out in the Mental Health Taskforce.

6.2.2 Health and care closer to home

Health and care will be available closer to home for all, ensuring that people receive care in the best possible setting at a local level and with local accountability. We already have many high quality services outside acute settings across NCL, but our health and care closer to home model will focus on scaling these services up, reducing variation and making this the default approach to care. Social care will play a key role in the design, development and expansion of the future model.

> Ms Sahni is 87 and has four chronic health problems. Previously, she had to book separate appointments with different primary care professionals to have all of the relevant check-ups and appointments that she required. In future, Ms Sahni will be in a special "stream" of patients who will have all of their care co-ordinated by a very experienced GP. This will allow her to see the specialist heart or diabetic nurses at the Integrated Care Centre located at her GP surgery. There will also be a care navigator in the team who can help to sort things out for her at home, including community support when she needs it.

We will address the sustainability and quality of general practice, including workforce and workload issues. It is recognised that for some people, health and care being delivered closer to their home is not always the best choice, and therefore high quality hospital-based and care home services will continue to be available when needed.

At the heart of the care closer to home model is a 'place-based' population health system of care delivery which draws together social, community, primary and specialist services. This will be underpinned by a systematic focus on prevention and supported self-care, with the aim of reducing demand on the system over time. We will deliver the right care at the right time to the whole population. The care closer to home model is one of the key vehicles by

which we will contribute towards the overall delivery of the Better Health for London outcomes.

Exhibit 5: Delivery of the Better Health for London outcomes through the health and care closer to home model
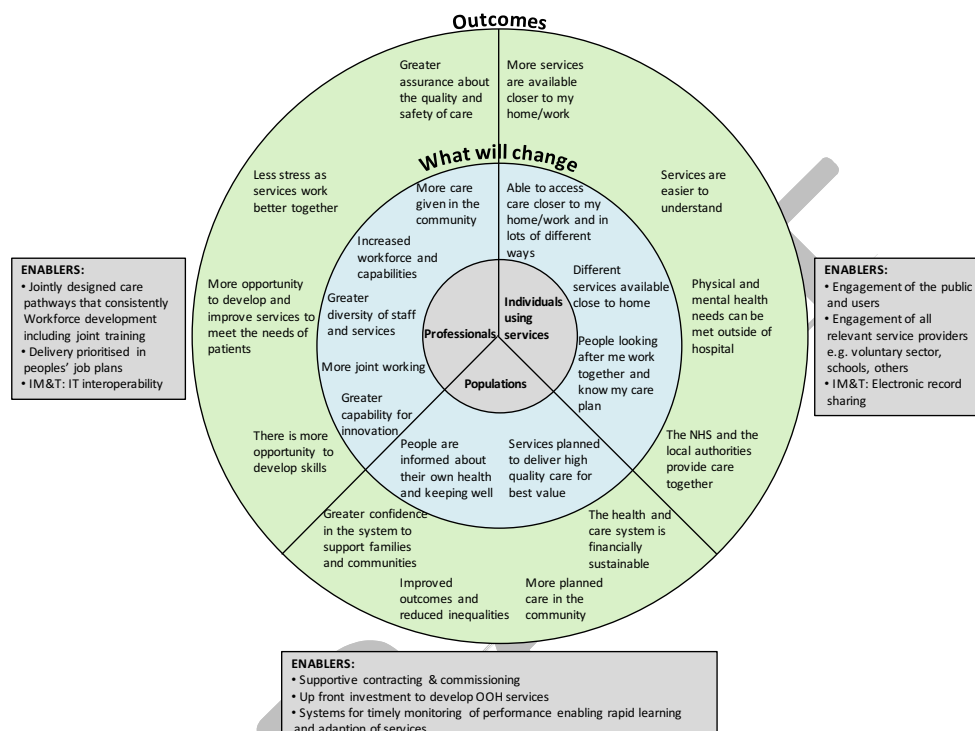
Specific interventions that make up the scope of the care closer to home model include:

- **Developing 'Care Closer to Home Integrated Networks' (CHINs):** CHINs may be virtual or physical, and will most likely cover a population of c.50,000 people. They will be home to a number of services including the voluntary and community sector to provide a more integrated and holistic, person-centred community model, including health and social care integrated multi-disciplinary teams (MDTs), care planning and care coordination for identified patients. Interventions focussed on the strengths of residents, families and communities; improving quality in primary care; and reducing unwarranted variation will also operate from CHINs, including Quality Improvement Support Teams (QIST) to provide hands-on practical help for individual GP practices to ensure a consistent quality standard and offer to all patients. This will include support for case finding and proactive management of high blood pressure, atrial fibrillation and diabetes. We have already piloted CHINs, for example the Barnet Integrated Local Team (BILT)[33] hub which provides coordinated care for older residents with complex medical and social care needs, as well as providing support

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[33] Barnet integrated Care Locality Team, 2016

to carers. The BILT hub has been open since April 2016 and is a joint funded health and social care pilot.

- **Extending access to primary care:** patients will be able to access consultations with GPs or other primary care professionals in their local area for pre-bookable and unscheduled care appointments between 8am and 8pm 7 days a week.
- **Supporting healthier choices:** in line with our prevention agenda, the care closer to home model will include upscaling our smoking cessation activities by 9-fold to reduce prevalence and hospital admissions; increasing alcohol screening and the capacity of alcohol liaison services and alcohol assertive outreach teams across NCL; scaling up weight management programmes with integrated physical and wellbeing activities; and reducing unplanned pregnancies by increasing the offer and uptake of long acting reversible contraception.
- **Improving access through technology and pathways:** telephone triage, virtual consultations and online booking systems will be available for all patients.
- **Supporting patients through social prescribing and patient education:** the care closer to home model will include a greater emphasis on social prescribing and patient education. Support will be available for patients, carers and professionals to be confident users of information and IT solutions that enable self-management and care, as well as care navigation support to direct patients to the right services.
- **24/7 access to specialist opinion in primary care:** primary care will be able to provide more complex patients with a number of options for specialist opinion outside of the hospital itself. These range from: 1) advice only 2) an urgent 'hot clinic' appointment in an out-patient clinic 3) assessment in an ambulatory emergency care facility and 4) admission to an acute assessment unit. In addition, consultant-led clinical assessment and treatment services offered in CHINs will enable more patients to be managed in the primary care setting. Specialties to be considered include gynaecology; ENT; urology; dermatology; musculo-skeletal; and ophthalmology.
- **GP front door model in Emergency Departments:** we will review the existing provision across NCL of GP led triage, treatment and streaming for all ambulatory patients will be provided at the front door of Emergency Departments. GPs and nurses on the door make decisions about where the patient is best treated – which could be in the urgent care centre or emergency department, or redirection to alternative services.
- **Falls emergency response team and multifactorial intervention:** multifactorial interventions combining regular exercise, modifications to people's homes and regular review of medications will prevent people from falling in the first place. If they do fall, falls partnership ambulance vehicles will be available with advanced, multi-disciplinary practitioners. In addition, a specific falls service will support patients to remain at home after a fall.
- **Enhanced rapid response (ERR):** a rapid response team will prevent an admission to hospital for those in crisis, providing enhanced therapy, nursing and social work support to support people to stay in their own home.

- **Acute care at home:** where there is a medical need, acute clinical care will be provided at home by a MDT to provide the best possible patient experience and outcomes, and enable the patient to benefit from holistic integrated care.
- **Frailty units:** a dedicated service, such as that already in place at the Whittington, that will be focussed on rapid assessment, treatment and rapid discharge of frail older people that could potentially be co-located within the Emergency Department. This will enable ambulatory care for people aged over 65. These would be rolled out across NCL.
- **Enhanced care home support:** provided to stabilise and / or treat residents in the care home where appropriate thereby reducing the level of conveyances, unplanned attendances and admissions to secondary care. The care closer to home model will prevent emergency readmissions from care homes through development of a care home bundle, including a proactive approach to prevention and early identification of complications.
- **End of life care:** we will support people at the end of life to receive the care that they need to enable them to die in their place of choice via rolling out the Co-ordinate My Care (CMC) care planning programme, and ensuring the new Integrated Urgent Care service (see section 6.2.4) has access to CMC plans.

Acheiving care closer to home will need to be underpinned by strong resilient communities that are able to support residents live independently at home, where that support is needed. The support may be needed from families, carers, neighbours or from voluntary and community groups all of whom have central roles to play.

We plan to bring together the funding currently used for Locally Commissioned Services (LCS) and the premium spent on Personal Medical Services (over and above GMS) and establish one LCS contract framework for the whole of NCL. This LCS contract will have agreed outcomes which are shared with the Health And Care Closer to Home Networks (CHINs) and the Quality Improvement Support Teams (QISTs) so that all local GPs are provided with the necessary funding and incentives to fully engage with these vital components of the health and care closer to home work. Delivery of this whole system alignment is partly dependent on NHS England (London) delegating commissioning of the PMS premium to the CCGs which is currently under discussion with all key parties.

In support of delivering our health and care closer to home model, Islington CCG has expressed an interest in becoming an Integrated Personal Commissioning (IPC) site in order to improve health and wellbeing outcomes through personalised commissioning, improved care and support planning and developing an asset based approach to support solutions.

The IPC site will:

- improve outcomes for patients with care delivered closer to home, and aim to reduce unplanned admissions
- realign service provision in light of new service developments related to IPC and Personal Health Budgets
- review existing contracts to assess impact and identify opportunities for realignment based on a number of other developments such as New Care Models and IPC.

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Improving outcomes will be the crucial measure of success of the care closer to home model. Using national and international evidence, we have estimated that some of the outcomes that our health and care closer to home model could potentially deliver are:

- 70% of people at the end of their life will have a care plan to support them to die in their place of choice
- 4% decrease in unplanned pregnancies
- a reduction in alcohol consumption with 10% fewer alcohol-related hospital admissions
- up to 150,000 fewer emergency department attendances
- 63,000 fewer non-elective admissions
- 35,000 fewer outpatient attendances
- 10% reduction in falls-related hospital admissions
- a halving of the numbers of late HIV diagnoses
- 50,000 weight management referrals leading to a reduction in excess weight
- 66% of people with high blood pressure have it diagnosed and controlled
- 55% of people with atrial fibrillation are receiving anti-coagulants
- 69% of people with diabetes have controlled blood glucose.

6.2.3 Mental health

We will develop a 'stepped' model of care (see exhibit 6) supporting people with mental ill health to live well, enabling them to receive care in the least restrictive setting for their needs.[34] We recognise the key role and accountabilities of social care for people with long-standing mental ill health and drawing on this will be central to the success of the stepped model.

Exhibit 6: The mental health 'stepped' model of care

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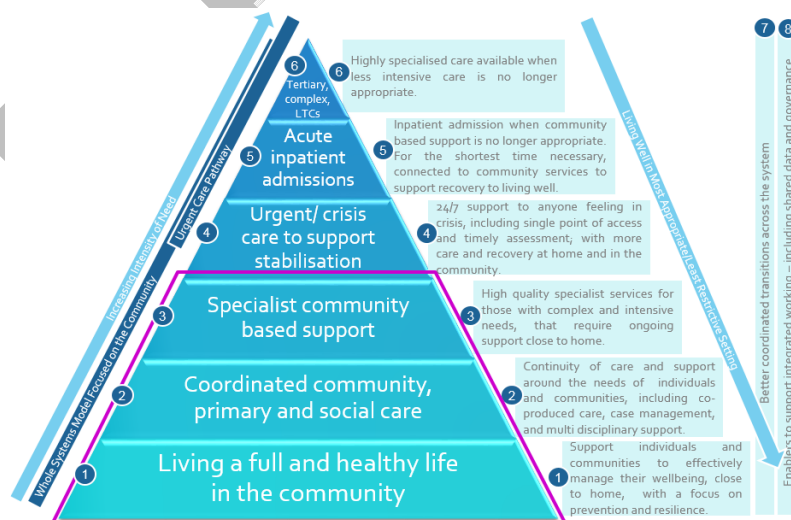
[34] As identified in the Mental Health Taskforce Report

We aim to reduce demand on the acute sector and mitigate the need for additional mental health inpatient beds. This will improve overall mental health outcomes across NCL, reduce inequalities for those with mental ill health, enable more people to live well and receive services closer to home and ensure that we are treating both physical and mental ill health equally. We will achieve the key mental health access standards:

- more than 50% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within 2 weeks of referral
- 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral, with 95% treated within 18 weeks.

> Maisie suffers from dementia, and is cared for by her husband Albert. Previously, after falling at home, Maisie was admitted to hospital. Due to the accident and change of surroundings, Maisie was agitated and more confused than normal. In future, the hospital will have Core 24 liaison psychiatry meaning that the liaison team will be able to help the hospital support both Maisie's physical and mental health needs. As Maisie will receive holistic care it will mean that she is ready to be discharged sooner than if only her physical health needs were supported. Maisie's husband Albert will also be supported by the dementia service, allowing him to continue to care for Maisie at home.

Initiatives will cover mental health support for all age groups and include:

- **Improving community resilience:** both for the general population, and those at risk of developing mental ill health or of it becoming more severe. For the general population this includes a promotional drive aimed at increasing basic mental health awareness including self-awareness, normalising mental health needs and reducing stigma. For the at risk population focus will be given to improving access and support through training of non-mental health specialists to recognise mental ill health symptoms, improving service navigation, development of open resources, and provision of individual and group therapies; employment support to help people to maintain and get back into work including through Individual Placement Support[35]; and suicide prevention work to strengthen referral pathways for those in crisis, linked to the local multiagency suicide prevention strategies.[36] This will be delivered in conjunction with other regional and national schemes such as the London digital wellbeing platform. We will continue to build upon current work; for example Barnet CCG and local authority are already working towards a dementia friendly borough by providing lunch clubs, reminiscent therapy and engaging with local shops to raise awareness.
- **Increasing access to primary care mental health services:** ensuring more accessible mental health support is delivered locally within primary care services, developed as part of the CHINs; enabling both physical health and mental health needs to be

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[35] Five Year Forward View - 29,000 more people living with mental ill health should be supported to find or stay in work (~725 within NCL)
[36] Five Year Forward View - Reduce suicide by 10%

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supported together[37]. We will offer support directly to patients and support to GPs and other professionals; enabling more people to access evidenced based mental health services[38], and more care to be offered through CHINs rather than requiring referral to secondary care mental health services. Services will include increasing the IAPT offer to reach 25% of need.[39]

- **Improving the acute mental health pathway:** building community capacity to enable people to stay well and reduce acute presentations. This includes developing alternatives to admission by strengthening crisis and home treatment teams; reviewing Health Based Place of Safety (HBPoS) provision with the view to reduce the number of units and to have a sector wide provision that meets all requirements; and investing in longer term supported living arrangements to ensure effective discharge, enabling more people to live well in the community.
- **Developing a Female Psychiatric Intensive Care Unit (PICU):** we will ensure local provision of inpatient services to female patients requiring psychiatric intensive care, where currently there is none. This will enable patients to remain close to their communities, with a more streamlined and effective pathway ensuring a focus on recovery.[40]
- **Investing in mental health liaison services:** scaling up 24/7 all-age comprehensive liaison to more wards and Emergency Departments, ensuring that more people in Emergency Departments and on inpatient wards with physical health problems have their mental health needs assessed and supported.
- **CAMHS and perinatal:** initiatives as set out in section 6.2.1.
- **Investing in a dementia friendly NCL:** looking at prevention and early intervention, supporting people to remain at home longer and supporting carers to ensure that we meet national standards around dementia, including a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

An important enabler of a number our initiatives is the redevelopment of both the Barnet, Enfield and Haringey Mental Health Trust St Ann's site and the Camden and Islington Foundation Trust St Pancras site (in conjunction with the proposed relocation of Moorfields Eye Hospital Foundation Trust to the St Pancras site).

The proposed developments of the St Ann's and St Pancras sites would:
- transform the current inadequate acute mental health inpatient environments on both sites
- provide more therapeutic and recovery focussed surroundings for patients and staff
- improve clinical efficiency and greater integration of physical and mental health care
- release estate across the trusts, to enable development of community-based integrated physical and mental health facilities
- develop world class research facilities for mental health and ophthalmology enabling practice to reflect the best evidence

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[37] FYFV – at least 280,000 people with severe mental ill health have their physical health needs met (~7,000 within NCL)
[38] Five Year Forward View - more adults with anxiety and depression have access to evidence based psychological therapies (~15,000 within NCL)
[39] Five Year Forward View
[40] Five Year Forward View - inappropriate out of area treatments for acute mental health care should be eliminated in all areas by 2020/21.

- provide land for both private and affordable housing, as well as supported housing for service users and housing for key workers.

6.2.4 Urgent and emergency care[41]

Over the next five years, we will deliver urgent and emergency care (UEC) services that are reliable, work well together and are easily understood. Our services will be consistent and inspire confidence in patients and professionals; supported by the use of an integrated digital care record that can be accessed across organisations. The first 2 years will focus on reducing variation in our services and the latter years will focus on transformation of the urgent and emergency care system, aligning closely with the care closer to home model.

> Mary is 83 years old and lives at home with her husband. Mary had a fall at home and injured her ankle. Her husband was unable to help her get up so he called 999 for an ambulance. Mary was taken to the nearest A&E and admitted to hospital, where she is diagnosed with a urinary tract infection (UTI). She was reviewed by the consultant: a plan was put in place for treatment of her UTI and physiotherapy was recommended for her ankle. Over the weekend, Mary's UTI improved, but there was no consultant to review her condition or physiotherapist to provide her care, so Mary was unable to go home. When going to the toilet in the night, Mary fell again and stayed in hospital for a further 2 weeks. Mary became increasingly less mobile and more frail and dependent.
>
> In future when Mary falls, her husband will dial 999, and a paramedic will be dispatched. When the clinical assessment does not suggest any fractures, the crew will access the local directory of services whilst on scene and electronically refer Mary to the Acute Care at Home service with request for a 12 hour response. Mary will then be visited at home by the falls team the next day who will design a package of care for Mary including reablement, allowing Mary to stay at home. The falls team will be able to detect if there is anything unusual about Mary's behaviour, and make a rapid appointment with her GP if they suspect a UTI. Mary will then get the antibiotics she needs to resolve this at an early stage.

Our aims are to:

- **Create a consistent UEC service across NCL:** all UEC services in NCL will meet National and London-wide quality standards[42] which will promote consistency in clinical assessment and the adoption of best practice. Patients will be seen by the most appropriate professional for their needs, which may include directing them to an alternative emergency or urgent care service.
- **Develop and implement a high quality integrated UEC service:** all urgent care services across NCL (including NHS 111, GP out of hours, Urgent Care Centres) will work together to offer consistent care. These services will be renamed 'Integrated

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[41] This workstream includes all aspects of Urgent and Emergency Care provision delivered in the acute setting, including support for people to leave hospital. Also in scope is the development of a high quality, integrated urgent care system.
[42] As defined by the NHS E UEC designation process

Urgent Care'. We have commissioned a joined up new Integrated Urgent Care service provided by one provider, LCW, which goes live in October 2016. This service combines the NHS 111 and GP Out-of-Hours (OOH) services, and allows patients to access a wider skill mix of specialised clinicians in a new NHS 111 clinical hub.

- **Develop high quality, responsive 7-day hospital UEC services:** people will be supported to leave hospital as quickly as possible through building close links between acute care providers and social care. We will support shorter hospital stays by operating a simplified discharge or integrated 'discharge to assess' model: planning post-acute care in the community, as soon as the acute episode is complete, rather than in hospital before discharge. This will be the default pathway, with non-acute bedded alternatives for the very few patients who cannot manage this.
- **Develop high quality, responsive 7-day community services:** where possible, people will be supported and treated at home by community and ambulance services. For those people who do require ambulance transfer, the ambulance services will be able to use any UEC services that meets the patient's need.
- **Develop high quality ambulatory care services across NCL:** we will develop a service that reduces avoidable, unplanned admissions to hospital, such as that already in place at the Whittington. All UEC services will create consistent ambulatory care pathways that support people to have their care on a planned basis, wherever possible. This will provide same day emergency care to support patients to be assessed, diagnosed, treated and able to go home the same day without an overnight admission. This model will be rolled out across NCL.

The focus on urgent and emergency care services will reduce the number of unplanned admissions to hospital and support people to go home from hospital as soon as possible. This will improve patient experience, improve outcomes and make sure that people have their care on a planned basis wherever possible.

6.2.5 Social care

Social care is a crucial part of many of our workstreams, particularly care closer to home, Transforming Care, and mental health, as well as children's and public health interventions. We are considering how local authorities can work with the workforce leads across NCL to design and develop proposals specifically for social care, including a focus on the sustainability of provider workforce, the sustainability of the registered workforce and stimulating the personal assistant workforce. We will ensure that our plans factor in practical steps that we can take as partners to address provider failure and the huge risks around capacity and quality in the domiciliary market.

The role of social workers will be essential to delivering on our model for health and care closer to home, in addition to the role of home care workers, personal assistants, blended role between district nurses and care workers. The workforce workstream will consider these career pathways, making careers in these areas more attractive to support increased sustainability of the workforce. We will quantify any investment that might be needed in workforce from a social care point of view e.g. increasing numbers of domiciliary care

workers and, drawing on learning from elsewhere, we will quantify the return on investment.

Social care is also built into our mental health model, including a broader dimension of public service support such as employment support workers. Learning disabilities is a key area of focus given that half of social care spend is on this group, and that children with special educational needs and learning disabilities have worse long term outcomes in both health and education. We need to start supporting those with learning disabilities from early childhood to ensure early detection and appropriate intervention. Many of our interventions, including health visiting, early years, community paediatrics, CAMHS, and working directly with schools will ensure that we better support these children. We plan to scale up our Transforming Care work to implement enhanced community provision; reduce inpatient capacity; upgrade accommodation and support for those with learning disabilities; and roll out care and treatment reviews in line with published policy to reduce long lengths of stay in hospitals and improve independence.

As part of our STP we will explore collaboration and consolidation opportunities between local authorities in areas such as the hospital discharge pathway and the mental health enablement process. We will consider what can be commissioned differently and/or at scale - particularly across health and social care, for example nursing homes. We will focus on ramping up the use of data analysis and risk stratification; working cohesively with public health across the patch; leveraging telecare; and sharing of ideas and learning about best practice in terms of health and social care integration. Our pan-NCL bed state analysis will consider non-health beds, including the 6,440 care home beds in NCL, so that we gain an in-depth understanding of why people end up in these beds and how best their needs could be met elsewhere (as well as the resources it would take to do this).

We recognise the co-dependencies between health and social care: any change in either sector may have a significant impact on the other. As we continue to develop our plans, we will ensure local authorities are involved throughout so that we can mitigate any risks around this together, and transform the system so that it is truly integrated.

6.2.6 Optimising the elective (planned care) pathway

Building on the opportunities identified through RightCare, we will reduce unwarranted variation in elective (planned) care across providers in NCL. This will include reducing variation in the length of stay in hospital and the number of outpatient appointments received by patients with similar needs. Optimised pathways will ensure patient safety, quality and outcomes, and efficient care delivery.

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Previously, John (who is 75 and has pain in his knee) made an appointment with his GP. The GP referred him to the hospital where he was seen in outpatients and sent for an MRI scan. A consultant established that John needed a knee replacement. John was about to go on a trip to visit family in the USA for 2 months, so the consultant sent him back to his GP. When he returned John saw the GP again as well as the consultant, who sent him to preoperative assessment. He was found to have high blood pressure, and was sent back to the GP for treatment. Once his blood pressure was under control, John was listed and then admitted for surgery. He spent about 5 days in hospital, and then returned home.

In the future, John will see an extended scope physiotherapist at the GP surgery for his knee pain. The physio will arrange the MRI, and discuss the results with John. The physio will identify that John has raised blood pressure while completing his electronic referral template to the consultant at the hospital, and liaise with the GP to make sure this is treated before he is referred. John will have his hospital appointment and pre-operative assessment on the same day, and will be given all the information he needs to prepare for after the operation.

We will draw on local examples of best practice, such as the South West London Elective Orthopaedic Centre; and international best practice, such as Intermountain's hip replacement pathway redesign, which reduced the cost of total hip replacement by a quarter.[43] Building on the evidence, we will redesign pathways with local clinicians, responding to local needs and opportunities. We will initially focus on areas with high volume or high variability, where there is opportunity to achieve high impact by making changes, such as orthopaedics.

We will leverage the following opportunities for improvement to elective pathways:

- expert first point of contact: making sure people have access to the right expertise from their first appointment in primary care
- one-stop services: so that people do not need to attend multiple outpatient appointments before their procedure
- efficient surgical pathways: to ensure maximum use of staff and theatres
- timely discharge planning: to reduce unnecessary time in hospital.

To deliver on the above, a series of interventions will be put in place at each stage of the elective pathway. These are illustrated in exhibit 7.

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[43] James and Savitz (2011). How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts . Health Affairs

Exhibit 7: Interventions that support optimised elective pathways

Pre-primary care	Primary care	Outpatient care	Inpatient pre-operative care	Surgery	Inpatient post-operative care	Follow-up post discharge
• Non-medical support and education	• Expert first point of contact • Only when ready • Structured referral template • Diagnostic protocols • Shared protocols • Monitoring and transparency	• One-stop outpatient clinics • MDT clinic	• Preoperative assessment • Re-check prior to surgery • Short-notice reserve list	• Consultant-level feedback • Ring-fenced elective beds • Theatre utilisation	• Enhanced recovery • Effective planning for discharge	• Nurse led or virtual follow up

For orthopaedics, implementation of these high level interventions includes:
interventions includes:

- **Better use of non-medical support and education:** promoting non-medical support staff as the first line for minor concerns (e.g. at gyms), greater use of pharmacists, and giving patients access to more information online.
- **Expert first point of contact:** the first person the patient comes into contact with would be a GP with special interest or experienced physiotherapist, who would know the full range of treatment options available. As a consequence of this, more outpatient referrals would have diagnostics already performed and patients would be supported by the right information when they are making decisions about onward treatment.
- **Use of a structured referral template:** allowing all information to be available at the first clinic appointment. Ideally, this would be an electronic form which would reduce the risk of unnecessary follow up appointments as all relevant diagnostics and information are readily available to clinicans at the initial appointment. Structured referral templates are currently used by some providers and commissoners in NCL to good effect, but would be used more widely as part of the optimised elective pathway.
- **Improved diagnostic protocols:** administrative protocols would be ordered to ensure that the appropriate tests are being conducted to diagnose patients. This would limit repetitive tests being ordered, which is better for patients and optimises resource use.
- **Use of NCL-wide shared protocols:** would ensure that patients are being managed in a consistent way. It would build relationships and teams across the whole system, fostering trust and reducing duplication in tests, appointments and treatments as a result.
- **Only when ready:** patients are only referred when they are ready and available for treatment. This avoids a second GP appointment and re-referral.
- **Better monitoring and transparency:** peer review and support would be established to ensure referrals are appropriate, enabling clinicians to have an open dialogue

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regarding the quality of referrals and continuously improve their own referral practices.

- **One-stop outpatient clinics:** access to simultaneous pre-assessment and additional diagnostics in a single place, reducing the need for unnecessary follow ups.
- **Multi-disciplinary team (MDT) clinics:** clinics which consist of multiple different people working together to triage to the most appropriate clinician. Consultants, extended scope physios and GPs with special interests would all working together in a single setting to form the MDT.
- **Pre-operative assessments conducted at the first outpatient appointment:** if patients are not found to be fit, then their plan is reviewed the same day. This would be supported by greater use of e-self assessment by patients in their home. Rehab and post-operative packages of care would be arranged prior to referral, enabling patients who are at risk of staying for long lengths of time in hospital to be proactively identified.
- **Re-check prior to surgery:** patients will be contacted 48-72 hours before their surgery to reduce the risk of late cancellations. This check will ensure patients are still well enough for surgery, and want to go ahead with the planned procedure.
- **Short-notice reserve list:** to ensure that gaps caused by late cancellation can be filled by patients who are ready for treatment which allows theatres to be used most efficiently.
- **Consultant-level feedback:** transparency of list utilisation and case volumes per list. This allows for peer challenge to take place between consultants, to ensure the highest quality and most efficient practices are being maintained.
- **More effective planning for discharge:** discharge planning services will be offered earlier in the process, before patients are admitted to hospital. This will give greater access to community support services, and reduce delays in discharge.
- **Enhanced recovery pathways will be consistently applied**: patients will have a greater understanding of their expected length of stay when they are admitted, and be advised on the best course of action to avoid staying for longer.
- **Ring fenced elective beds will be available:** to reduce wasted theatre time, and diminish the risk of infection for elective patients.
- **Theatre utilisation will be optimised:** by scheduling cases and ensuring that critical equipment is properly scheduled to maintain the order and running of lists.

In addition to the improvements being worked through for orthopaedics, further specialties have been identified for focused pathway design. These are:

- Urology
- General surgery
- Colorectal surgery
- Hepatobiliary and pancreatic surgery
- Upper gastrointestinal surgery
- Gynaecology
- Gynaecological oncology
- Ear, Nose and Throat (ENT)

- Vascular surgery
- Breast surgery
- Musculoskeletal (MSK)
- Ophthalmology
- General medicine
- Gastroenterology
- Endocrinology

As well as delivering efficiency savings, reducing variation in planned care will improve patient outcomes and experience through:

- improved access to information and support to help people manage conditions without surgical intervention
- support for people to access to the right professional expertise the first time, rather than being referred between several different professionals
- improved access to surgical interventions as capacity will be freed up
- patients receive a single outpatient appointment rather than needing to make several attendances
- less time spent in hospital, meaning less chance of acquiring infections and reducing the risk of lost independence
- ensuring access to the right post-operative support, helping patients get back to normal life more quickly.

Reducing variation will also improve staff experience, including ensuring access to the right professional expertise when needed, better access to high quality diagnostics, improved relationships between professionals in different care settings and increasing sharing and learning from best practice across the local professional communities.

6.2.7 Consolidation of specialties

We will identify clinical areas that might benefit from being organised differently (e.g. managing multiple services as a single service), networking across providers, or providers collaborating and / or configuring in a new way in order to deliver high impact changes to major services. While changes of this sort can be challenging to implement and controversial with the public, we should not shy away from considering making changes

In London, two thirds of early deaths in people under 75 are from cancer and heart disease, there is a high risk of heart disease among the local population and the number of people diagnosed with cancer is growing. Specialists, technology and research are spread across too many hospitals to provide the best round-the-clock care to all patients. If we were to improve local survival rates for heart disease and all cancers in line with at least the rate for England, over 1,200 lives could be saved each year. (Source: UCLH news, 14 March 2014)

UCLH, Barts Health, the Royal Free and a number of other north London trusts implemented a significant service reconfiguration to address these issues. Cardiovascular care services provided at The Heart Hospital, The London Chest Hospital and St Bartholomew's Hospital were combined to create an integrated cardiovascular centre in the new building at St Bartholomew's. For 5 complex or rare cancers, specialist treatment is provided in centres of excellence across the area. Services for other types of cancer and general cancer services, such as most diagnostics and chemotherapy, continued to be provided locally.

where we are sure that significant improvements in the quality of care can be achieved.

We are not starting from scratch in this area: considerable service consolidation and specialisation has already taken place in NCL. Recent examples where we have successfully done this include:

- Cardiac / cancer (see case example box)
- Neurosurgery
- Pathology Joint Venture
- Renal medicine
- Hepatology and hepatobiliary surgery
- Neurosurgery
- Vascular surgery
- Ear, Nose and Throat (ENT)
- Bone Marrow transplantation
- Upper gastrointestinal
- Malignant gynaecology
- Cardiology
- Major trauma services
- Stroke services
- Plastic surgery
- Respiratory sub-specialties
- Cancer services including: pancreatic cancer, renal cancer, skin cancer, prostate cancer, head and neck cancer

However, we recognise that there may be other service areas which are or will become vulnerable in the future. There are many reasons why consolidation of services might be considered as a possible opportunity for improvement. First and foremost, we agree that improving quality should be the key driver for exploring consolidation, particularly where there is clear evidence of patients achieving better outcomes. Where there is a 'burning platform' and it is widely accepted that a service needs urgent attention (for example, in addressing issues of workforce sustainability), consolidation will be explored as an option. Releasing cost savings to support overall system sustainability is another driver for exploring potential consolidation opportunities.

This work is at an early stage. No decisions have been made, but we have identified services where we will review whether some form of consolidation may be worth consideration. It is recognised that fundamental, large scale reorganisation may take longer than the 5 year strategic horizon of the STP. As such, we have made no assumptions of financial benefit from this work.

To understand where we should focus further work, senior clinicians have systematically assessed services based on whether consolidation or alternative networking is required and / or could be beneficial. This has enabled us to identify a long list of services potentially in scope for further work over the 5 year period, for example:

- Emergency surgery (out of hours)
- Maternity services, in the context of the Better Births initiative (see section 6.2.1)

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- Elective orthopaedics
- Mental health crisis care and place of safety
- Mental health acute inpatient services
- Histopathology
- General dermatology services

Over the next year each of these services will be reviewed in light of whether they would benefit from consolidation or networking. We are in the process of developing proposals to bring together some mental health inpatient services in order to drive significant improvements in quality and patient experience as set out in the mental health workstream (see section 6.2.3). In addition, work is under way to understand potential opportunities for consolidation of mental health places of safety.

6.2.8 Cancer

We will save lives and improve patient experience for those with cancer in NCL and beyond. Commissioners and providers across NCL joined together to form our Cancer Vanguard, in partnership with Manchester Cancer and Royal Marsden Partners, with the aim of achieving earlier cancer diagnosis, ensuring effective use of cancer outcomes information and adoption of recognised best practice across the full spectrum of cancer pathways.

Previously Margaret, aged 60, went to see her GP with persistent epigastric pain for several weeks. She was otherwise well, and did not have reflux, diarrhoea, vomiting or weight loss. Over the course of next 3 weeks, Margaret's GP organised tests and ruled out any inflammation, heart problem, or gallstones that could cause the pain. He also started Margaret on a tablet (lansoprazole) to try to reduce inflammation from the acid on her stomach lining. However, Margaret's pain was more persistent this time and she was still worried.

In the new system, Margaret's GP will be able to refer her to the Multidisciplinary Diagnostic Centre at UCLH despite the fact that her symptoms are not considered "red flag". Here, Margaret will be assessed for vague abdominal symptoms. A clinical nurse specialist will see her 4 days after referral. The team will identify that Margaret has early stage pancreatic cancer and because it is picked up early she will be able to access potentially curative keyhole surgery.

Our cancer workstream is derived from the Vanguard agenda and encompasses a range of improvements to current practice. The key areas of focus include:

- **Early diagnosis:** to address impact of late diagnosis on survival outcomes across NCL, we will target specific causes of late diagnosis and poor detection rates. Targeting colorectal and lung pathways are a particular focus given the high percentage of patients receiving late stage diagnoses, often in Emergency Departments. We will roll out the Multi-disciplinary Diagnostic Clinic model for vague abdominal symptoms, promote adoption of straight to test models and deliver a programme to improve awareness of cancer symptoms in primary care.
- **New models of care:** we are developing the case for a single provider model for

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radiotherapy in NCL, to help achieve financial sustainability, reduce variation in clinical protocols and improve patient access to research and clinical innovations. This is being explored between the North Middlesex University Hospitals NHS Trust, the Royal Free NHS Foundation Trust and University College London Hospitals NHS Foundation Trust and also links with the hospital chains Vanguard led by the Royal Free. We will increase provision of chemotherapy closer to home, establishing a quality kitemark for chemotherapy and supporting self-management. The first patient treatment in the home for breast cancer will be available by the end of September 2016.

- **Centre for Cancer Outcomes (CCO):** to deliver robust outcomes data, improve pathway intelligence and address important population health research questions we will produce balanced scorecards which can made available to MDTs, providers and commissioners through a free to access web based platform.
- **Research and commercialisation:** we will leverage our unique position nationally in cancer to improve care for people with cancer, generate additional revenues across the system, and generate efficiencies by avoiding unnecessary interventions.

6.2.9 Specialised commissioning

Specialised services are those provided in relatively few hospitals / providers, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills. In NCL, the main providers of specialised acute services are University College London Hospitals NHS Foundation Trust (with income totaling £317m) and the Royal Free London NHS Foundation Trust (with income totaling £273m). A further 10 providers receive an additional £128m in income for the delivery of specialised services. This includes three specialist hospitals: Royal National Orthopaedic Hospital NHS Trust, Moorfields Eye Hospital NHS Foundation Trust, and Great Ormond Street Hospital NHS Trust. Barnet, Enfield and Haringey Mental Health NHS Trust and the Tavistock and Portman NHS Foundation Trust provides specialised mental health services. As well as caring for the local population, the specialised services provided by hospitals in north central London are also accessed by a population from outside of NCL.

We recognise that planning for specialised services can have an impact across the region (and potentially nationally), and are therefore working closely with NHS England, London region to develop plans in this area. At a pan-London level, 11 priority transformation initiatives for specialised services have been identified. These are:

- Paediatrics
- Cardiovascular
- Neuroscience and stroke
- Renal
- Cancer
- Adult mental health
- Child and Adolescent Mental Health Services (CAMHS)
- Trauma

- Women and children
- Blood and infection
- Medicines optimisation

On review of these pan-London initiatives, our clinical leadership identified 5 areas which resonated strongly as opportunities where we could lead the way in transforming specialised services. We are in the process of progressing plans in the following 5 areas:

- **High cost drugs:** this involves reviewing and strengthening adherence to starting and stopping rules for all high cost drugs. There is already work ongoing in NCL in this area, which has revealed that clinicians are good at starting people on these drugs but poor at stopping them. We will set clear criteria around the use of high cost drugs at an NCL level. In addition, we will reduce the spend on cancer drugs through the Cancer Vanguard Pharma Challenge process, which includes programmes on biosimilars, home administration and system intelligence.
- **Elective spinal surgery:** we will rapidly progress work on assessment, pre-surgical pathways and stratification to ensure patients are directed to the best possible place. This will help us balance demand and capacity more effectively.
- **End of life chemotherapy:** we will undertake a comprehensive review of chemotherapy usage close to the end of life. Using the evidence on when to stop end of life chemotherapy, we will develop protocols around this. We will work across the whole pathway on this issue, and link stopping acute chemotherapy to end of life discussions in primary care, working closely with the Cancer Vanguard to deliver this.
- **Imaging:** we will contain growth in imaging costs by eliminating the need for re-acquisition due to inadequate or unavailable scans. For patients, this will increase the speed of diagnosis and result in a reduction in duplicated contrast or radiation exposure. Implementing a networking approach to imaging will help us to deliver on this, as well as use of information management and technology to enable providers to share information on the scans which have already taken place.
- **Spinal cord injury:** we will redesign the pathway locally to address patients are currently waiting in Intensive Care Unit (ICU) beds to access specialist spinal cord injury rehabilitation services. Waiting in ICU beds can cause the onset of other symptoms leading to worse outcomes for patients and high costs for the system.

We recognise that our planning on specialised services is less developed than many other parts of the STP. We will continue to work with the specialised commissioning team in NHS England, London Region to develop more detailed plans in this area.

6.3 Productivity

6.3.1 Commissioner productivity (BAU QIPP)

We will continue to deliver significant "business as usual" efficiencies throughout the 5 year period. Business as usual (BAU) QIPP (Quality, Innovation, Productivity and Prevention) comprises savings commissioners expect to deliver as part of their normal activities. These are efficiencies in areas of CCG spend not covered by our other workstreams and include opportunities in the following areas:

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- **Mental health:** this includes ongoing non-transformational efficiencies, consistent with parity of esteem requirements. Examples of mental health QIPP are the management of out of sector placements and streamlining the pathways with specialist commissioning across forensic and mental health services.
- **Community:** spend on community services was c.£133m in 2015/16. There is an assumption of increased efficiency equivalent to 1.5% per annum supported by benchmarking work and transition to new models of care.
- **Continuing care:** spend on continuing care was c.£90m in 2015/16. There is an assumption of increased efficiency equivalent to 2.1% per annum supported by existing framework agreements.
- **Primary care prescribing:** spend on primary care prescribing was c.£205m in 15/16. There is an assumption of increased efficiency equivalent to 2.5% per annum including the adoption of generic drugs where possible, the adoption of local quality schemes to improve consistency and effectiveness. This is in the context of assumed growth of 5-7% per annum.
- **Programme costs (including estates):** this includes measures to reduce void costs and better alignment of health and care services to reduce the overall estate footprint whilst maintaining and improving service quality.

6.3.2 Provider productivity (BAU CIP) and system productivity

Significantly improving provider productivity is an essential part of the work to address our financial challenge. Our plans assume significant delivery of CIP (Cost Improvement Programmes), improving provider productivity.

We have identified opportunities for system productivity (defined as those areas where CIP delivery is dependent on trusts working together) to deliver financial savings whilst maintaining or improving quality. Our plans also assume savings from improvements to contracting between CCGs and trusts which will be realised system wide.

Specific initiatives to improve productivity include:

- **Workforce:** we will establish a shared recruitment and bank function across providers meaning that staff can be deployed between providers in the system; as well as improving retention of current staff and upskilling the health and social care workforce to enable delivery of new models of care. We commit to complying with the maximum total agency spend and hourly rates set out by NHS Improvement.
- **Procurement:** we will reduce purchasing unit costs with increased volume and scale across all providers by reducing clinical variation in product choice and undertaking joint action on drugs and medicines management.
- **Back office:** we will create centralised functions for payroll and pensions, finance and estates in order to reduce our overheads and improve service resilience. In addition we will:
  - Consolidate IT services to reduce costs whilst improving the resilience and quality of services

- o Enhance the existing share procurement arrangements to reduce non-pay costs
  - o Pool our legal budgets and resources, considering options to consolidate outsourced resources or appoint an in-house legal team.
- **Operational and clinical variation:** we will collectively reduce average length of stay, maximise theatre utilisation and streamline clinical processes, in addition to the changes proposed through the elective workstream.
- **Contract and transaction costs:** Releasing savings from streamlining transactions and contracting. This will be delivered through implementing new commissioning arrangements (which may facilitate joint procurement of services from the Commissioning Support Unit (CSU), for example) and leveraging the opportunities associated with joint commissioning between local authorities and CCGs.
- **Other:** Additional existing provider productivity schemes: estates, clinical admin redesign, service transformation, income etc.

6.4 Enablers

6.4.1 Digital

We will use digital technologies and information to move from our current models of care to deliver proactive, predictive, participatory, person-centred care for the population we serve.

There is significant and immediate opportunity for digital to transform our current delivery models and seed completely new, integrated models of health and social care. We recognise the strength of both the clinical and financial case for digital and its potential impact in strengthening productivity, providing ease of access to our services, minimising waste and improving care. Our ambition is to become a national leader in population health management enabled by informatics, to reduce variation and cost and improve care.

We will prioritise and increase pace of appropriate digital technology adoption within our organisations, realigning the demand on our services by reducing the emphasis on traditional face to face care models. In addition, we will explore new digital alternatives that will transform our services, with the aim of moving care closer to home, enabling virtual consultations and providing our patients with the information and resources to self-manage effectively, facilitating co-ordinated and effective out of hospital care. We will utilise opportunities for real-time, fully interoperable information exchanges to provide new, flexible and responsive digital services that deliver integrated, proactive care that improves outcomes for our patients.

Our digital programme proposes the creation of an NCL Population Health Management System (exhibit 8), which supports prevention, service transformation and productivity, and would enable us to meet the national mandate of operating paper free at the point of care by 2020. Through this system we will move from a landscape of diversity and variation to one of shared principles, consolidation and joint working for the benefit of the population.

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Exhibit 8: NCL Population Health System Management
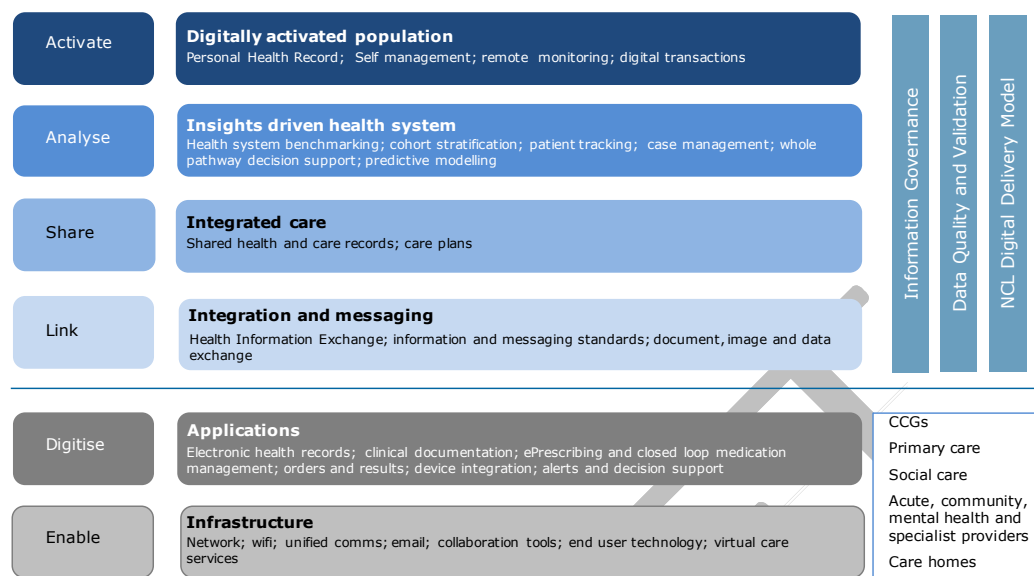
The 6 workstreams that make up our digital strategy are:

- **Activate**: We will provide our citizens with the ability to transact with healthcare services digitally, giving them access to their personal health and care information and equipping them with tools which enable them to actively manage their own health and wellbeing.
- **Analyse**: We will use data collected at the point of care to identify populations at risk, monitor the effectiveness of interventions on patients with established disease and deliver whole systems intelligence so that the needs of our entire population can be predicted and met.
- **Link**: We will enable information to be shared across the health and care systems seamlessly.
- **Share**: We will create and share care records and plans that enable integrated care delivery across organisations.
- **Digitise:** We will support our providers to move away from paper to fully digital care processes; including documentation, ordering, prescribing and decision support tools that help to make care safer.
- **Enable**: We will provide infrastructure which enables our care professionals to work and communicate effectively, anywhere at any time, and facilitate new and enhanced models of care closer to home.

To deliver on our digital strategy we will need to invest £159m, with a further £21m in 2020/21 (see section 8.3).

6.4.2 Estates

Our vision is to provide a fit for purpose, cost-effective, integrated, accessible estate which enables the delivery of high quality health and social care services for our local population. The priorities for development of our estates strategy are:

- to respond to clinical requirements and changes in demand by putting in place a fit for purpose estate
- to increase the operational efficiency of the estate
- to enhance delivery capability
- to enable the delivery of a portfolio of estates transformation projects.

There a number of barriers to achieving this, including:

- the complexity of the estates system in NCL, including the number of organisations and the differences in governance, objectives and incentives between each organisation, which often results in organisations working in silos
- misaligned incentives, which do not encourage optimal behaviour
- lack of affordability, specifically the inability for trusts to retain capital receipts, budget "annuality" and the difficulty of accessing capital investment for re-provision
- the complexity of developing business cases in terms of getting the right balance of speed and rigour, and the different approvals processes facing different organisation types (for example, there are different capital approval regimes operating across the NHS and local government).

We are working as part of the London devolution programme to pilot devolved powers in relation to the health and care estate. As part of this, we are asking for:

- local prioritisation and investment of capital receipts, including those that would otherwise be retained nationally
- NHS capital business case approval to be accelerated and consolidated through the implementation of a jointly owned and collaborative NCL / national process (or devolved to sub-regional or London-level)
- development of enhanced and revised definitions of value for money, which consider social value, wider community benefit and system sustainability at the sub-regional level
- new approaches for the accounting treatment of multi-year projects for non-foundation trust providers, in support of our plans
- developing local flexibilities in terms and conditions for the primary and community health estate to improve quality and utilisation
- support to agree the London-level and NCL delivery options to enhance our work
- ability to pay off PFIs using money raised from capital sales and/or a commitment by national partners to renegotiation of such agreements, where they have been identified as a significant barrier to financial sustainability and/or the facility is less than 50% utilised and no other utilisation solution will address the issue.

We anticipate the following benefits:

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- a whole system approach to estates development across NCL, with different partners working together on projects and developing a shared view of the required investment and development to support clinical change
- the ability to undertake better local health economy planning, including establishing estates requirements
- increased affordability of estates change across NCL
- greater incentives to dispose of surplus property, releasing land for housing
- focused action on the development of the estates requirements to deliver care closer to home
- greater efficiency and flexibility in the estate, reducing voids and improving utilisation and co-location which will support financial savings

Across the sites of Moorfields, St Pancras, St Ann's we are beginning to evidence qualitative benefits of working together to deliver estates value and improvement. The sector for a number of years has had unresolved estates issues relating to poor mental health inpatient accommodation and potentially saleable and high value estate at St Pancras Hospital. The 3 providers are working together on this strategic estates project which aligns estates priorities between all 3 trusts.

The proposed programme, which is still subject to consultation, would see sales proceeds from surplus assets used to deliver new purpose built mental health accommodation, and the eventual relocation of Moorfields Eye Hospital to the St Pancras site. Clinical improvements would be prioritised through the building of a new Institute of Mental Health and an integrated Eye Hospital and Institute of Ophthalmology at the current St Pancras Hospital site.

The three trusts are currently refining their outline business cases, with Board decisions due in late 2016 and early 2017. Subject to consultation, further testing of economic viability and planning permission, the specific benefits of the work will include:

- development of a new world class research, education and clinical care facility housing an integrated Moorfields Eye Hospital and UCLH's Institute of Ophthalmology, transforming ophthalmology facilities that are at present a constraint on continuous improvement
- improvements to the estate to meet CQC "must dos" including new mental health inpatients facilities for Camden and Islington NHS Foundation Trust (including the integration of physical and mental health and social care through an integrated practice unit at St Pancras). Also, new facilities for Barnet, Enfield & Haringey Mental Health Trust at St Ann's Hospital, Tottenham
- a world class UCLH Institute of Mental Health and associated patient care and educational facilities at St Pancras Hospital
- potential to deliver c.1,500 new housing units in London, significantly contributing to the NHS target for release of land for residential development
- improvements to environmental sustainability, as the new builds will deliver a balance between BREEAM ratings for 'green' initiatives, the cost of the capital build requirements to deliver them and the whole life cycle benefits in terms of costs and

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a more sustainable future for our planet. We will design, build and operate in a manner that supports recycling and use of low carbon technology.

The schemes are planned at a total capital cost of c.£400m (see section 8.3) with joint provider engagement under the umbrella of the estates devolution pilot driving completion of the final scheme by 2023. It is planned that £326m of this is financed by sale proceeds with the remainder funded from a variety of sources, including philanthropy.

Progressing this scheme may lead to a platform for sector wide capital prioritisation and create an improved incentive framework for asset disposal and enhanced utilisation, which will give rise to a locally originated capital funding stream.

In line with the findings of Healthcare for London in 2014, our analysis shows that significant capital work is required across NCL to improve the primary care estate. The primary and community estate needs improvement in a number of areas:

- development of CHINs to enable the delivery of the care closer to home model
- expansion and development of primary care facilities to ensure registration for a significantly expanding population and extended hours access
- whilst some capital to enable delivery may be available through the estates technology and transformation fund (ETTF), it is unlikely that this will cover the full set of requirements of £111m. Devolved powers will enable us to secure capital to deliver these much needed improvements and reduce the running costs of this estate.

Exhibit 9: NCL CHIN estate planning

NCL CCG CHIN current locational planning (NB Early stage and subject to full consultation)		
Barnet CCG	North East South West	Vale Drive Health Centre: The site identified is a LIFT building and hence it will improve utilisation Finchley Memorial Hospital: A LIFT building which is a natural hub and this will improve utilisation Grove Mead and/or new Colindale HC: A new health centre/CHIN is planned for Colindale (ETTF & S106) Edgware Community Hospital: ECH is another natural activity hub and also an underutilised site at present
Camden CCG	North North East South West	Hampstead Group: An extension to an existing practice is planned to create a health centre/CHIN (ETTF) Kentish Town Health Centre: A LIFT building which is a natural hub and this will improve utilisation Somers Town: An existing practice that is well placed to serve as a CHIN West Hampstead: An existing practice that is well placed to serve as a CHIN
Enfield CCG	North East South East South West North West	Freezy Water/Ordnance Community Centre: Existing practices that perform and are well placed (CHIN TBD) Forest Road HC and Evergreen HC: LIFT buildings in Edmonton and this will improve their utilisation Winchmore Hill: An ETTF scheme aims to extend an existing practice to develop a health centre/CHIN hub Chase Farm/Cockfosters (Holbrook House): Either on the Royal Free hospital site or within a new mixed-use
Haringey CCG	North East South East South West North West	Somerset Gardens: An ETTF scheme aims to extend an existing practice in the White Hart Lane re-gen area Tynemouth: A well placed existing practice currently providing extended access Hornsey Central (Queenswood): A LIFT building which is a natural hub and this will improve utilisation Bounds Green: A well placed existing practice currently providing extended access
Islington CCG	North Central South	Archway: An ETTF scheme to develop a new build health centre/CHIN Islington Central: A well placed and effective existing practice which can serve as a CHIN Ritchie Street: A well placed and effective existing practice which is able to serve as a CHIN

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6.4.3 Workforce

We aim to ensure that NCL becomes the place of choice to train, work and live healthy lives. This includes co-creating, communicating and collaboratively delivering a compelling offer to attract, develop retain and sustain a community of people who work in health and care in NCL. Our workforce needs to move further towards a person-centred approach and this means developing a whole range of new skills, training modalities and new roles.

Our vision is for staff to be part of the wider NCL workforce, not just part of a single organisation. Through this we will achieve efficiencies in employment by managing services collectively across the footprint. We will create sustainable career pathways to attract, develop and support a workforce fit for purpose in the changing health and care landscape. We will work with NCL organisations across all care settings (including social care) to support their collaborative efforts to be excellent employers – employers of choice, committed to looking after the wellbeing of staff whilst also preparing them to begin delivering the new care models. This will support NCL organisations to recruit and retain staff, particularly where employee turnover rates are high or where there are staff shortages. Career pathways will not be limited to a single care setting and will offer our staff opportunities to experience a wide range of different opportunities which fit their own aspirations. This process will allow us to work towards the development of an integrated employment model and a personal career passport for staff to develop their career over the long-term within NCL.

We aim to improve employee wellbeing and reduce avoidable sickness absence cost-effectively, therefore increasing lifetime productivity. We will focus on implementing the healthy workplace charter in NHS organisations, local authorities and in small and medium sized businesses.

Through equipping the existing workforce with new skills and ways of working, we will both ensure that our people are working to the best of their ability as well as adapting roles to meet the changing requirements of our services. We will support some of those people currently working in hospital settings with the skills and confidence to work across the care pathway, reaching out into community care settings and delivering the care closer to home model. We will similarly enhance the capabilities of those currently working in social, community and primary care. We will equip all our existing and future staff with motivational and coaching skills, competence in promoting self-care and prevention, and the enhancement of emotional resilience in themselves, their teams and their patients. All frontline NHS and local authority staff will be trained online in Making Every Contact Count (MECC), with key frontline staff also receiving face-to-face training. All non-medical frontline staff will receive training in Mental Health First Aid (MHFA). All NHS and social care staff will be trained in basic dementia awareness, with more advanced training for frontline staff who are more likely to encounter people living with dementia.

While most of the people who will be engaged in delivering the NCL vision are already with us, working in roles which will need to adapt or change in some way, we will also support the establishment of a small number of new roles, such as physician's associates, care

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navigators and advanced clinical practitioners. We will undertake expert strategic workforce planning and redesign, and commission training for skill enhancement, role diversification and new role implementation.

To enable transformation, we will deliver system-level organisational development, supporting system leaders as individuals and as teams through the transformation journey to enable personal resilience and courageous action. In addition, we will train everyone in a single approach to continuous quality improvement to create a culture of continuous improvement to deliver clinical excellence and quality care.

Health, social care and public health delivery is not limited to employees of our traditional employers, and our notion of working with the 'wider workforce' extends to the numerous carers, volunteers and citizens who improve the life of our population. In order to improve the general wellbeing of our population and make use of the substantial social capital across our footprint, we will educate and support patients, carers and those in their communities in areas such as self-care, self-management, dementia and mental health awareness. Building on our 'wider workforce' vision and aligning with initiatives such as the Alzheimer's Society ambition for London to be a dementia friendly city by 2020, we will support the training of groups such as barbers, hairdressers, librarians and teachers to gather a better understanding of dementia and other long term conditions. Across NCL, we have already built five strong Community Education Provider Networks (CEPNs), and these will provide an effective vehicle for delivery of this aim. We will review the provision of learning and development across NCL to ensure we make the best use of existing assets to encompass the wider healthcare community including patients and carers. Our immediate aims will be to standardise and streamline statutory and mandatory training, align induction and share in-house learning and development capacity.

Exhibit 10: Integrated workforce model
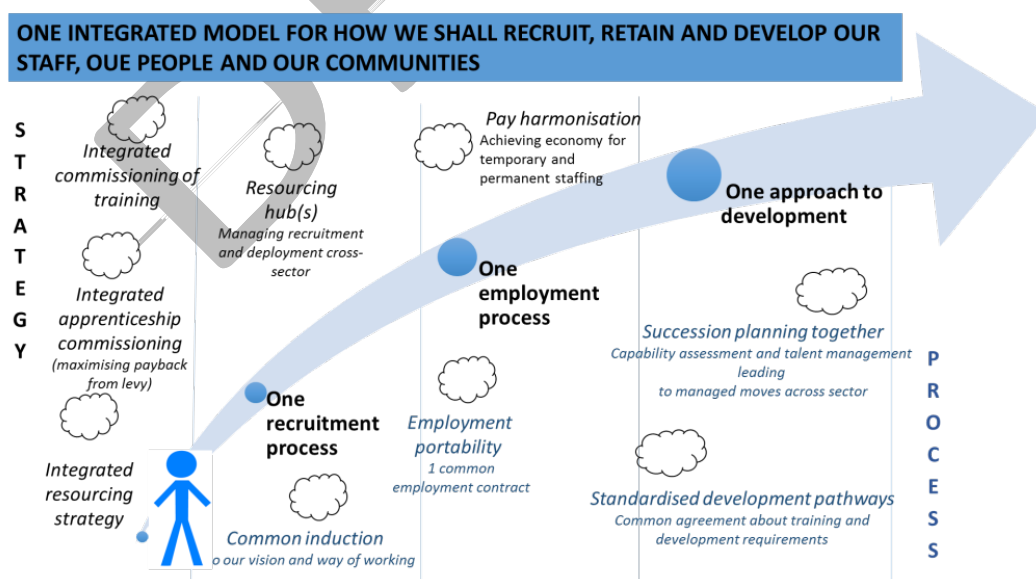
6.4.4 New commissioning and delivery models

As part of the STP development process, and in response to the changing healthcare landscape in NCL, the 5 CCGs have been exploring ways of working more collaboratively together whilst also seeking to strengthen joint commissioning with local authorities. We have concluded that a more formalised degree of cooperation between the 5 CCGs will improve health commissioning, particularly in response to:

- the development of new models of care, including larger provider organisations such the Royal Free Vanguard.
- increasing financial risk
- stretched capability and capacity.

Our work has covered the development of a proposal for joint governance of strategic commissioning decisions (see section 9.2.1); the development of a common commissioning strategy and financial strategy; and, a review of CCG management arrangements, with a view to shaping new ways of commissioning. With a focus on population health systems and outcomes and the transition to new models to deliver these, our objective is to further strengthen strategic commissioning over the next 2 years. We have agreed that any new commissioning arrangements need to balance the importance of local relationships and existing programmes of work with the need to commission at scale.

The governing bodies of each of the CCGs have agreed to the need for new executive management arrangements including shared roles across the CCGs: an Accountable Officer; a Chief Finance Officer; a Director of Strategy; and, a Director of Performance. Additionally, in order to ensure the continued role of each CCG in respect to its local commissioning and joint work with local government, local Directors with responsibility for local functions and services have been proposed.

These new leadership positions will work with each of the CCGs, as well as the new shared governance structure described in section 9.2.1, to ensure that health commissioning in NCL delivers the best possible health and wellbeing for the local population whilst ensuring value for money. The arrangements will be further considered by governing bodies in November with the expectation that the new leadership will be in place no later than 1 April 2017.

In parallel, commissioners and providers across the system have been working together to define our direction of travel in terms of new delivery models. We already have significant work we can build on relating to this, including the Royal Free London's provider chain model; the UCLH Cancer Vanguard; the Moorfields Eye Hospital ophthalmology specialty chain; and, the Royal National Orthopaedic Hospital NHS Trust chain of orthopaedic providers.

We have consulted with the leaders of all organisations across the system to get views on the different options for new delivery models, and the broad consensus includes moving towards:

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- whole system working with a population rather than individual organisational focus
- a deeper level of provider collaboration, including collaboration between primary care, community services, acute services, mental health services and social care services.
- the establishment of some form of 'new delivery vehicle' or 'new delivery system' to support this provider collaboration.
- a transfer over time of some elements of what we currently consider commissioning functions (for example, pathway redesign) into these new delivery vehicles.
- a move towards some sort of population based capitated budget for the new delivery vehicles.
- the retention of a strategic commissioning function responsible for holding the delivery vehicles to account, with accountability for outcomes rather than inputs based on principles of commissioning for value.

Further work needs to be done to resolve issues and differences of view around the following:
- the organisational form for the new delivery vehicles
- the optimal population size for population health management
- the geography over which new delivery vehicles should operate
- the form and governance of the strategic commissioning function
- which commissioning functions should remain with the strategic commissioning function and which should be undertaken through the new delivery vehicle.
- the scope of the new delivery vehicles
- unresolved issues such as how to manage patient choice, specialised services and other flows outside of the delivery vehicle and a full understanding of the legal framework which might impact on implementation
- speed of implementation.

Discussions continue across health and care commissioners and providers in NCL to establish agreement about the nature and scale of new delivery vehicles. Different care models are still being considered, and this work is being steered through the STP governance framework.

6.5   Measuring our success

We have established the anticipated impact of each of our workstreams to ensure we remain on track to close the key gaps as set out in our case for change. However, to ensure that the breadth of our workstreams collectively meet the scale of our ambition, 11 overarching outcomes have been developed by the London Health Commission for the Better Health for London strategy. These have been adapted for NCL and endorsed by the clinical cabinet for our STP. We will know if we have been successful by measuring impact against these outcomes over the next 4 years.

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Exhibit 11: NCL STP outcomes

Ensure that all children are school-ready by age 5. Achieve a 10% reduction in the proportion of children obese by Year 6 and reverse the trend in those who are overweight

Help all our residents to be active and eat healthily, with 70% achieving recommended activity levels

Reduce working days lost due to sickness absence

Reduce smoking rates in adults to 13% - in line with the lowest major global city.

Reduce the gap in life expectancy between adults with severe and enduring mental illness and the rest of the population by 5%

Increase the proportion of people who feel supported to manage their long-term condition to the top quartile nationally

Transform general practice in in NCL so residents have access to their GP teams 8am-8pm, and primary care is delivered in modern purpose-built/designed facilities

Work towards having the lowest death rates for the top 3 killers: cardiovascular disease, Cancer, respiratory disease and close the gap in care between those admitted to hospital on weekdays and at weekends

Fully engage our residents in the design of their services, and achieve a 10 point increase on the poll data regarding engagement in designing services.

Put NCL at the centre of the global revolution in digital health and ensure this improves patient outcomes

We want to reduce air pollution across NCL, to allow our residents to live in healthier environments

7 Delivery plans

A delivery plan has been developed for each of our workstreams, setting out the scope; objectives; financial and non-financial impact with trajectories; any investment requirements and the key risks to successful delivery. We will finalise the details of the delivery plans over the next few months as we agree the detailed phasing and investment timetables.

The delivery plans will be live documents and will continue to be iterated as the programme develops. In addition, each workstream is required to develop a full programme initiation document which will provide a reference point for every workstream to ensure planned delivery is on track, and to support the effective management of interdependencies between workstreams.

8 Bridging the financial gap

The financial analysis that we have undertaken (see exhibit 2) shows the significant gap between anticipated growth in demand (and therefore cost growth) for the NHS in NCL and the growth in funding that the NHS expects to receive over the 5 years of the STP. Without changing the way that we work together as a system to provide a more efficient, joined up service across organisations, this would leave us with an estimated £876m deficit in 2020/2021.

The STP in NCL has brought together organisations across health and social care to jointly discuss how we can address this financial challenge as well as making progress in improving the quality of, and access, to services. Based on the plans and analysis set out in this STP, which have been developed with and by local clinical experts, we will reduce the annual deficit over the next five years to £75m (exhibit 12) – whilst this addresses more than 90% of the financial gap, we recognise that further work is needed.

The key elements of the plan are set out in detail elsewhere in this document. Exhibit 12 shows how these contribute to the improvement in the annual financial position of the NCL system over 5 years. The key areas of work are:

- **Care closer to home:** savings of £114m have been estimated from improving access to primary care; proactively identifying need and early intervention to avoid crisis; rapid response to urgent needs to prevent hospital admissions; providing community-based and ambulatory-based care; and reducing delays to discharge.
- **Prevention and the support of healthier choices:** this is estimated to result in savings of £10m.
- **Mental health outreach and liaison:** this is estimated to result in savings of £6m.
- **Optimising the elective pathway**: savings of £55m have been estimated from benchmarking against best practice; working closely with clinicians; optimising flow through theatres (increasing throughput); and reducing length of stay - in addition to the excellent work that our hospitals and other providers do to improve productivity each year.
- Additional plans are being developed relating to the **UCLH Cancer Vanguard** scheme and **Royal Free Hospital Chain Vanguard** which are estimated to deliver £35m.
- **System level productivity** savings of £98m are planned to be achieved alongside the 'business as usual' cost improvements across providers in NCL of £218m and local commissioner business as usual efficiencies (QIPP) of £57m.
- We have identified a potential saving of £24m per year through 'buying out' a number of **Private Finance Initiative** hospitals, bringing management of these facilities back within the public sector. We will continue to work with the Department of Health and others to develop these plans, recognising that there are a number of constraints.
- Although detailed plans have not yet been developed, we have been advised by NHS England to assume that the NCL proportion of the **London Ambulance Service (LAS)** financial gap of £10m and the estimated **specialised commissioning** pressure of £137m will be fully addressed by LAS and NHS England respectively. NCL hospitals provide a very significant amount of specialist care and it is therefore essential that NHS England works together with the STP on how these services can flourish whilst

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also addressing the financial pressures associated with the growth in specialist activity (which in most developed economies is higher than growth in other services due to new technologies, drugs and clinical interventions).

- Further work is ongoing in relation to developing a fuller understanding of the social care financial position and pressures. At present no financial values have been included as advised by NHS England, but this has not prevented the STP from working very closely across both health and social care. In particular the NHS within NCL is seeking to learn from local authority colleagues best practice in relation to reducing cost whilst improving the experience of people who use services and the public.

These improvements cannot be achieved without investment. The plan is based on investment of £64m in prevention and care closer to home, and £4m in elective care. We have also assumed that £31m of our indicative £105m share of the Sustainability and Transformation Fund will be required to fund national policy priorities over and above these investments, in addition to that already assumed within the 'do nothing' scenario.

The savings set out above are predicated strongly upon reducing significant activity in acute hospitals, in particular reducing demand for inpatient care. We know that realising such savings can be difficult in practice and are contingent upon removing or re-purposing capacity within acute hospitals. As such, through working with the clinical cabinet of clinical leaders within NCL we have assumed that the cost savings that will be realised from each avoided day of acute hospital care will be significantly lower than the average tariff that is currently paid to providers by commissioners for this care. This is reflected in a £53m 'risk adjustment' in the financial analysis.

8.1 Normalised forecast outturn by year

Each year there will be a number of one-off costs and income streams to the commissioners and providers within NCL. Our 5 year financial analysis is initially based upon the "normalised" (or underlying) financial position in 2016/17 which is then projected forward. We estimate that 2016/17 outturn will be a normalised deficit of £216m (£101m on an in-year basis). Significant one-off figures within this include UCLH's transitional funding that it is receiving to compensate for the financial impact of moving cardiac services to the new, world class centre at Barts hospital, and the Royal Free's transitional funding in relation to the merger with Barnet and Chase Farm. The underlying figure also includes a £40m adjustment which is an estimate of the combined risk to the NHS provider and commissioner forecast outturn. This has arisen as a result of potentially different assumptions between NHS commissioners and providers about the value of work undertaken by the end of 2016/17. We have reached an agreed view on forecast outturn activity and will continue to work urgently to ensure consistency of payment assumptions between different parts of the NHS within NCL. All parties have agreed a more 'open book' approach to contract agreements that will ensure a consistent, system-based approach.

The STP plan shows a gradual improvement in the financial position over the 5 years of the STP (exhibit 13). The normalised position improves year on year. This pattern is in part caused by the requirement for majority of the investment in the early years of the STP, with benefits accruing in the later years.

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8.2 2017/18 forecast operating plan

In 2017/18 we estimate that our in-year position will be a £95m deficit for NCL against a draft system control total of £13m surplus (which we anticipate will change over the coming weeks due to a number of technical issues). This incorporates significant investment during the year on service transformation and delivery of the Five Year Forward View:

- investment in service transformation: £25m. This relates to the care closer to home (£23.5m), elective (£0.8m) and outpatient (£0.4m) workstreams
- other recurrent investment by CCGs and trusts – included within the CCG and trust cost movements it is estimated at £25m in 17/18 to deliver elements of the 5YFV priorities
- other non-recurrent costs (estimated at £20m in 17/18) for investment in Vanguard costs, IT digital costs, and STP programme costs.

In line with NHSE guidance we have also assumed that we will receive our 'fair share' of the national Sustainability and Transformation Fund (£105m) in 2017/18. This compares to the £52m currently notified to NHS providers, and additional a further £53m improves our revised forecast operating plan position to a deficit of £62m – see exhibit 14.

8.3 Capital expenditure

We recognise that the national capital budget for the NHS is highly constrained over the course of this parliament, and will continue to work hard to minimise the need for significant capital investment unless there is a strong return on investment. NCL also has a number of creative proposals that will seek to maximise disposal proceeds from sites no longer required, and use these to reinvest in the priority areas of the STP as well as the potential to provide additional, much-needed housing for the residents of NCL.

There are a number of large capital schemes that are already approved and underway within the STP and, whilst far from being 'business as usual' these are included in the 'do nothing' scenario as their approval pre-dates the STP work. Total capital, before specific STP-related investment, is £1.2bn over the 5 years. This includes:

- **UCLH new clinical facilities:** haematology-oncology and short stay surgery – (£137m); Proton-beam therapy (£130m), ENT and dental facility to consolidate two existing hospitals onto the main University College Hospital campus (£98m) and other more minor schemes. UCLH have approved DH funding of £278m (£51m public dividend capital (PDC) and £227m DH Loan) as well as anticipated, ring-fenced disposal proceeds to finance these developments
- **Royal Free - Chase Farm redevelopment:** (£183m), which includes £93m of approved DH funding (£80m PDC and £13m DH Loan).

In addition to these major developments there is of course significant business as usual capital investment such as equipment replacement and building maintenance, funded through depreciation, cash reserves and other sources of funding (including disposals).

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The additional gross capital requirements to implement the transformation programme set out in the STP totals £542m, with a much smaller net investment requirement after taking into account disposals, donations and grants:

- **Estates redevelopment:** relating to our St Pancras/St Anns/Moorfields proposals: £404m, assumed to be funded through disposals £326m), DH loans (£39m) and Donations (£37m), of which **£272m** (including short term bridging loans and repayments) occur within the period covered by this STP (i.e. before 2020/21) and is included above. This scheme, including an assumption of DH loan funding, has yet to be agreed, and will be subject to normal Business Case processes through NHS Improvement.
- **Primary Care for Care Closer to Home and 5YFV investment: £111m** assumed to be funded predominantly through ETTF (£60m – all bids submitted), s106/CIL/GP contributions (£26m), grants and other sources.
- **IT investment: £159m** with a further £21m in 2021/22. All assumed to be funded by ETTF (circa £10m – bids submitted for the Person Held Record/IDCR) or through the central Digital Transformation Fund.

We recognise that further work is needed to develop full business cases for the above, and at present these figures are estimated - particularly in relation to primary care and digital investment. In developing these schemes we will seek to maximise the use of existing buildings and other assets, and minimise the need for new capital investment, together with applying a robust requirement for return on investment for each scheme. However, we fundamentally believe that investment in primary care and digital technology is central to the transformation of services that is needed in NCL to address the gaps in service quality, access and finance, and wholly consistent with the Five Year Forward View and requirement to be paper-free at the point of care by 2023. It would be wrong to assume that such investment is not required and will not deliver value simply because of the stage in development of these plans that NCL is currently in.

The estates redevelopment relating to St Pancras, St Ann's and Moorfields, and the estates devolution work, offers an exciting and compelling vision as to how existing assets, disposals, redevelopment and construction of new facilities can be financially efficient as well as delivering significant benefits to patients, service users and the wider population.

In addition, we will continue to engage as an STP with the work being led by Sir Robert Naylor in relation to property strategy across the NHS, to further understand how being a pilot area in this can help NCL make best use of its current assets to support the delivery of our STP vision.

8.4 Next steps to address the financial gap

We are very clear that we have more to do to close the financial gaps for the remainder of 2016/17 and across the next 4 years of the STP.

We will therefore undertake a period of further intensive work over the next 8 weeks both to improve confidence in delivery of current estimates, whilst concurrently working on other areas to further improve the position. As far as possible we will aim to do this by

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Christmas, so that our operating plan submission improves on this submission. However, we do believe that there is a risk that the gap will not be fully closed in every year whilst ensuring that we continue to prioritise quality of and access to services, particularly as we balance the need to invest in the early years to deliver transformational benefits in later years. It is also essential that STPs and their constituent organisations and leadership are given the regulatory headroom to develop longer term plans, and that the 'new models of care' being developed give clarity of financial accountability to support the financial challenges that the STP faces.

We have identified a number of immediate actions to improve our current financial position, which include:

- early delivery of high impact care closer to home interventions
- accelerated delivery of stretch targets for high impact elective pathways
- increased effort in terms of delivering efficiencies through provider productivity schemes
- reducing any non-value added contracting costs
- implementation of pay harmonisation and shared principles around usage of bank and agency staff
- leveraging existing capacity in NHS providers to reduce outsourcing of activity to the independent sector
- other non-recurrent savings measures
- assessing and incorporating the impact of 2017/18 tariff changes.

There are also a number of areas that we will explore further as we believe there may be significant savings to be found. These include:

- maximising clinical productivity across providers, for example introducing shared clinical rotas
- developing alternative pathways for the London Ambulance Service to avoid conveyance to Emergency Departments
- rolling out standardised pathways to all specialities
- identifying opportunities to reduce the length of stay for patients receiving specialist services
- reviewing any plans that require capital and have not yet been agreed to establish the most cost effective way to deliver agreed outcomes
- rapid implementation of cancer initiatives, including early diagnosis, new models of care, end of life interventions and research and innovation
- re-providing cost effective services for the c.20% of people we estimate are currently in hospital beds but are medically fit to leave
- putting in place a peer review challenge approach across all areas of spend to identify further opportunities to reduce or avoid spend, and to aid collective delivery of plans.

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Exhibit 12: Bridging the financial gap to 2020/21

Adjusted NCL 'Do something' financial gap

£m

Value	Category
(876)	Total Do nothing (June STP)
80	16/17 Operating plan delivery
(40)	16/17 Outturn risk
(10)	LAS 20/21 deficit
23	Adjustment to 20/21 do nothing
55	1% surplus adjustment
(29)	Specialist Trusts Do nothing (T&P, RNOH)
(797)	Do nothing (17/18 - 20/21)
114	Care Closer to Home (CCH)
10	Prevention
6	Mental Health
(53)	Delivery risk adjustment
(64)	Investment (CCH, Prevention, MH)
55	Elective pathway
(4)	Non-NCL provider intervention adjustment
6	Elective pathway investment
218	System productivity
98	BAU CIP
57	BAU QIPP
105	STF funding
(31)	STF enabler investments
35	Vanguards (Cancer, Royal Free)
10	LAS solutions
137	NHSE Spec Comm
24	PFI intervention
(75)	2020/21 Do Something' residual gap

Exhibit 13: Normalised forecast outturn by year

Draft NCL normalised forecast outturn 16/17 - 20/21
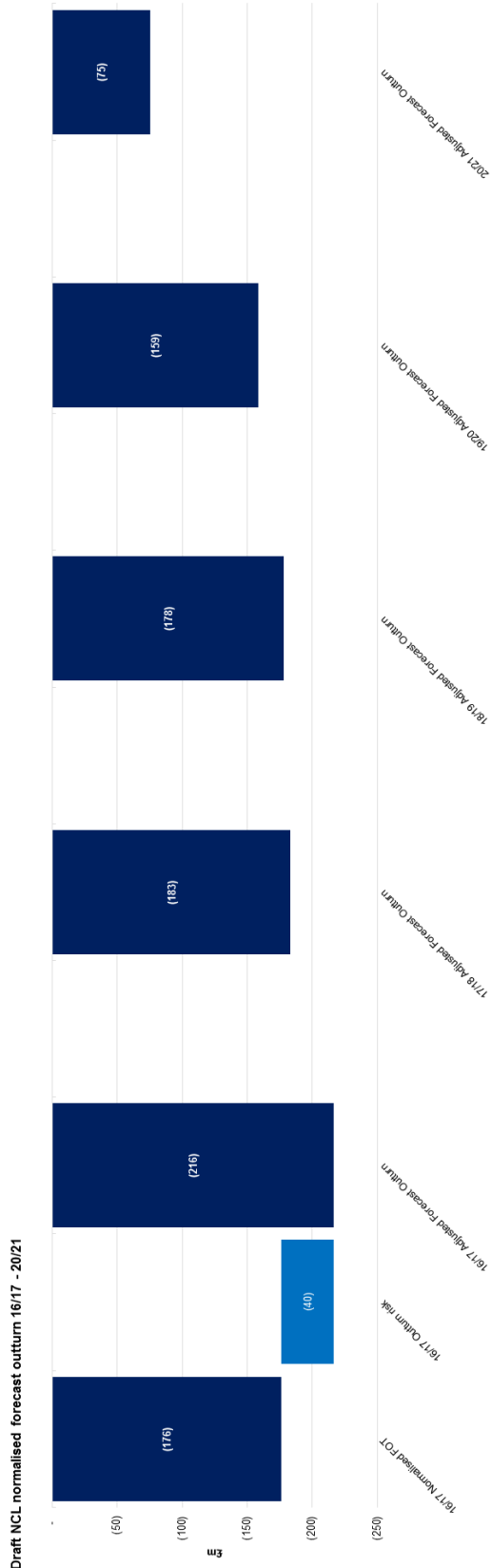
Exhibit 14: Forecast 2016/17 outturn control total to 2017/18 forecast operating plan

16/17 Forecast Outturn Control Total to 17/18 Forecast Operating Plan
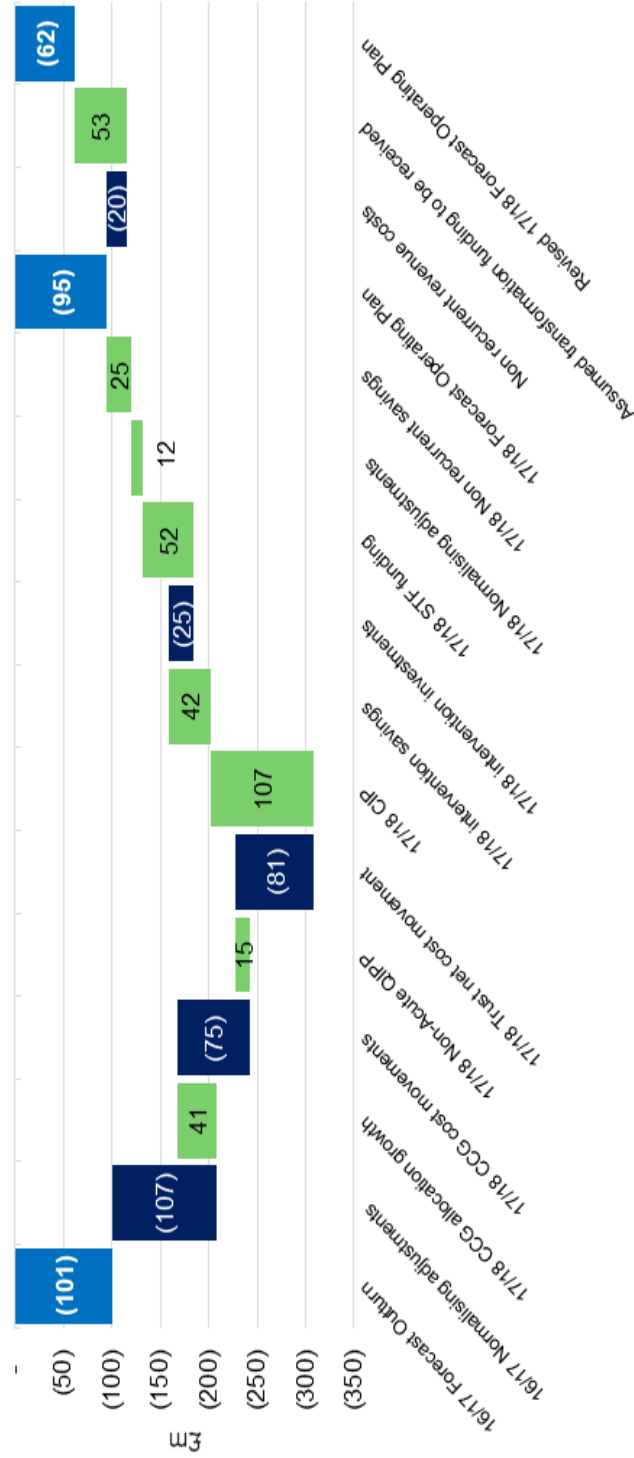
Note: The 16/17 in year FOT of £101m together with the £107m 16/17 normalizing adjustments represents the normalized 16/17 position excluding the specialist trusts (RNOH, T&P). Including the specialist trusts normalised 16/17 position (£8m) brings the combined 16/17 normalised deficit to £216m (shown in exhibit 13).

9   How we will deliver our plan

9.1   Delivery through 2 year contracts in NCL

Delivering the STP is a priority for health and care commissioners and providers in NCL - therefore it is essential that commissioning intentions and contracts reflect this. In line with national guidance, we are entering into a planning round for 2 year contracts covering 2017/18 and 2018/19. We will use this opportunity to ensure all contracts are strategically aligned to the STP, thus enabling its delivery. Whilst we recognise that implementation might look different in different local areas, we know that it will only be possible to deliver on the STP if we are all pulling in the same direction. Setting up 2 year contracts based around our STP delivery plans will both enable rapid implementation and support a longer term move to new relationships between commissioners and providers, reducing transactional costs and building the foundation for the development of new commissioning and delivery arrangements.

Exhibit 15: High level plan for 2 year planning round to support delivery of the STP
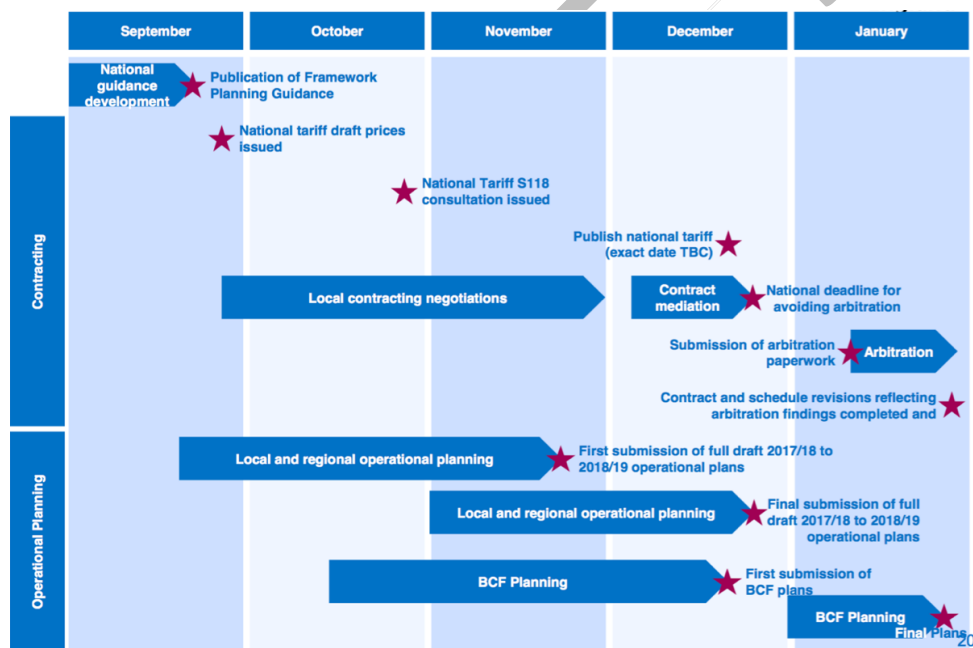
We have developed a proposed process and a set of draft principles for managing the contract negotiations that will take place over the next couple of months. Our leadership group will meet regularly (every 2 to 3 weeks) to ensure leadership alignment, assess progress on operating plans, and to ensure that the behaviours of teams reflect the agreed NCL approach.

We have agreed that operating plans and contracts will need to be strategically consistent with the STP. To achieve this, all finance and activity alignment will be overseen by the STP finance and activity modelling group, with overall plan alignment to be overseen by the NCL wide planning group led by the CCGs. All interim finance and activity submissions by CCGs and trusts between 21 October and 23 December should therefore be aligned across NCL

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before submission. Whilst organisations will individually follow up queries with NHS England or NHS Improvement on 2017/18 control totals, no organisation will agree their individual target unless and until there is a pan-NCL plan agreed.

The risks of delivery of operating plans will be identified and jointly owned and managed, with the following principles:

- simplicity
- reducing transaction costs
- incentivising the changes in care delivery as set out in the STP
- incentivising the delivery in improved productivity as set out in the STP
- locating risk where it can best be managed
- an open book approach
- use of agreed sources of data.

In the current context of the financial position and management capacity across the system, we will ensure in the first 2 years of the STP that we are prioritising our efforts in the areas which will add the most value in terms of increasing health and wellbeing for people; improving the quality of care people receive; and ensuring value for tax payers' money. We will focus our energies on achieving maximum benefit and we will seek to identify areas where we can further and faster to build confidence and momentum.

We will identify resources to take forward areas of further potential benefit. In addition, we will set up a process for independent peer review challenge of all areas of discretionary spend in providers and CCGs to identify further opportunities to reduce or avoid spend and to aid the collective delivery of plans.

9.2   Decision making in the programme

The STP is a collaboration between a range of sovereign organisations in NCL, each with its own governance and decision-making structures. We have not to date introduced any collective decision-making structures. However we have worked together to produce both the Case for Change and the STP.

The STP is a work in progress and therefore has not been signed off by any of the organisations within the STP. We will take this STP through the public sessions of each of the NHS provider boards, CCG governing bodies and Local Authorities for their support and input into the next steps.

9.2.1   Collective governance arrangements for CCGs

Going forward, in order to support a more collaborative commissioning approach across NCL, the 5 CCGs will need a mechanism for collective decision making. Governing Bodies have recognised this requirement and have agreed the principle of establishing a joint NCL-wide governance structure for some elements of commissioning.

Further work is being done on the details of the proposed joint governance structure. Engagement on the design has been ongoing during October 2016 and will continue with further details to be presented at Governing Body meetings in November 2016.

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9.3   Programme architecture

In coming together as an STP footprint, we have developed a governance structure, which enables NHS and local government STP partners to work together in new ways. The NCL STP Transformation Board brings together executives from all programme partners monthly to oversee the development of the programme. It has no formal decision making authority, but members are committed to steering decisions through their constituent boards and governing bodies. Three subgroups feed into the Transformation Board: the Clinical Cabinet, the Finance and Activity Modelling Group and the Transformation Group.

The Clinical Cabinet meets fortnightly to provide clinical and professional steer, input and challenge to all the workstreams as they develop. Membership consists of the 5 CCG Chairs, the 8 Medical Directors, clinical leads from across the workstreams, 3 nursing representatives from across the footprint, a representative for the Directors of Public Health and representatives for the Directors of Adult Social Services and the Directors of Children's Services respectively.

The Finance and Activity Modelling Group is attended by the Finance Directors from all organisations (commissioners and providers). This group also meets fortnightly, to oversee the finance and activity modelling of the workstream plans as they develop.

The Transformation Group is an executive steering group made up of a cross section of representatives from all organisations and roles. This group is specifically responsible for driving progress between meetings of the Transformation Board, and meets fortnightly to do so. Membership includes the SROs of all workstreams.

Additionally, the NCL STP has a full time PMO which facilitates and coordinates the meetings of the main governance groups, as well as delivering communications and engagement support to the programme.

Exhibit 16: NCL STP current governance structure
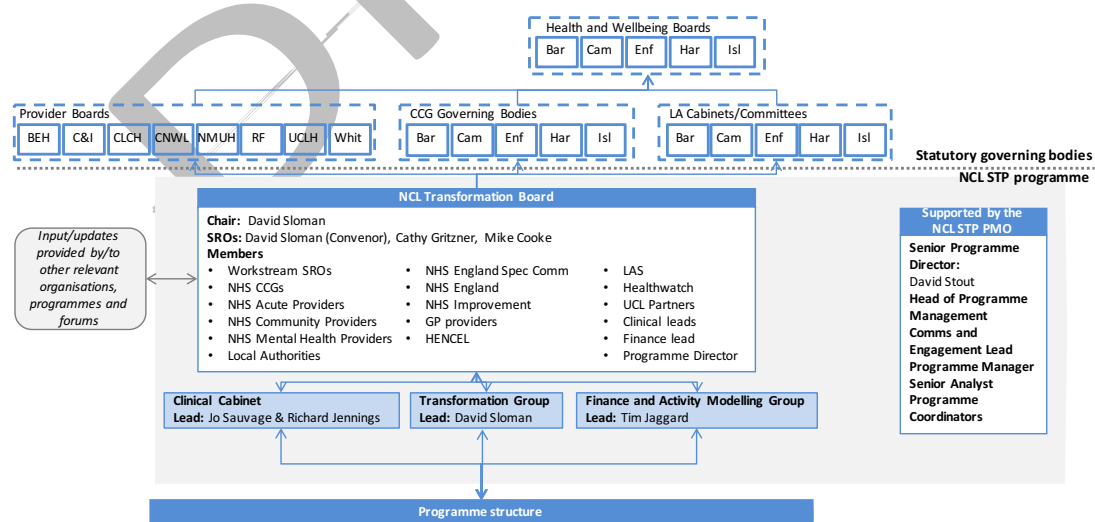
The component workstreams of the NCL STP feed into the overarching governance framework. The workstreams are responsible for developing proposals and delivery plans in the core priority areas. Every workstream has its own governance arrangements and meeting cycles which have been designed to meet their respective specific requirements, depending on the core stakeholders involved.

9.3.1 Future programme architecture

We recognise that as we move from planning to implementation that we will need to amend our programme architecture to ensure that it is fit for purpose. We will work with the Transformation Board to agree any required changes to the programme architecture so that we are ready to move forward with implementation from the new year.

Our initial proposal for discussion is set out in exhibit 17.

Exhibit 17: Proposed future programme architecture
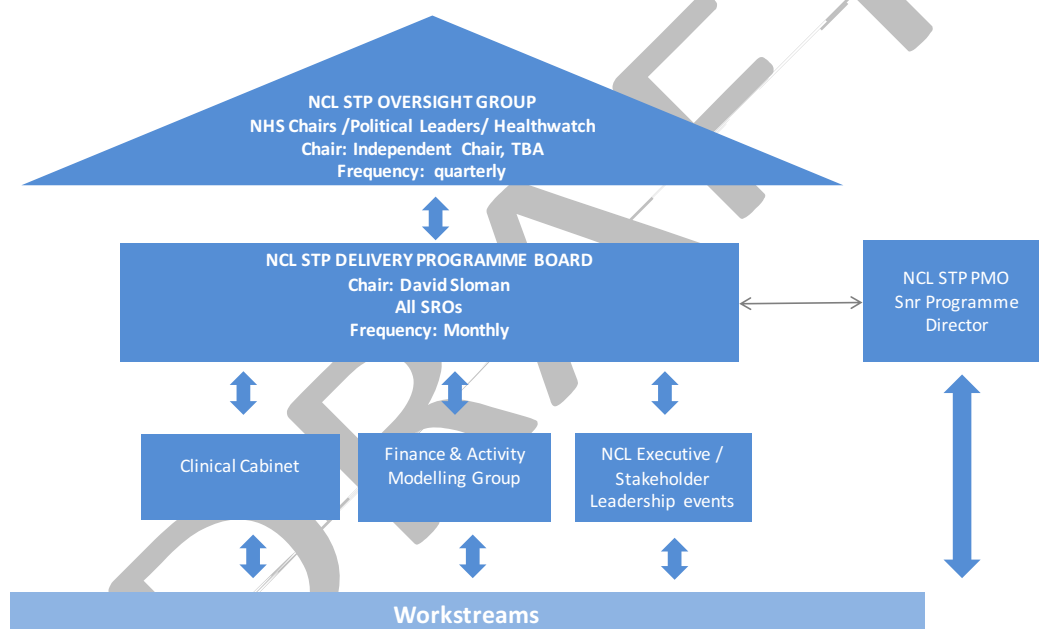
This structure would comprise the following new groups:

- **STP Oversight Group:** This oversight group would be made up of Chairs and political leaders and would go some way to address the current 'democratic deficit' and representation of views of the local population. It is proposed that this group meet quarterly and might benefit from an appointed Independent Chair. Membership of this group would ensure scrutiny of the delivery of STP delivery and ensure a better connection with the NHS boards, governing bodies and local authority leadership.
- **STP Delivery Programme Board:** To drive and oversee the progression and delivery of the STP. It is proposed that the delivery board meet monthly. This would replace the Transformation Group.

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- **Executive leadership events:** CEOs and other relevant executive directors and stakeholder representatives would meet periodically as requested by the Delivery Board in order to resolve delivery issues.

9.3.2 Health and wellbeing boards

CCGs are required to involve their local Health and Wellbeing Board (HWB) when preparing their commissioning plan so that HWBs can consider whether their draft plans take proper account of the local health and wellbeing strategy. As CCG commissioning plans will be set within the context of the STP, it will be important that we engage with HWBs as we develop the STP. Engagement of HWBs will also be an important means of ensuring engagement of local political leadership in the STP process.

9.3.3 Overview and scrutiny committees

Local authorities have a role in reviewing and scrutinising matters relating to the planning, provision and operation of health services in their local area. Commissioners and providers of NHS services (including NHS England, CCGs, NHS trusts, NHS foundation trusts and private providers) must consult the local authority where they are considering any proposal for a substantial development or variation of the health service in the area. Ordinarily, where the services in question are commissioned by NHS England or CCGs (as the case may be), the commissioners carry out this exercise on behalf of providers. Providers of public health services commissioned by the local authority are also required to consult the local authority in the same way as commissioners and providers of NHS services.

The local authority may scrutinise such proposals and make reports and recommendations to NHS England and the Secretary of State for Health. Legislation provides for exemptions from the duty to consult in certain circumstances, for example where the decision must be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff. As part of the overview and scrutiny process, the local authority will invite comment from interested parties and take into account relevant information available, including that from Healthwatch.

We have a Joint Health Overview and Scrutiny Committee (JHOSC) in place across NCL which has already put the STP on its agenda as a standing item. We will ensure that we liaise closely with the JHOSC as the STP plans develop so that we can plan ahead for any likely need for public consultation. In addition, we will discuss plans with any relevant local authority overview and scrutiny committees as we move towards local implementation.

9.4 Programme resourcing

We have dedicated resources in place to support the delivery of the STP, with an agreed overall programme budget of £5m in 2016/17. Each workstream has a Senior Responsible Officer (SRO). Some workstreams have shared leadership, where a mixed skillset is required. All of these individuals are senior Executive level - Chief Executives, Medical Directors or Finance Directors - ensuring leadership of the highest quality. Each SRO is supported by a dedicated programme manager, and in some cases a broader team of support. A programme budget for 2016/17 has been allocated to each of the workstreams based on

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their proposed requirements. STP partner organisations are also giving in kind to each of the workstreams to ensure high quality plans can be delivered at pace.

We will review the requirements for 2017/18 and beyond as we finalise the delivery plans and phasing of implementation. A £10m resource requirement to deliver the plan has been factored into our financial modelling.

10 Engagement

We have come a long way since being asked to come together as 22 health and social care organisations with disparate views last December. It takes time to build trust and develop shared a shared vision of the future between people and organisations, and to get everyone working towards the same goals. We are now all aligned behind a collective agenda and are ready to share it more widely, seeking input and feedback on our draft plans to date.

The most important people we need to engage with are those who use our services – the residents of NCL. We have specifically created a shared core narrative for this purpose – ensuring it is in patient-focused and accessible in language to begin to involve people in the process. Now that we are in a position to communicate our collective thoughts effectively, our intention is to engage residents, local Councillors, our workforce and other key stakeholders to get feedback on our plans. We have held initial public meetings in each of the 5 boroughs to begin the process of co-design with patients, people who use services, carers, families and Healthwatch.

Our approach going forward will be to collaborate more extensively with people who use services and carers, local political stakeholders as well as members of the public, to ensure that our residents help inform our decisions. This approach is guided by the following core principles (often called the "Ladder of Citizen Participation"). We will undertake different types of engagement as set out on the ladder as appropriate:

1. 'inform' stakeholders
2. 'engage' with stakeholders in open discussions
3. 'co-design/ co-produce' services with stakeholders

Feedback from our local residents will be fundamental to our decision making and will help us shape the way the final plan is implemented.

10.1 Our future plans

We will now build on the success of our initial public engagement events by:

- holding a quarterly forum in each borough
- holding pan-NCL events on specific issues that may arise in support of the borough level events
- hosting meetings with the public on focussed topics such as urgent and emergency care, primary care, and mental health to get in-depth input from the community
- organising 'Tweet chats' on specific areas of interest
- developing a designated YouTube channel and populating it with relevant resources.
- using partner digital media channels – Twitter, Facebook, Instagram – to promote our public engagement programmes and information. We will also use these channels to test ideas and progress on local priorities which will help us develop our plans further.

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To do this, we will:

- use Healthwatch, other patient representative groups and resident's associations, local authority engagement networks and the range of other networks available to reach out to the public and share our draft plans
- work in partnership with communications teams across NCL organisations and use their wide range of community channels to socialise the STP, for example Camden CCG's citizens' panel and Enfield's Patient Participation Groups Network.
- use existing online engagement tools that CCGs, local authorities and providers have to engage specific audiences and reach those who may be unable to attend our events.

We recognise it is crucial to ensure our local political stakeholders are actively involved in the oversight of the plans as they develop. We are planning on doing this by:

- planning regular face to face meetings between the STP leadership team and local councillors and MPs, along with Ministers in the Department for Health if required to seek their regular advice on all proposed changes
- continuing to share progress updates of the STP at all meetings at the Joint Health Overview and Scrutiny Committee (JHOSC)ensuring that all political channels through CCGs, local authorities and providers are kept fully briefed on the STP as it develops and any public concerns for the regular engagement they undertake with elected leaders
- logging all media stories and regularly updating the Transformation Board and those meeting with elected members on the STP as it develops, media development and any public concerns.

There is also a need to engage more of our own workforce in the planning process. We will do this via:

- the weekly STP newsletter that we have set up for those working within the organisations of the STP
- providing people working within our organisations with regular updates on progress through internal newsletters and bulletins, weekly / monthly updates from Chief Executives
- hosting sessions with a wider set of clinicians and social care practitioners to get their input into the priorities and delivery areas. This will include working with our GP Federations to engage primary care providers to ensure our workforce is a driver and owner of change
- running events within our membership organisations to showcase the range of work which is happening across NCL and to ensure staff understand the current plans, and how they may affect them as we progress into implementation.

We will continue to build our communications and engagement capabilities across the system. We are planning to host a workshop with communications leads from across sectors to co-design the future engagement strategy, having now identified the key audiences that we need to engage with across the 5 boroughs. The strategy will include the design of a programme of deliberative-style events which will bring together different groups to more

directly shape our plans. We will establish a designated communications and engagement workstream to oversee delivery of the strategy, with a Senior Responsible Officer for engagement.

10.2 Public consultation

A formal public consultation is not needed for every service change. However, it is likely to be needed should substantial changes to the configuration of health services in a local area be proposed as our plans develop and we are committed to ensuring we consult widely and effectively.

We are already beginning to develop a comprehensive picture of local views and concerns through our early engagement, building an extensive stakeholder and community database and contacts which will enable us to develop a detailed plan of those affected by any proposed changes.

We also have an existing relationship with both general and specialist media outlets (including digital). We are already working on STP stories with these stakeholders and will continue to do so whether formal consultation is required or not.

10.3 Equalities analysis and impact assessment

Under the Equality Act 2010, we are required to analyse the effect and impact of the NCL STP in relation to equality. We are committed to carrying out an equality impact assessment to ensure our plan does not discriminate against disadvantaged or vulnerable people, or other protected groups.

Our equality analysis will consider the effect on different groups protected from discrimination by the Equality Act to ensure any changes are fully effective for all target groups and mitigate against any unintended consequences for some groups. We are committed to undertaking an Equalities Impact Assessment as our plans become more fully developed.

We already have a good overview and analysis of equality information from across the NCL footprint through our existing and ongoing partnership work with the 5 local authorities, CCGs, providers and other representative organisations. We are building on local regular equality audits of residents, patients and staff to ensure good engagement with protected groups and others, so that we can better understand the actual or potential effect of changes to functions, policies or decisions through the STP. This will help us to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Throughout our engagement to date, and building on the insight above, we have taken advice on best practice to ensure that all our public facing work is as fully accessible as possible, including sharing information in a variety of formats to ensure our we are able to engage all our residents, using interpreters or Easy Read material where required. We will continue to hold events and meetings in accessible locations (accessible for people with disabilities and easily reached on public transport, with adaptations made for attendees'

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communication needs). Our aim is to enable different groups to be fully involved as the STP progresses.

11 Conclusion and next steps

The STP is work in progress and we recognise that we have much more work to do to deliver the vision we have set out.

The immediate next steps between now and Christmas are to:

- to take steps to stabilise our financial position, developing more detailed ideas in the areas we have not yet fully explored
- agree the priorities for implementation in the first 2 years of the STP to ensure that we focus initially on the improvements which will make the most impact on our triple aims most quickly.

At the same time, we are clear that we will not lose focus on the longer term transformation that will support sustainability.

There remain many issues to resolve and we know we do not have all the answers. But we are determined to succeed and will continue to work with people who use services, the public and our staff to find solutions in the months and years ahead.

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

Board of Directors: November 2016

Item : 9

Title : Refresh of Mission and Values Statement

Summary:

The paper covers a revised draft of the Trust's Mission and Value statement on which the views of the Board of Directors are sought prior to consultation with the Council of Governors, staff and other stakeholders.

For : Consultation

From : Chief Executive

Page 1 of 4

Refreshing our statement of Mission and Values

1. Introduction

1.1 At its meeting in October 2015 the Board of Directors signed off an updated statement of Mission and Values for the Trust.

1.2 During the course of subsequent discussions with the Council of Governors, a number of Governors, and in particular Governors who had subsequently joined the Council, raised concerns that this version did not sufficiently describe the unique identity of the Trust.

1.3 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

1.4 A revised draft is attached which includes an introductory section which attempts to address concerns while broadly keeping the essence of the objectives and values agreed as part of the earlier statement.

1.5 The Board of Directors are asked to offer their views on the new proposed statement.

1.6 We propose also to take the draft statement to the next Council of Governors meeting on 1st December and to undertake a brief consultation with staff and other stakeholders.

2 Recommendation

2.1 The Board of Directors are invited to:

- Consider and offer comments on the revised draft of mission and values set out at **Annex A.**

Paul Jenkins
Chief Executive
November 2016

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

Tavistock and Portman NHS Foundation Trust

Statement of Mission and Values

Mission

For almost a100 years, the Tavistock and Portman clinics have embodied a distinctive way of thinking about and understanding mental distress, mental health and mental wellbeing. Our approach is grounded in psychoanalytic, psychodynamic and systemic theory and practice which seeks to understand the unconscious as well as conscious aspects of a person's mental distress and places the person, their relationships and social context at the centre of our practice.

Our creative and skilled staff continue to develop these ideas, applying them to contemporary challenges with new interventions, services and models of care.

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

Aims

In doing so 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.

- Be a national centre of thought leadership and research.

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

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 improvement science.

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

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

- We are outward facing, making a significant contribution to the development of public policy working with others who share our values and can enable us to achieve our mission.

Item : 11

Title : **Service Line Report - Gloucester House Annual Report**

Purpose :

The purpose of this report is to monitor quality, safety and progress of Gloucester House during the academic year 2015-16.

The following report has been reviewed by the chair of CYAF and the Management Team

This report focuses on the following areas:
- Quality and Effectiveness
- Patient / User Experience and Responsiveness
- Patient / User Safety
- Risk
- Finance
- The future

For : Discussion

From : Gloucester House Head Teacher

Gloucester House

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Contents:

Gloucester House, The Tavistock Children's Day Unit:

1. Introduction

Gloucester House is a specialist school for children with social, emotional and mental health difficulties. We are a multidisciplinary service across mental health and education. We work with up to 21 children and their families at any one time. We work with children of primary and early secondary age. See www.gloucesterhouse.net for more information.

2015-2016 has been the second phase implementation period of the revised service model. The key areas of work during the academic year have been opening a third class, developing and staffing the outreach service and working with Century Films to support the documentary following three children at Gloucester House.

In this paper we provide an update in relation to progress over the year. We also outline the current position and provide an overview of other significant developments, risks and achievements at Gloucester House.

2. Occupancy

2.1 Last year continued the trend of steady occupancy rates and more demand for the service than we were able to accommodate. Table **2.2** gives the figures for the last four years.

2.2 Occupancy 2012- present:

	2012/2013			2013/2014			2014-2015			2015/2016		
	Autumn	Spring	Summer	Autumn	Spring	Summer	Autumn	Spring	Summer	Autumn	Spring	Summer
Occupancy	7.5	7.5	8	7	8	9	10	15	15	18	15	19
Referrals	4	2	1	0	2	2	5	5	2			
Admissions	1	2	1	0	2	1	2	3/4	1	4	0	4
Discharges	3	0	1	2	0	1	1	0	1	3	0	3

2.3 The children came from the following local authorities: Barnet, Haringey, Enfield, Lewisham, Harrow, Hackney, Ealing, Hounslow, and Merton. Barnet are maintaining their SLA for 6 children.

2.4 Current occupancy by borough and Key Stage – Autumn 2016

3.

Borough	Key stage 1	Key stage 2	Key Stage 3	Total
Barnet	0	2	4	6
Haringey	0	0	1	1
Waltham Forest	1	0	0	1
Enfield	0	1	1	2
Hackney	0	1	1	2
Harrow	0	1	0	1
Ealing	0	2	0	2
Merton	0	1	0	1
Hounslow	0	0	2	2
Total number of pupils	**1**	**8**	**9**	**18**

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Demand and capacity:

3.1 In 2014-15 we had 27 enquiries/referrals and 11 referrals we processed through to assessment. In 2015-16 we had 12 enquiries with NFA and 30 sets of referral papers. Out of those referrals we responded to some by phone; some families and professionals visited and some we offered Outreach either because no places available or because we thought Outreach was a more appropriate offer. Out of the 6 referrals we offered Outreach to, only 2 became Outreach cases. The other Outreach cases we worked with were referred directly as Outreach.

We were not able to accept all referrals last academic year due to:
(a) Gloucester House needed to pace the work to maintain quality and safety.
(b) Referrals not appropriate due to age or identified need.

We increased capacity to 21 last year and maintained our numbers to average breakeven over the year. We currently have 19 in the service (breakeven 17). Between 3-4 are likely to move on in January 2017. We are currently processing 4 cases to maintain numbers at 19 as long as quality and safety can also be maintained.

Last year was the first year in many that Gloucester House had 18 children (at least 15 years) and we feel it is important to monitor quality and safety, including impact on the staff, before taking numbers up to capacity.

3.2 – The Outreach Service:

We have carried out 6 pieces of Outreach work during the last academic year and are working with 4 this term.

We have been developing the service model and marketing literature, staffing the team and reviewing and evaluating interventions over the year. The development of a robust business model is also in process.

3.3 - **Financial position:**

In April 2015 we covered costs and contributed an additional surplus. Breakeven was 14 in 2014-15. Due to increase in capacity this was revised to 17 for the financial year 2015-16. An additional contribution was factored into our breakeven figure.

This financial year to date we are maintaining a breakeven average in terms of numbers of children.

It is possible that we may contribute a surplus during 2015-16 but developing the Outreach service and maintaining quality, safety and stability and looking after our staff team and community is the more important focus at this time.

4. Staffing

4.1 - The staffing model was revised in the context of rising pupil numbers and evaluating our capacity gaps. It is not yet clear whether the current staffing model is adequate, as staff continue to raise issues around capacity. This will be looked at in a forthcoming review of the model. The staffing model for 15-16 is based on a breakeven of 17 (including an increased contribution to the Trust built in).

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4.2 - Staffing model 2015-16:

Expenditure	Pay Band	Model 1	Model 2
		1st revised (breakeven 16/17; capacity 21)	2nd (breakeven 16/17; capacity 21)
Central Staff			
Head Teacher	Teachers	0.9	0.9
Deputy Head	Teachers	1	1
Psychotherapist	Band 8a	0.55	0.55
Lead Nurse (Clinical Lead)	Band 8a	0.9	0.9
Psychiatrist	Consultant	0.2	0.2
Clinical Nurse Specialist	Band 7	0.6	0.9
Family therapist	Band 8a	0.2	0.2
Clinician (TBA)	Band 7	0.6	0
Total Central Staff		4.95	4.95
Class staff			
Teachers	Teachers	3.0	3.0
Progress Support Workers (formerly TAs) and Therapeutic Support Workers (term time only)	Band 4	4.8 (4 staff)	4.8 (6 staff)
Total Class staff		7.8	7.8
Admin Staff			
Admin Support	Band 5	0.9	0.9
Admin Support	Band 3	0.6	0.6
Total Admin Staff		1.50	1.50
Total Staffing wte.		14.25	14.25

Gloucester House

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5 **Safety and IRFs:**

5.1 The tables below indicate numbers of children and numbers of reported incidents since the new model began in April 2014. It can be seen that the numbers of incidents fluctuate and though at points numbers seem to rise considerably it is usually consistent with the increase in numbers of children. At points of significant change numbers of incidents increase but the pattern illustrates that as the institution resettles so do numbers of incidents.

Analysing the data in a bit more detail with Lisa Tucker we noted that numbers of children absconding the building has significantly increased since January 2016. Incidents of verbal or physical abuse also rose in Q4 2015-16 but were still less per child than the last two quarters in 2014-15.

5.2.1

	Q1 **2014-15**	**Q2** **2014-15**	**Q3** **2014-15**	**Q4** **2014-15**
Date:	**April- June**	**July- Sept**	**Oct- Dec**	**Jan-March**
Number of children on roll:	**9**	**10**	**10**	**15**
Incidents reported by the Gloucester House Day Unit:	57	34	78	114
Average per child:	6	3	8	8

5.2.2

	Q1 **2015-16**	**Q2** **2015-16**	**Q3** **2015-16**	**Q4** **2015-16**
Date:	**April- June**	**July- Sept**	**Oct- Dec**	**Jan- March**
Number of children on roll:	**15**	**16**	**18**	**15**
Incidents reported by the Gloucester House Day Unit:	45	41	80	99
Average per child:	3	3	4	7

5.2.3

	Q1 **2016-17**	**Q2** **2016-17**	**Q3** **2016-17**	**Q4** **2016-17**
Date	**April- June**	**July- Sept**	**Oct- Dec**	**Jan- March**
Number of children on roll	**15**	**19**	**19**	
Incidents reported by the Gloucester House Day Unit	75	68		
Average per child:	5	4		

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5.3 Ongoing institutional change, recruitment of new staff, other specific staffing issues and the presence of Century Films have had an impact on Gloucester House. In addition to this, wider institutional pressures such as CQC and ongoing efficiency savings had a trickle down impact.

The increased number of children since the new model has highlighted ongoing issues with the building. The pod and nurture space have been successfully moved and the new arrangement works well and has been positively received by parents/carers and children. However, in addition to the increased numbers of absconsions since January 2016, the Estates department reported increased wear and tear on the fabric of the building. The Estates teams at the Trust have been working with Gloucester House to try to mitigate the ongoing risks; however there continue to be some operational risks due to issues particular to this building.

6. Implementation period - revised service model

6.1 Implementation Aim

The primary aim was to implement a revised service model for Gloucester House School in accordance with proposals made in the March 2014 Staff Consultation Paper.

The new lower cost model was designed to preserve the key principles, aims, vision and quality of the original Gloucester House model. Whilst the ethos remained the same, the cost saving was achieved by adapting the management structure and the clinical structure.

6.2 Work of the implementation period:

The implementation phase of the new model began on 22.4.14 and was due to be completed by the end of the summer term 2014. The implementation phase was in fact much longer and took place between May 2014 and July 2015.

Due to increased demand a decision to further revise the model was taken to increase capacity to 21 and breakeven to 16/17. This was implemented in the 2015-16 academic year.

6.3 In order to implement the further revision of the service model the following activities took place:
- A new class was opened.
- The pod and nurture space were relocated.

6.4 Areas of Risk and/or Concern:

In the context of increasing capacity and increasing numbers of children and families we work with we identified and monitored areas of risk and concern within Gloucester House and at the Steering Group. I have outlined the risk identified followed by an evaluation:

- **Continued pressure on staff through a further period of change and expansion could lead to staff exhaustion/burnout:** We still have a motivated and committed team but the pressure on staff through the changes has been commented on widely.

- **Possible impact on children and families of further change:** The changes to the classes had a far greater impact on children and families than we anticipated and it took the children a long time to settle into their new classes.

- **Possible impact on quality and safety with increased numbers of children/families:** Numbers of incidents did rise during the period of change but had significantly fallen again by the end of the academic year. When comparing figures numbers per child have dropped. Issues with the building have been noticeable with increased numbers of children and families but the move of the pod and the nurture space has been very successful.

Gloucester House

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- **Further recruitment of permanent staff to Gloucester House and the new Outreach Service which may not remain viable if referral/ interest in our service wane:** Interest in the service is steady and ongoing. We have a mixture of bank and permanent staff which also mitigates risk.

6.5 Proposed Action Plan to address issues arising:

- To maintain numbers at 19 for this term. Between 3 and 4 children will be leaving in December. We are processing 4 referrals to fill those places but will pace this carefully to maintain as much stability as possible within the community.

- We will monitor staff morale through meetings/supervision etc.

- We will continue to monitor children and family engagement before any further increase towards capacity.

- Continuing to use some bank staff for posts associated with the outreach service.

- Continue to monitor incidents proportionally and compare with other periods.

- To undertake a review of the service model at the end of 2016-17 academic year to ensure that the model is viable in terms of staffing, numbers of pupils and estates.

7. Outcomes 2015-16.

7.1 Outcome measures show that Gloucester House continues to support the educational and social and emotional development of children who attend. Due to changes in assessment systems at Gloucester House and nationally we do not have 'like for like' comparable data from the previous year for academic and behaviour attainment this year.

From low starting points (100% of children significantly underachieving in at least two areas and the vast majority of children significantly underachieving across the curriculum) the children made expected and above rates of progress**.** 100% achieved rates of progress in line with nationally expected rates in reading; 91% in writing and 83% in maths.

Some children achieve in reading, writing, communication and mathematics at rates of progress exceeding nationally expected rates. For example; out of 10 children for whom we have more than one reading assessment 100% have improved their reading age; 6 making very good progress (more progress than the amount of time with two significant improvements – one of 2 years 6 months in 9 months; one of 2 years in 9 months).

From our spelling age data; out of 10 children for whom we have more than one spelling assessment 100% have improved their spelling age. 5 making progress at a faster rate than time in the setting; significant improvements one 4 years in 10 months; 1 4 years in 1 year; 1 2 years 3 months in 6 months.

7.2 - Exit Data: We had 5 leavers during this academic year – one in October 2015; two in December 2015 and two in July 2016. All children underachieving on entry:

4 out of 5 children made excellent progress during their time here academically and socially. The fifth child was only here briefly and became a LAC child during his time here. He had very significant learning needs and we focused mainly on supporting his emotional, social development and developing confidence and competence in basic academic skills due to particularly difficult contextual issues.

The destinations were 2 mainstream, one mainstream special secondary, 1 day SEMH provision and one residential home/school.

From ESQ (Experience of Service Questionnaires) 100% of pupils and their parents/carers reported that they felt they were treated well, that their views were taken seriously , that people know how to help them and were working together to do so.

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8 - Staff Story – Interview with Shar Camilleri

I definitely came here by chance. I've worked with children for 20 years and had worked in so many PRUs, mainstream schools etc. This was the place I liked best and that's why I've always stayed. I've worked here for about 10 years sometimes on bank but permanent for over 2 years.

What do you particularly like? The amount of thought that goes in and the emphasis on education. In other settings they give up on the education. I also like the therapeutic setting and therapeutic way of working.

What's difficult? Feeling or actuality -it always feels like there's not enough time. It would be good to have more time to put into the job. It's so busy all the time and there are so many different things to think about. However you never get bored and it keeps you on your toes. You definitely feel you've done a full day's work when you finish!

What could we do better?
- More administrative support.
- A way to alleviate the bottle necks of the demands of paperwork.

Shar Camilleri
Progress Support Worker

9 Feedback from Stakeholders:

9.1 - Parents/carers feedback:

Parents/ carers have positive views of the provision. This is evidenced by questionnaires completed bi-annually.

The high attendance rate we have for parents/carers at individual meetings, group meetings, celebration days demonstrates their appreciation of our work and their involvement in the life of Gloucester House. 100% of parent/carers attended at least one of the parents' days during the year. 100% of parents/ families are engaged and attending parent/family work meetings.

Parents/carers were surveyed twice during this academic year. From the parents/carers who completed questionnaires

The majority of parents/carers scored the statements in the agree and strongly agree categories.

Particular highlights in Spring 2016 were:

- 100% felt they were well informed about their child's progress.
- 100% felt teaching was good at Gloucester House.
- 100% felt that staff encouraged their child to become mature and independent.

In Summer 2016 highlights were:

- 100% think that Gloucester House helps their child manage and reflect on their behavior.
- 100% feel comfortable to approach Gloucester House with questions, problems & complaints.
- 100% think that staff expect their child to work hard to achieve his/her daily targets.
- 100% felt their child was fairly treated.
- 100% felt there is a good range of activities that their child finds interesting and enjoyable.

In Spring and Summer 2016:
- 100% felt that staff encouraged their child to become mature and independent.
- 100% felt their child was treated fairly.

9

During the year we improved on the number of parents/carers reporting that they are informed of topics taught. (57% Spring to 86% in Summer moved from 'agree' to 'strongly agree' in this question).

We also improved on parents/carers feeling bullying was dealt with well from 58% in Spring answering 'agree' or neutral to 86% 'strongly agree' in Summer 2016.

9.2 - Interviews with children for trust board: Suggested questions sent to me by Gervase Campbell.

Interviews conducted by Nell Nicholson on 07.11.16. Two children within their first year here the third child more long-standing.

What is your story, how did you come to be at the Tavi? Because I have anger management problems. I punched a teacher in her arm twice .Then my mum took me out of the school because she didn't think it was the right place for me.
What have we done well? You've helped me a lot with my problems. You've helped me to be calmer. The talking, the strategies; you listening to me has helped me.
What isn't so good? I don't like the pod. **What could be better?** Put padding back on the door of the pod.

What is your story, how did you come to be at the Tavi? It's really bad. I never came to the classroom. I didn't go to my class. I went to a hub at my old school but I didn't manage there. I didn't follow instructions and the teacher kept chasing me and then I hurt this kid badly. I broke a keyboard. I pulled another boy's pants down because he was annoying me. I got in big trouble .I didn't get to say my goodbye to my school…. I hope for the future that I'll go to a mainstream school.
What have we done well? You've helped me. You've helped me to stay in class. You make sure I'm ok. Staff here listen to me and help me.
What isn't so good? I don't know. **Is there anything about Gloucester House you don't like?** I don't like curry. I don't like pretzels.

What is your story, how did you come to be at the Tavi? I came here for anger problems and some other reasons.
What have we done well? You've helped me to calm down. You've helped me to talk and you've helped me by listening. You've helped me by teaching me strategies. You've helped me with my education by giving me confidence in my learning.
What isn't so good? What could be better? You could pay more attention to 'secrecy'. Keep a better eye on children telling each other secrets.

10. Significant Achievements of 2015- 16

- Continued increasing numbers of referrals
- Maintained positive feedback from stakeholders
- Maintained motivation in staff team despite significant pressures and change
- Maintained good and better outcomes for children and families in the service
- Managing the impact of Century Films and being able to use this as a positive learning activity for the whole community though the collaborative filming project culminating in each child producing their own film.

11. The Future:

- Preparing for Ofsted.
- Developing the outreach service.
- Embedding the new model.

Nell Nicholson
November 2016

Board of Directors : November 2016

Item : 12

Title : Chief Executive's Report

Summary:

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

For : Discussion

From : Chief Executive

Chief Executive's Report

1. Kids on the Edge

1.1 The first of three documentary films about the work of the Trust was screened on Wednesday 16th November on Channel 4. This featured the work of our Gender Identity Service. Further films are scheduled for broadcast on 23rd November and 30th November featuring the work of Gloucester House and our community CAMHS service.

1.2 We have been very pleased with the quality of the films produced by Century Films and by the sensitivity with which they have handled the issues presented by the cases they have covered. There has been a significant level of follow up publicity about this first programme, and the series more widely.

1.3 I am immensely grateful to the service users, clinicians and family members who have featured in the programmes. They have shown great courage and honesty in doing so and as a result I am sure will make it easier for others affected by these issues to discuss them and seek help.

1.4 I would particularly wish to acknowledge the clinicians who have taken part in the programme. They come across, universally, as caring and thoughtful and epitomise the values of the organisation. I would also like to thank Laure Thomas, Emma Heath and other members of the Communications Team and senior clinical managers who have worked closely with Century Film throughout the project to ensure that it has been success and to make sure that the interests of service users and clinicians were fully respected at all stages.

2. New members of the Executive Team

2.1 It has been a pleasure to welcome this month Terry Noys our new Director of Finance and Deputy Chief Executive and Chris Caldwell our New Director of Nursing.

3. Alumni events

3.1 On 22nd November we are holding our first designated Alumni event with a talk on the subject of Broken Attachments. This will be followed by a range of subsequent alumni specific events and the marketing of more general Trust events to alumni. We are undertaking a range of work alongside this to improve the quality of our alumni database.

4.   FDAC

4.1   On 10th November a number of Trust representatives attended a roundtable on the future sustainability of FDAC organised by Isabelle Trowler, Chief Social Worker for Children at the Department for Education.

4.2   This was well attended from across Government.   We are continuing to develop proposals for a social investment funding model for the service for the longer term.

5.   i-Thrive Community of Practice event in Manchester

5.1   I attended a fourth community of practice event for the i-Thrive partnership in Manchester.   This included the launch of i-Thrive hub for the North which will, amongst other things, will support the implementation of the Thrive model across Greater Manchester.

Paul Jenkins
Chief Executive
21st November 2016

CEO's Report

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

Board of Directors: November 2016

Item : 13

Title : Waiting Time Analysis by Team

Purpose:

The purpose of this report is to provide analysis and narrative commentary for waiting times by team. This is presented on a month by month 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, 15 November 2016
- Management Team, 17 November 2016

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 Lee Chesham, Data Quality Manager

Waiting Times Analysis by Team

1. Introduction

1.1 As requested by the October Board of Directors the following paper provides a detailed analysis and narrative for waiting times by team and service on a month by month 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 October 2016.

1.2 The scope of the report covers the average waiting time of ALL those waiting within a month period for each team and service (London contracts). This differs from our waiting time contract target which is about internal breaches. Table 1 of the report provides details covering the main scope of this review. For information only Table 2 provides details of the internal breach numbers and percentages for the main services for Q1 (April – June) and Q2 (July – September). The report also does not include any information relating to waiting times from first appointment to treatment. Areas not covered in the scope of this review can be considered separately if required.

1.3 The following services and the relevant waiting time targets have been included:
   1.3.1 Adolescent (<18) = 8 weeks
   1.3.2 Camden CAMHS = 8 weeks
   1.3.3 Other CAMHS = 8 weeks
   1.3.4 Adolescent (=>18) = 11 weeks
   1.3.5 Adults = 11 weeks
   1.3.6 Portman Clinic = 11 weeks
   1.3.7 GIDS = 18 weeks
   1.3.8 City and Hackney = 18 weeks
   1.3.9 Westminster = 6 weeks

1.4 This report shows the average wait times by team and service offered in the Trust. The data is for patients under the London Contracts, NHS England contracts for GIDS and Portman and separately the City and Hackney contract.

1.5 Waiting time information is taken from the date the referral was received to the first appointment. Team and Service Leads have provided commentary on what action plans are in place to improve waiting times, and where these are well met, what actions have been taken to get to that place. They were not asked to detail actions taken systematically to address a waiting time problem and indeed actions may differ across teams and services. This is perhaps something that should be agreed across the organisation.

2. Summary

2.1 Table 1 shows the average weeks waited for services and teams across the organisation, on a month by month basis. The average waiting time is included along with the number of patients currently waiting for first appointment at the end of October.

2.2 Whilst currently meeting the target of 8 weeks adolescent services are seeing a waiting time increase in September and further in October. This currently stands at 8.6 and 8.7 in two teams.

2.3 Adult teams: The Lyndhurst team has seen a decrease in waiting times whereas the Hemel Team saw an increase in September with a significant drop from 17.1 to 10.7 weeks in October. City and Hackney teams have also seen an increase in waiting times.

2.4 Increases in waiting times leading to breaches are noted in specific Camden CAMHS teams, the GIDS service overall and Westminster FAS Pre-birth assessment team.

![The Tavistock and Portman NHS Foundation Trust logo]

Table 1: Waiting Times, 1 Apr – 31 Oct 2016. London Contracts

SERVICE/Team	Average WEEKS waited from referral received to first appointment									
	Apr	May	Jun	Jul	Aug	Sep	Oct	Avg	Target	*n* patients waiting in Oct-16
Adolescent	**6.3**	**5.9**	**5.4**	**5.0**	**5.2**	**7.2**	**8.2**	**6.3**	**8**	**34**
Numbers seen & waiting by quarter end*		63			46					
ADOLESCENT Camden Team	8.1	8.4	7.9	7.6	5.3	8.0	7.9	7.6	8	16
ADOLESCENT Central and East Team	8.0	6.1	1.0	2.0	4.7	8.2	8.7	6.3	8	7
ADOLESCENT North and West Team	6.5	4.3	4.3	4.2	5.8	8.2	8.6	5.9	8	10
ADOLESCENT Parents Cons Service	2.9		0.9					1.5	8	0
ADOLESCENT Trauma Unit	4.3							4.3	8	0
ADOLESCENT YPCS	3.3	4.3	3.4	1.6	4.0	1.3	2.9	3.1	8	1
Adults	**9.1**	**10.2**	**10.2**	**10.5**	**11.2**	**10.3**	**8.8**	**9.9**	**11**	**108**
Numbers seen & waiting by quarter end *		134			138					
ADULTS Belsize	9.3	12.5	13.1	10.0	11.9	9.6	9.3	10.4	11	35
ADULTS Couples Unit	8.1	8.8	10.7	8.1	8.1	9.1	7.7	8.3	11	17
ADULTS Fitzjohn	8.5	8.3	1.0				0.7	4.0	11	3
ADULTS Group Team		0.0	4.3	4.9				3.0	11	0
ADULTS Hemel Team	6.0	7.1	6.9	7.8	14.3	17.1	10.7	9.8	11	3
ADULTS Lyndhurst	10.8	11.4	11.9	15.1	12.2	12.4	11.0	11.9	11	35
ADULTS Trauma Unit	6.3	5.3	3.8	6.3	8.1	6.7	5.3	5.9	11	15
Camden CAMHS	**3.9**	**3.6**	**3.7**	**4.1**	**4.5**	**4.8**	**4.4**	**4.1**	**8**	**165**
Numbers seen & waiting by quarter end *		250			241					
Camden Adolescent Intensive SS	3.0	2.8	5.9	0.0	0.1	0.5	0.2	2.8	8	4
Camden CAMHS Intake							0.7	0.7	8	1
CAMHS LAC	5.2	1.2	2.4	4.5	4.8	7.9	10.4	5.2	8	3
Complex Assessment	1.7	6.1	6.5	14.9	19.3	7.6	10.3	9.0	8	4
Complex Needs Outreach	6.8	1.7	1.0	2.1		3.7	2.7	3.0	8	1
IEYS			1.3	5.7	10.1	14.4	18.9	10.1	8	1
NORTH Primary Care	4.0	2.6	1.1	0.6	4.7	2.6	2.3	2.6	8	1
NORTH Primary School Service	2.0	3.5	1.8	1.7		0.6	1.2	2.1	8	8
NORTH Secondary School	4.0	2.1	1.5	1.8	3.9	2.7	2.5	2.5	8	6
NORTH Service	4.7	4.6	3.6	3.9	3.5	3.9	3.7	4.0	8	55
Refugee Service	2.9	1.9	4.2	2.5	4.9	4.3	3.1	3.3	8	6
SOUTH Primary Care	5.7	6.6	4.9	1.1	1.9		0.8	3.5	8	8
SOUTH Primary School Service	3.2	2.5	2.1	1.2		2.0	1.8	2.4	8	3
SOUTH Secondary School	7.1	0.6	1.3	1.0		0.8	1.4	1.6	8	5
SOUTH Service	3.8	3.1	3.9	4.8	3.6	3.7	2.9	3.7	8	25
TOPS				2.7	7.1	2.9	1.5	2.9	8	3
WF Perinatal - Camden				2.1				2.1	8	0
WF Perinatal - Euston	2.3	4.5	4.8	4.6	3.3	4.6	9.0	4.5	8	3
WF Perinatal - Kentish Town East	1.2	2.6	2.5	2.3	2.2	2.0	2.0	2.1	8	3
WF Perinatal - Kentish Town West	4.0			3.3	7.7	12.0	8.7	6.9	8	2
WF Perinatal - Kilburn	1.7			3.6	8.0	12.3	16.7	7.3	8	1

WF Perinatal - Kings X & Holborn	3.4	7.9	5.2	2.1	2.3	5.4	9.6	4.5	8	1
WF Perinatal - YPS	2.0	2.5	3.0	4.9	3.7	5.3	13.9	3.9	8	2
Whole Family	7.9	5.2	9.2	10.2	9.3	7.8	9.6	8.3	8	19
YPS	2.1							2.1	8	0
City and Hackney	**11.4**	**12.5**	**13.0**	**13.1**	**14.2**	**15.0**	**18.6**	**14.0**	**18**	**204**
Numbers seen & waiting by quarter end *		323			347					
CHPC Community Project Team	4.3	5.2	3.7	2.7				3.9	18	0
CHPC Intake						0.0		0.0	18	0
CHPC Team A	7.7	8.7	9.0	8.4	9.5	10.4	12.9	9.6	18	175
CHPC Team B [data to be confirmed]									18	12
CHPC Team C [data to be confirmed]									18	9
CHPC Waiting Team	9.9	9.3						9.7	18	0
TCPS Care Planning Team	4.1	4.0	5.1	6.3	6.1	7.5	12.6	6.0	18	8
GIDS	**14.7**	**15.6**	**16.2**	**18.0**	**19.4**	**21.9**	**23.3**	**18.7**	**18**	**862**
Numbers waiting by quarter*		**645**			**999**					
GIDS Leeds	10.1	11.6	11.7	13.5	16.4	17.9	19.2	14.3	18	145
GIDS London	16.2	17.0	17.9	19.5	20.4	23.0	24.0	20.1	18	674
GIDS South West	14.1	14.2	15.2	17.9	19.3	21.6	25.2	18.6	18	43
Other CAMHS	**5.9**	**5.5**	**5.5**	**5.6**	**5.4**	**6.2**	**5.9**	**5.7**	**8**	**78**
Numbers seen & waiting by quarter end *		115			129					
Child Sexual Abuse Hub							1.0	1.0	8	1
Family Service	3.9	3.0	4.0	4.9	4.1	5.8	5.6	4.6	8	26
Fostering and Adoption	11.2	3.4	3.4	5.2	6.4	10.7	8.1	6.5	8	13
Lifespan	6.2	7.1	7.0	6.4	6.4	4.9	5.5	6.2	8	38
Portman	**5.9**	**4.8**	**4.1**	**4.1**	**4.4**	**5.8**	**6.3**	**5.0**	**11**	**15**
Numbers seen & waiting by quarter end *		40			30					
PORTMAN Glasser	8.8	5.5	4.6	4.5	3.3	4.8	7.6	5.4	11	4
PORTMAN Limentani	4.1	4.0	3.7	3.8	5.0	6.5	5.8	4.7	11	11
Westminster Service	**3.0**	**3.3**	**3.8**	**4.3**	**5.1**	**4.4**	**6.6**	**4.6**	**6**	**14**
Numbers seen & waiting by quarter end *		18			33					
FAS Contact Assessment						1.3	5.7	3.5	6	1
FAS Family Assessment	3.8	3.2	3.8	4.7	5.2	4.3	5.6	4.5	6	11
FAS Intervention				0.9	3.2	4.1	11.1	4.4	6	1
FAS Pre - Birth Assessment	1.1	4.3		2.9	7.3	11.6	14.3	6.1	6	1

*Data correct at 15 November 16 *waiting by quarter data taken from quarterly quality report*

Table 2:Waiting Time Internal Breaches Q1 and Q2 2016/17

Waiting Times Waiting time no more than 8/11/18 weeks (56/77/126 days) dependent on service from receipt of referral). **INTERNAL BREACHES PRESENTED ONLY**	Target%	Q1 n/% Trustwide = 75/740 (10.1%) n/% London Contracting = 73/562 (13.0%)	Q2 n/% Trustwide* = 62/740 (8.4%) n/% London Contracting** = 82/901 (9.1%)*	Q1	Q2
**Adolescent Service	< 8 weeks - 56 days (threshold 10%)	9/63 (14.3%)	***3/46 (6.5%)		
**Camden CAMHS		44/250 (17.6%)	14/241 (5.8%)		
**Other CAMHS		15/115 (13.0%)	26/129 (20.2%)		
**Adult Complex Needs Service	< 11 weeks - 77 days (threshold 5%)	5/134 (3.7%)	8/138 (5.8%)		
NHS England Portman		0/40 (0%)	0/30 (0%)		
NHS England GIDS	< 18 weeks - 126 days (threshold 10%)	427/645 (66.2%)	663/990 (67%)		
**City & Hackney		13/323 (4.0%)	31/347 (8.9%)		
Westminster Service	< 6 weeks - 42 days	2/18 (11.1%)	10/33 (30.3%)		

Data taken from the Q1 and Q2 Quarterly Quality Report and relates to London Contracts only

3. Detailed analysis and commentary

3.1 Adults Service
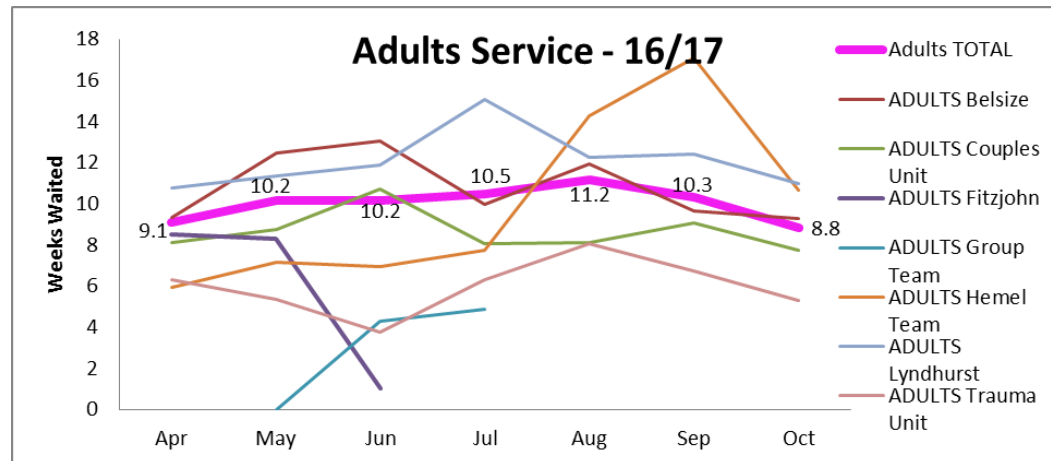
The Adult Complex Needs Report indicates that although under general pressure, the average target time of 11 weeks from referral to 1st assessment appointment is only exceeded in August. There is a general management problem of resources during the holiday period. This is a periodic issue to anticipate in future.

Resources are generally limited by the numbers of trainees available especially in the large generic units, Lyndhurst and Belsize. The Hemel service, an outlying primary care service, is restricted to one clinician, so the referral management particularly during the holiday period is problematic. A recent audit into the Hemel service will assist in the management of demand.

3.2 CYAF (Camden CAMHS – selected teams)
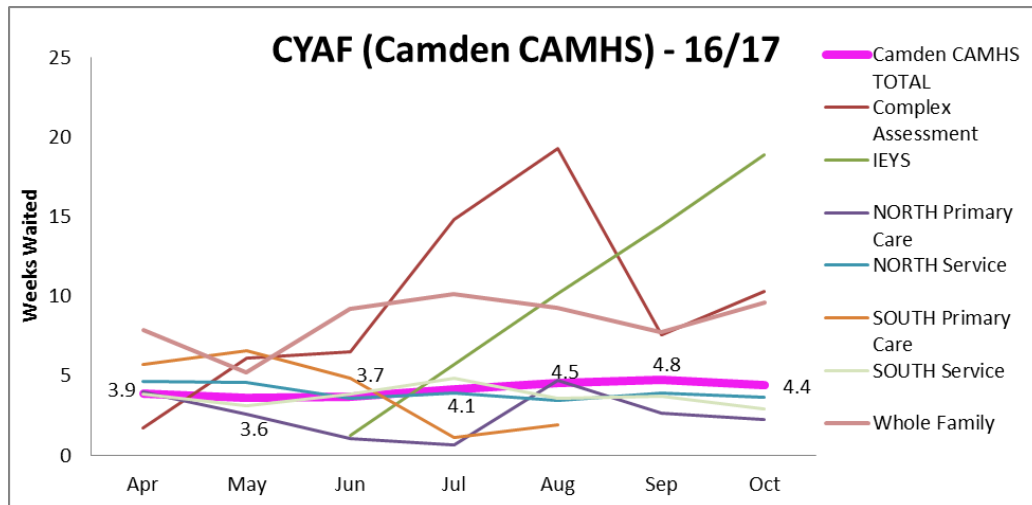
Performance on the whole is good. Sally Hodges, CYAF Director commented: *'In Camden we have negotiated a band 7 to back fill senior staff in the intake system, who will be telephone triaging cases and directing to services more swiftly to meet our target of getting advice and appropriate redirection. This is likely to have a significant impact on our waiting times. I know in IEYS the waits are getting longer but there are very clear reasons for this with staff maternity, sickness and leaving.'*

3.3 CYAF (Other CAMHS)
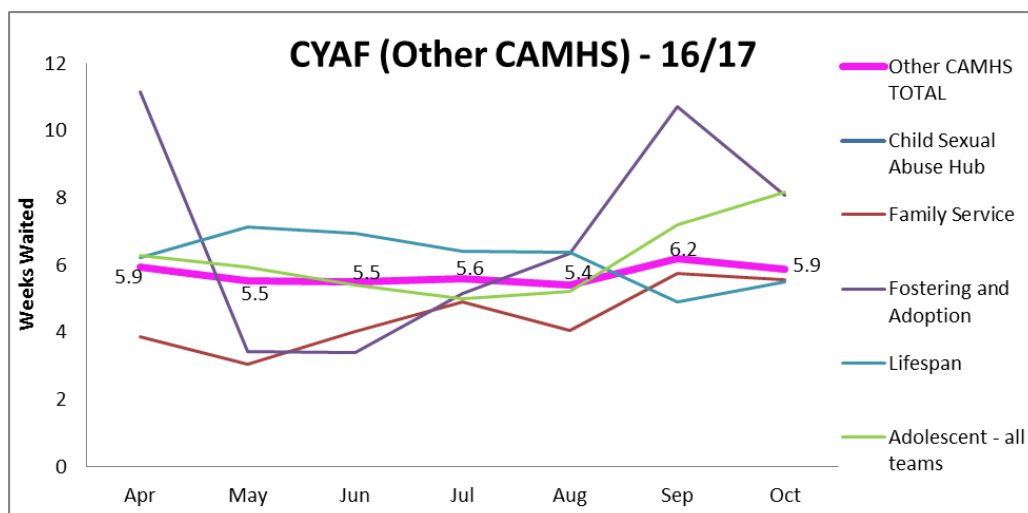
Please note that the combined Adolescent teams' average waiting times have been included in this graph. Historically for external reporting, the Adolescent teams have been reported separately.

3.4 City and Hackney Service

The City and Hackney data is artificially divided into teams. Data for CHPC Teams B and C are currently being reviewed and will be available for the Board meeting.

Tim Kent, Primary Care Service Lead confirmed that the service is highly valued by GPs and PCPCS is currently experiencing considerable pressure after the recent de-commissioning of five posts which formed our PCPCS One Hackney Psychological Therapies Outreach service called Care Planning.

- The service has high waiting times due to its popularity with referrers, mainly GPs and local psychiatric services that are desperate for treatment resources for complex patients in the community. The service has run at around 30% over capacity for years with a porous and flexible intake boundary for 'between the gaps' patients. Effectively the service is considerably under-resourced relative to capacity.

- In our Q1 CCG review we concluded with commissioners that their encouragement for the service to open up well beyond the original 'GP only' referral has led to approximately 35% of referrals effectively managing other services lack of capacity and design re complex multi-morbidity. So a radical overhaul is underway.

- Re the waiting list specifically we have one waiting list specific clinician in place in August and two more from the start of October. This had led to a small reduction in Q2 but a more significant anticipated drop in Q3. These clinicians are in role until end of March 2017 with no ongoing funding agreed.

Activity
1) The predicted trajectory of the 3 Band 7s seeing these patients is as follows:
   April – June: Recruitment.
   July – September: The service sees 36 patients from the 178 patients waiting by end of Q2.
   Oct – December: The service sees 72 patients from the 178 patients waiting by the end of Q3
   Jan – March: The service will have seen 108 patients from the 178 patients waiting by the end of Q4

   Therefore the service would look at a reduction of 12 patients per month.

2) As published in the PCPCS performance Q4 report, the service currently has a 14% DNA rate. Therefore a cautious guess at how

much this rate would reduce the number waiting from the 178, would be 10 patients out of the remaining 70.

3) Staffing Update
   We have employed one bank band 6 clinician from August 2016; 2 x band 7 clinical psychologists from October 17th 2016; 1 x band 7 social worker / psychotherapist from September 5th '16.

4) We anticipate that this investment will see a reduction in the 178 reported patients on the waiting list to 30 remaining.

5) Additionally the service have taken on two new honorary members of staff (both experienced professionals who are undertaking psychotherapy training) who will be dedicated to treatment cases.

6) The service has discussed gate-keeping measures with the commissioners in the Q3 and Q4 2015/16 CQRG meetings and as part of the proposal agreed in March we have agreed to prioritise referrals from GPs rather than secondary sources. This should go some way to address the on-going demand for the service which would see additional patients added to the 178 patients reported in March. We are also now enforcing a much stricter intake policy such that lower cluster patients are sent to IAPT or more appropriate treatment resources. This means that unmet need will increase elsewhere in the system.

Waiting List Update
Of the 178 reported waiting in March 2016:
- 115 patients have entered into treatment.
- 35% (*n*=33) who have recently entered into treatment since March 2016 are being seen by newly employed clinicians.
- 2 patients have moved out of area, therefore not eligible for treatment
- 10 patients have refused treatment, subsequently have been discharged
- 5 patients have dropped out of therapy, again discharged.

This leaves us with a remaining 68 patients from the 178 originally reported.

At present we have 204 patients awaiting therapy (inclusive of the 68), due to the consistent increasing number of referrals – a trend that has been seen year-on-year and high acceptance rate of the service. The waiting list is approximately ten months long but this is a decrease from Q3 and Q4 2015/16.

3.5 Gender Identity Development Service

GIDS - 16/17
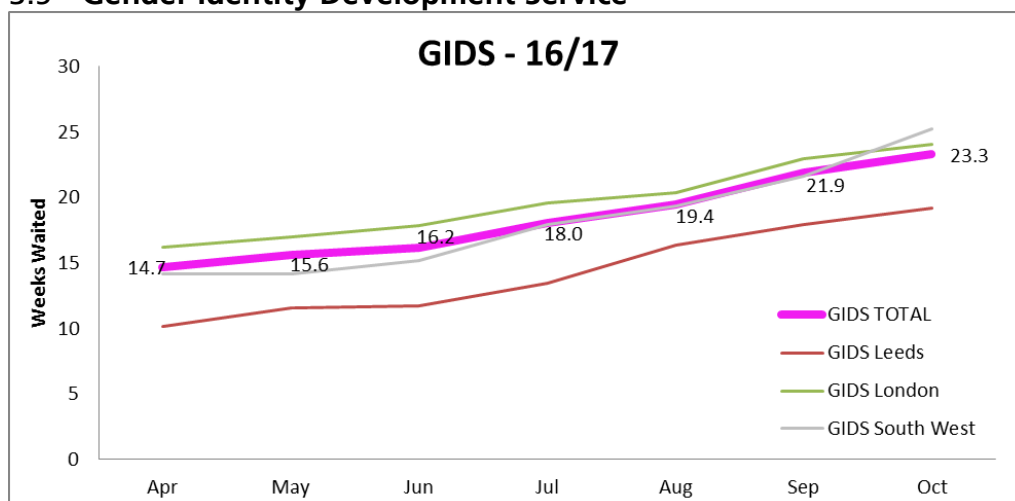
The plan is to bring the waiting time back in line with the 18 week referral to treatment requirement by the end of June 2017 but this is to be confirmed. Clinical and administrator recruitment is on track to enable the service to meet requirements. Details of GIDS waiting lists initiatives follow:

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 & benefits of group first appointment
- Offer timely appointments to over 17 year olds and facilitate appropriate, informed choices regarding transition to adult services.
- Provide information about GIDS and what is offered in Child and Adolescent Services.
- Collect standard questionnaire data to inform referrals to adult services.
- Signpost to information and support groups.
- Opportunity to connect with other young people.
- Space to think reflect, explore and discuss. Gender, NHS Pathways, Support, Physical interventions.
- Information about physical interventions.

- Provide information about adult services and framework for decisions about where to be referred. Promote client choice about pathways by providing information and empowering clients to research and make a personal judgment about where they want to be referred.

Follow-up
- Individual appointment to complete assessment
- June 2016: 16 group appointments offered. 11 attended. All offered 1:1 follow-up.
- August 2016: 16 group appointments offered. 11 attended. All offered 1:1 follow-up.
- November 2016: 16 group appointments offered.
- Feedback has overall been excellent. Paper presented at BAGIS inviting adult services to comment and feedback on content of report.

Audit and evaluation
% who don't wish to attend group/DNA
% who choose for direct referral to adult services following group meeting & 1:1
Feedback questionnaires to evaluate usefulness, satisfaction, content
% who require/choose ongoing input from GIDS

ii)   Assessment Clinics

The aim is to manage waiting list and offer assessment appointments in an equitable framework. Whilst this is the aim 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 a number of other reasons, see challenges section below, it is not immediately possible to predict the impact on the waiting list.

Format
- Staff resource: Current clinician and New starter where possible, to use as training opportunity for new starters
- Three to four appointments with 3 follow up appointments about monthly, as appropriate and agreed with family.
- Standardised elements in assessment report – including care plan agreed with client and family

Challenges
Developing a flexible framework in which individual needs can be met.
For example:-

- 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.

Pilot to access impact and sustainability

Audit to include:
- Impact on clinicians caseload
- Impact on waiting list
- Client and family feedback

iv)   New specifications identify

Input agreed on case by case basis with a recognition that 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

3.6   Portman Clinic

Portman - 16/17
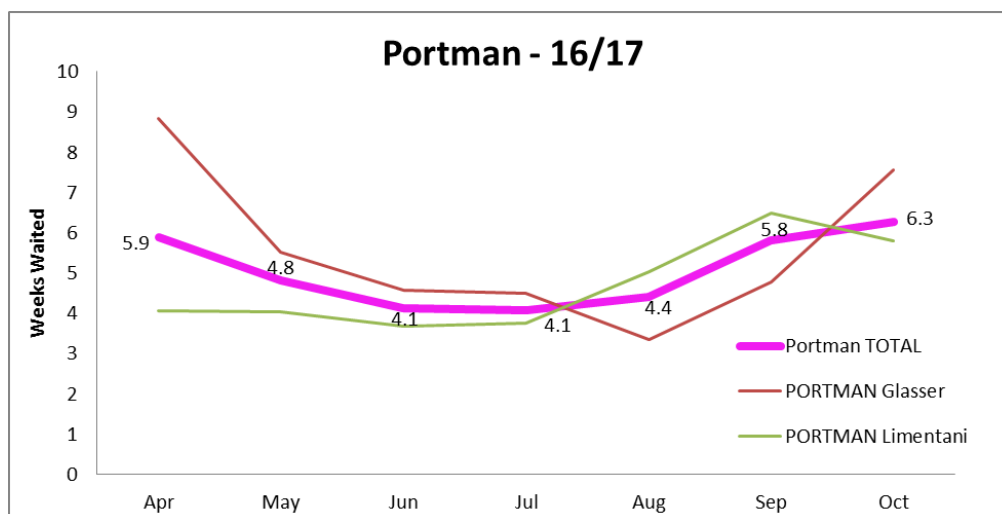
Jessica Yakeley, Portman Clinical Director, commented:

'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.'

3.7 Westminster Service
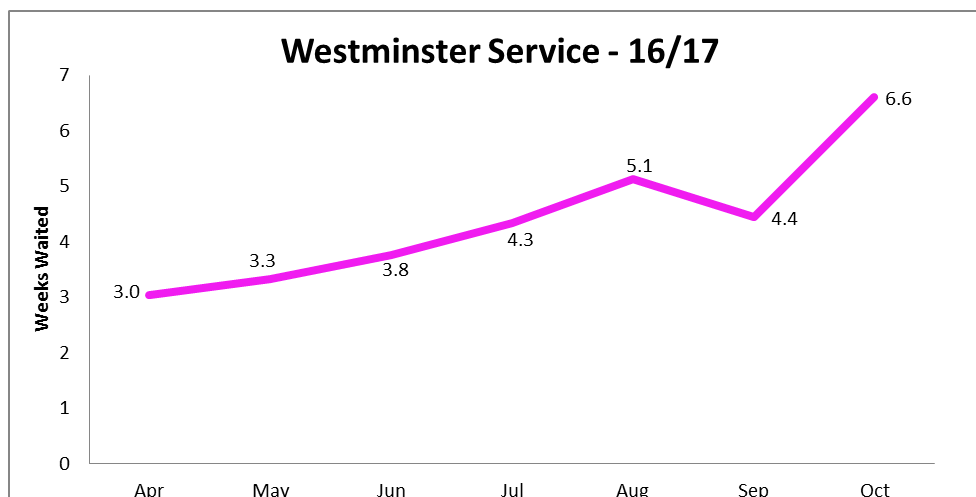
The Westminster service has a waiting list target of <6 weeks which has been steadily increasing. The Service Lead has confirmed the service is commissioned to complete 60 Assessments per year and received 33 referrals alone in quarter 2. Delays and engagement of clients in Q2 were predominately due to the holiday season. Work can only begin following a professional planning meeting with the referrer, followed by a service planning meeting which includes the parents.

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. This is clearly listed in our referral processes but 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 meant cases have had to wait for clinicians to become available to carry out the work.

Finally, 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.'

Lee Chesham　　　　　　　　　　**Marion Shipman**
Data Quality Manager　　　　　　　Associate Director Quality and Governance

Board of Directors : November 2016

Item : 14

Title : Finance and Performance Report

Summary:

After the seven months of the new year, a surplus of £1,193k is reported after restructuring costs, £425k above the revised planned surplus of £769k.

New posts, funded by our commissioners in order to meet higher service demand, are still being filled. Student numbers although higher than last year at 560 have not achieved planned levels of 682.

As a result of all these factors, income which is currently on plan will be below budget approximately £100k per month for the remainder of the year. This will be offset by reductions in expenditure.

The forecast for the full year is a surplus of £800k, in line with our revised control total.

The cash balance at 31 October was £6,652k, which is £2,249k above Plan mainly due to payment in advance from Health Education England for the national training contract.

For : Information.

From : Carl Doherty, Deputy Director of Finance

1. External Assessments: NHS Improvement

1.1 As noted previously, the Trusts Plan has a control total – i.e. required surplus – of £800k, which includes the allocation of £500k from the "targeted element" of the Sustainability and Transformation Fund.

1.2 The return for October was submitted on 15 November with a Use of Resources (UOF) metric of 1 (the highest rating).

2. Finance

2.1 Income and Expenditure 2016/17 (Appendices A and B)

2.1.1 The budget has been revised to reflect the changes outlined in 1.1 above. The additional £500k income, spread evenly across the year, is shown on line 2 in Appendix B; and is included in Clinical Income on Appendix A. The first quarterly instalment was received in August.

2.1.2 After October, the Trust is reporting a surplus of £1,193k after restructuring costs, £425k above the revised budget. Income is £234k below budget, and expenditure £716k below budget.

2.1.3 The cumulative income position to date of £234k adverse is mainly due to the following:

2.1.3.1 Consultancy Income is £185k below target due to TC Income below budget which has been offset by reduced expenditure.

2.1.3.2 Clinical Income is £57k above budget overall. Adult and Forensic Services income is £100k under budget due to a shortfall on NPA income and credit notes relating to last year; which is offset by a GIDU over-performance payment from 2015/16 and Day Unit high pupil numbers.

2.1.3.3 Training is currently £116k below plan but this trend will deteriorate after the start of the new academic year with student numbers below the anticipated level but still higher than last year.

2.1.4 The favourable position of £716k on the expenditure budget was due mainly to the under spends of £443k in GIDU, £206k in Primary Care and £105k in Tavistock Consulting due to vacancies and lower than expected non pay costs.

2.1.5 There are currently 635 Whole Time Equivalent (WTE) funded posts in October, of which 561 were occupied including 32 WTE bank and 18 agency staff.

2.1.6 Agency staff expenditure was £483k after 7 months, which is 14% over the cap set by NHS Improvement. This is one of the metrics in the new Use Of Resources (UOR) rating from October: it is essential that we do not exceed the cap by more than 50%; and better not to exceed it by more than 25% at year end.

2.1.7 The contingency reserve is a shortfall of £55k; however, three cost centres with significant underspends in the first quarter are expected still to have at least part of this underspend by the end of the year.

<mark>2.2 Forecast Outturn</mark>

2.2.1 The forecast is a surplus of £800k after restructuring, as shown in Appendices A and B. This reflects the outturn after remedial action has been taken by management to close a shortfall of £80k with actions currently being planned including discussions with the external auditors regarding capitalising renovation works.

2.2.2 Clinical income is currently predicted to be £47k above budget due to GIDS Named Patient Agreements (NPA's) and the Day Unit over-performing against targets.

2.2.3 Training income is expected to be £459k below plan due to a shortfall on student fee and HEFCE income. This will be offset by a reduction in Training expenditure of £212k due to a lower requirement for visiting lecturers and Portfolio staff.

2.2.4 TC Consultancy income is expected to be £200k below target but expenditure is forecast to be £190k below budget

2.2.5 Clinical expenditure is expected to be £1,046k below budget:

2.2.5.1 GIDS is expecting to increase their £443k under spend to £681k. The GIDS refurbishment has become a capital project offset by writing off the previous asset. There were 16 vacancies in October which resulted in a pay budget under spend in month of £107k, recruitment is ongoing.

2.2.5.2 Primary Care is £206k under spent after month 7 due to vacancies in Camden TAP and City & Hackney Project. There are plans to recruit temporary staff to reduce the size of the waiting list within City & Hackney and the under spend is expected to reduce to £190k at year end.

2.2.6 Training expenditure is expected to be £212k under budget at year end:

2.2.6.1 Portfolios are currently forecasting an under spend of £295k which reflects student recruitment numbers.

2.2.6.2 Junior Medical staff is expected to remain at £94k below budget.

2.2.7 The Central functions are currently forecasting an over spend of £651k which is primarily due and unbudgeted Relocation revenue costs.

2.2.8 Known restructuring costs are currently £113k and were not included in the Plan.

2.3 <mark>Cash Flow</mark>

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Finance & Performance

2.3.1 The actual cash balance at 31ˢᵗ October was £6,653k this is an increase of £2,596k on last month and is £2,249k above Plan. The increased balance was due to receiving the National Training contract quarterly in advance in addition to third quarterly payment from PHE for the FNP contract. The surplus against Plan is due to the advance payments mentioned offset by NHS Debt which is £440k below plan mainly due to City & Hackney CCG for £301k. Capital expenditure is £901k below Plan which has been offset by not utilising the agreed loan.

	Actual £000	Plan £000	Variance £000
Opening cash balance	3,356	3,356	0
Operational income received			
NHS (excl HEE)	8,506	8,946	(440)
NHS England (GIDS)	3,822	3,696	126
PHE (FNP)	2,869	2,398	471
General debtors (incl LAs)	6,471	6,510	(39)
HEE for Training	8,465	6,484	1,981
Students and sponsors	1,520	1,725	(205)
Other	210	0	210
	31,863	29,759	2,104
Operational expenditure payments			
Salaries (net)	(10,293)	(10,654)	361
Tax, NI and Pension	(8,217)	(8,715)	498
Restructuring	(203)	(363)	160
Suppliers	(8,904)	(7,761)	(1,143)
	(27,617)	(27,493)	(124)
Capital Expenditure	(620)	(1,521)	901
Loan drawdown	0	540	(540)
Interest Income	6	3	3
Payments from provisions	0	0	0
PDC Dividend Payments	(335)	(240)	(95)
Closing cash balance	6,653	4,404	2,249

2.4 Better Payment Practice Code

2.4.1 The Trust has a target of 95% of invoices to be paid within the terms. During October we achieved 89% (by number) and 94% by value for all invoices. The cumulative total for the year was 91% by number and 94% by value. In line with previous Board discussions, this is considered satisfactory; Finance will continue to work with colleagues to avoid delays as far as possible, but no additional action is planned.

2.5 Capital Expenditure

2.5.1 The capital budget for the year is £2,480k in total which includes £1,100k for the Relocation Project up to Full Business Case.

2.5.2 Up to 31ˢᵗ October, expenditure on capital projects was £645k which is £873k below Plan. The expenditure to date consists £426k on IM&T and £220k on Estates maintenance. The Relocation project has been charged to revenue.

2.5.3 Expenditure for the year is forecast to be £1,590k mainly due to reduced capital spending on Relocation offset by increased Estates work.

2.5.4 The Relocation project cumulative capital costs up to 31 March 2016 were £575k but this was reduced to £112k on the advice of our external auditors with the balance being charged to revenue.

Capital Projects 2016/17	Budget 2016/17	Actual YTD October 2016	Forecast 2016/17	Spend 2014/15	Spend 2015/16	Total Project	
						Spend to date	Budget to date
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Estates General	190	37	93			37	190
Relocation Project up to OBC	-	-	-		50	50	50
Relocation Project up to FBC	1,100	-	-		62	62	1,162
GID Building works		176	300			176	
DET Works		7	7			7	-
Total Estates	1,290	220	400	-	112	332	1,402
IM&T Infrastructure	300	251	300			251	300
IM&T Project Posts	125	-	65			-	125
IM&T Developments	390	-	390			-	390
IDCR	50	41	50	389	268	698	707
Student Info. Mgmt System	325	75	325			75	325
DET Intranet		58	60		16	74	31
Total IT	1,190	426	1,190	389	284	1,099	1,878
Total Capital Programme	2,480	646	1,590	389	396	1,431	3,280

3. Consultancy

3.1 Tavistock Consulting are a net £72k below budget after seven months. This consists of expenditure £105k under spent, offset by consultancy income £177k below budget. TC has forecast income to be £200k below budget and expenditure to be £190k below budget at year end

3.2 Departmental consultancy is £9k below budget after October.

4. Training

4.1 Training income is £116k below budget after October, student recruitment numbers are forecast at 560 against a target of 682 which reflects a shortfall of 18%. Recruitment has seen growth against last academic year (AY15-16) of 16%. This is a significant achievement when other HEI's are maintaining their student numbers. The long course fee income for the academic year 2016/17 is forecast at £4m against budget of £4.9m and therefore expected to fall short by £525k for this financial year with the shortfall mainly on LCPPD income due to a deferral and CP Trainees due to lower numbers than expected.

4.2 Education and training expenditure was £86k below budget spread across the service mainly due to vacancies. Portfolio pay is forecast to be underspend by £295k. This investment was budgeted for a growth of student numbers to 682.

Investment in new posts has not occurred due to target student numbers not being met. Growth has been managed with visiting lecturers and this is now forecast to present a deficit of £102k.

Carl Doherty
Deputy Director of Finance
16th November 2016

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST

INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2016-17

		Oct-16			CUMULATIVE			FULL YEAR 2016-17		
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	OPENING BUDGET £000	FORECAST OUTTURN £000
INCOME										
1	CLINICAL	1,981	1,986	5	15,333	15,390	57	25,547	20,500	25,594
2	TRAINING	1,745	1,635	(110)	12,053	11,938	(116)	20,776	20,740	20,318
3	CONSULTANCY	90	14	(76)	628	442	(185)	1,076	1,104	880
4	RESEARCH	64	62	(1)	107	106	(1)	179	53	179
5	OTHER	30	39	9	459	470	11	624	571	636
TOTAL INCOME		**3,909**	**3,736**	**(173)**	**28,580**	**28,346**	**(234)**	**48,203**	**42,967**	**47,607**
OPERATING EXPENDITURE (EXCL. DEPRECIATION)										
6	CLINICAL DIRECTORATES	1,789	1,526	263	13,227	12,511	716	22,579	18,454	21,617
7	OTHER TRAINING COSTS	1,195	1,227	(31)	8,356	8,162	194	14,315	14,263	14,082
8	OTHER CONSULTANCY COSTS	57	50	7	403	298	105	687	687	497
9	CENTRAL FUNCTIONS	739	807	(68)	5,051	5,327	(276)	8,511	8,233	9,145
10	TOTAL RESERVES	3	(0)	3	(24)	0	(24)	(41)	(291)	0
TOTAL EXPENDITURE		**3,783**	**3,609**	**175**	**27,013**	**26,298**	**716**	**46,050**	**41,345**	**45,342**
EBITDA		**126**	**128**	**2**	**1,567**	**2,049**	**482**	**2,153**	**1,622**	**2,265**
	ADD:-									
11	BANK INTEREST RECEIVED	1	0	0	5	7	(2)	8	8	8
	LESS:-									
12	DEPRECIATION & AMORTISATION	63	67	(4)	464	411	53	781	850	781
13	FINANCE COSTS	0	0	0	0	0	0	0	0	0
14	DIVIDEND	48	47	1	338	338	0	580	480	579
SURPLUS BEFORE RESTRUCTURING COSTS		**15**	**14**	**(1)**	**769**	**1,306**	**537**	**800**	**300**	**913**
15	RESTRUCTURING COSTS	0	0	0	0	113	(113)	0	0	113
SURPLUS/(DEFICIT) AFTER RESTRUCTURING		**15**	**14**	**(1)**	**769**	**1,193**	**425**	**800**	**300**	**800**
EBITDA AS % OF INCOME		3.2%	3.4%		5.5%	7.2%		4.5%	3.8%	4.8%

Finance & Performance

	All figures £000	Oct-16			CUMULATIVE			OPENING BUDGET	REVISED BUDGET	FORECAST	VARIANCE FROM REV BUDGET
		BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE				
	INCOME										
1	CENTRAL CLINICAL INCOME	623	613	(10)	4,421	4,400	(21)	7,397	7,536	7,520	(16)
2	SUSTAINABILITY AND TRANSFORMATION FUND	42	42	0	292	292	0	0	500	500	0
3	CYAF CLINICAL INCOME	431	458	27	3,220	3,338	118	5,490	5,544	5,593	49
4	AFS CLINICAL INCOME	471	450	(21)	4,497	4,397	(100)	4,127	6,989	6,930	(60)
5	GENDER IDENTITY	415	424	9	2,904	2,964	60	3,487	4,978	5,052	74
6	HEALTH EDUCATION ENGLAND TRAINING CONTRACT	605	605	0	4,232	4,232	0	7,254	7,254	7,254	0
7	CHILD PSYCHOTHERAPY TRAINEES	199	188	(11)	1,258	1,214	(44)	2,391	2,255	2,255	(0)
8	JUNIOR MEDICAL STAFF	70	78	8	489	525	36	838	838	874	36
9	POSTGRADUATE MED & DENT'L EDUC	7	13	6	51	50	(1)	88	88	88	(0)
10	PORTFOLIO FEE INCOME	546	486	(59)	3,163	3,091	(72)	6,072	5,892	5,368	(524)
11	DET TRAINING FEES & ACADEMIC INCOME	61	(4)	(65)	1,060	1,023	(38)	823	1,364	1,363	(1)
12	FAMILY NURSE PARTNERSHIP	257	269	12	1,800	1,803	3	3,274	3,086	3,116	29
13	TC INCOME	72	(0)	(72)	503	327	(177)	863	863	663	(200)
14	CONSULTANCY INCOME CYAF	2	0	(2)	12	14	3	48	20	25	5
15	CONSULTANCY INCOME AFS	16	14	(2)	113	101	(11)	193	193	192	(1)
16	R&D	64	62	(1)	107	106	(1)	53	179	179	0
17	OTHER INCOME	30	39	9	459	470	11	571	624	636	12
	TOTAL INCOME	**3,909**	**3,736**	**(173)**	**28,580**	**28,346**	**(234)**	**42,967**	**48,203**	**47,607**	**(596)**
	EXPENDITURE										
18	COMPLEX NEEDS	135	137	(2)	944	947	(3)	1,618	1,618	1,621	(3)
19	PRIMARY CARE	280	256	24	3,082	2,875	206	1,885	4,661	4,459	203
20	PORTMAN CLINIC	112	125	(12)	816	830	(14)	1,380	1,378	1,416	(38)
21	GENDER IDENTITY	383	111	272	2,057	1,614	443	2,795	4,027	3,346	681
22	NON CAMDEN CAMHS	378	435	(57)	3,018	3,106	(88)	5,273	5,197	5,282	(85)
23	CAMDEN CAMHS	436	415	21	2,886	2,742	144	4,803	4,967	4,810	157
24	CHILD & FAMILY GENERAL	66	47	19	426	398	28	699	730	682	48
25	FAMILY NURSE PARTNERSHIP	226	220	6	1,579	1,563	16	2,893	2,706	2,706	0
26	PSYCHOLOGICAL THERAPIES DEVT UNIT	40	27	13	348	305	43	124	356	360	(4)
27	JUNIOR MEDICAL STAFF	83	58	25	579	485	94	993	993	899	94
28	NHS LONDON FUNDED CP TRAINEES	197	209	(11)	1,246	1,262	(17)	2,370	2,233	2,275	(41)
29	TAVISTOCK SESSIONAL CP TRAINEES	2	1	0	11	9	2	18	18	18	(0)
30	FLEXIBLE TRAINEE DOCTORS & PGMDE	20	22	(2)	141	164	(23)	242	242	250	(8)
31	EDUCATION & TRAINING	295	368	(73)	2,352	2,365	(13)	3,598	4,004	4,005	(1)
32	VISITING LECTURER FEES	102	148	(47)	707	736	(29)	1,229	1,215	1,317	(102)
33	PORTFOLIOS	230	173	58	1,394	1,272	121	2,796	2,546	2,251	295
34	TC	57	50	7	403	298	105	687	687	497	189
35	R&D	25	30	(6)	163	167	(4)	155	295	298	(3)
36	ESTATES DEPT	159	255	(96)	1,111	1,429	(318)	2,045	1,904	2,543	(639)
37	FINANCE, ICT & INFORMATICS	231	232	(1)	1,623	1,602	21	2,562	2,744	2,763	(19)
38	TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	140	124	16	966	967	(1)	1,458	1,604	1,605	(0)
39	COMMERCIAL DIRECTORATE	43	42	0	291	268	22	464	521	498	23
40	HUMAN RESOURCES	52	45	7	382	420	(38)	642	642	681	(39)
41	CLINICAL GOVERNANCE	81	69	12	448	405	43	789	682	640	43
42	CEA CONTRIBUTION	10	10	(0)	68	68	(0)	117	117	117	(0)
43	DEPRECIATION & AMORTISATION	63	67	(4)	464	411	53	850	781	781	1
44	PRODUCTIVITY SAVINGS	0	0	0	0	0	0	(441)	0	0	0
45	CENTRAL RESERVES	3	(0)	3	(24)	0	(24)	150	(41)	0	(41)
	TOTAL EXPENDITURE	**3,847**	**3,676**	**171**	**27,478**	**26,709**	**769**	**42,195**	**46,831**	**46,122**	**709**
	OPERATING SURPLUS/(DEFICIT)	**63**	**60**	**(2)**	**1,102**	**1,637**	**535**	**772**	**1,372**	**1,484**	**112**
46	INTEREST RECEIVABLE	1	0	(0)	5	7	2	8	8	8	(0)
47	DIVIDEND ON PDC	(48)	(47)	1	(338)	(338)	0	(480)	(580)	(579)	1
	SURPLUS/(DEFICIT)	**15**	**14**	**(1)**	**769**	**1,306**	**537**	**300**	**800**	**913**	**113**
48	RESTRUCTURING COSTS	0	0	0	0	113	(113)	0	0	113	(113)
	SURPLUS/(DEFICIT) AFTER RESTRUCTURING	**15**	**14**	**(1)**	**769**	**1,193**	**425**	**300**	**800**	**800**	**(0)**

Finance & Performance

2016/17 Plan

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	3,356	4,349	4,382	4,417	4,346	4,410	4,289	4,404	4,473	4,586	4,707	4,785	3,356
Operational income received													
NHS (excl HEE)	1,388	1,888	1,318	1,088	1,088	1,088	1,088	1,088	1,088	1,088	1,088	1,088	14,386
NHS England (GIDS)	528	528	528	528	528	528	528	528	528	528	528	528	6,336
PHE (FNP)	984	236	236	236	236	236	236	236	236	236	236	236	3,576
General debtors (incl LAs)	1,300	1,010	900	1,000	900	700	700	972	970	773	970	1,071	11,266
HEE for Training	926	926	926	926	926	926	926	926	926	926	926	926	11,116
Students and sponsors	325	150	150	100	0	200	800	200	200	400	200	100	2,825
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
	5,451	4,738	4,058	3,878	3,678	3,678	4,278	3,950	3,948	3,951	3,948	3,949	49,505
Operational expenditure payments													
Salaries (net)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(18,264)
Tax, NI and Pension	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(14,940)
Restructuring	0	(144)	0	0	(219)	0	0	0	0	0	0	0	(363)
Suppliers	(1,600)	(1,559)	(1,107)	(929)	(509)	(729)	(1,328)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(12,761)
	(4,367)	(4,470)	(3,874)	(3,696)	(3,495)	(3,496)	(4,095)	(3,767)	(3,767)	(3,767)	(3,767)	(3,767)	(46,328)
Capital Expenditure	(206)	(351)	(264)	(269)	(134)	(79)	(218)	(264)	(219)	(213)	(154)	(114)	(2,485)
Loan	115	115	115	15	15	15	150	150	150	150	50	60	1,100
Interest Income	0	1	0	1	0	1	0	0	1	0	1	0	5
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	0	0	0	0	0	(240)	0	0	0	0	0	(240)	(480)
Closing cash balance	4,349	4,382	4,417	4,346	4,410	4,289	4,404	4,473	4,586	4,707	4,785	4,673	4,673

2016/17 Actual/Forecast

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	3,356	5,071	4,582	3,790	5,352	3,809	4,057	6,653	5,424	4,524	6,832	5,702	3,356
Operational income received													
NHS (excl HEE)	1,275	1,820	1,132	1,473	861	862	1,083	1,088	1,388	1,088	1,088	1,088	14,246
NHS England (GIDS)	45	661	925	558	529	575	529	528	528	528	528	528	6,462
PHE (FNP)	748	0	0	0	0	1,414	707	0	0	707	0	0	3,576
General debtors (incl LAs)	1,179	729	694	301	723	1,646	1,199	972	970	773	970	1,071	11,227
HEE for Training	2,391	133	134	2,824	189	23	2,771	0	0	2,779	0	0	11,244
Students and sponsors	306	56	71	113	92	442	440	200	200	400	200	100	2,620
Other	25	27	66	34	30	28	0	0	0	0	0	0	210
	5,969	3,426	3,022	5,303	2,424	4,990	6,729	2,788	3,086	6,275	2,786	2,787	49,585
Operational expenditure payments													
Salaries (net)	(1,499)	(1,429)	(1,434)	(1,427)	(1,476)	(1,505)	(1,523)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)	(17,903)
Tax, NI and Pension	(1,167)	(1,189)	(1,235)	(1,131)	(1,154)	(1,173)	(1,168)	(1,245)	(1,245)	(1,245)	(1,245)	(1,245)	(14,442)
Restructuring	(4)	(199)	0	0	0	0	0	0	0	0	0	0	(203)
Suppliers	(1,473)	(1,119)	(1,060)	(1,100)	(1,216)	(1,637)	(1,299)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(13,904)
	(4,143)	(3,936)	(3,729)	(3,658)	(3,846)	(4,315)	(3,990)	(3,767)	(3,767)	(3,767)	(3,767)	(3,767)	(46,452)
Capital Expenditure	(112)	20	(86)	(84)	(122)	(93)	(143)	(250)	(220)	(200)	(150)	(150)	(1,590)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	1	1	1	1	1	1	0	0	1	0	1	0	8
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	0	0	0	0	0	(335)	0	0	0	0	0	(240)	(575)
Closing cash balance	5,071	4,582	3,790	5,352	3,809	4,057	6,653	5,424	4,524	6,832	5,702	4,332	4,332

Board of Directors : November 2016

Item : 15

Title : Department of Education and Training Board Report

Purpose:

To update on issues in the Education & Training Service Line. To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 7th November 2016.

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

T&E Report

Page 1

Department 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 7th November 2016.

2.   Fee Review and Targets

2.1   The group discussed the 2017/18 fee review which had now been completed.

2.2   Victoria Buyer, Commercial Engagement and Development Unit Lead, explained how this had been carried out and the areas that were considered which included: full consideration of the impact of the changes on potential students in light of the prevailing financial climate as well as competitor's fees.

2.3   There has been a harmonisation of the pricing structure so that there are now 8 prices for courses that reflect the level and award rather than the previous 23 individual prices.

2.4   Target student numbers are still under consideration and will be set in due course after full consultation with course teams.

2.5   There are a number of operational and cultural issues that need to be addressed in the process of setting and agreeing next year's targets.

3.   ICT Project

3.1   David Wyndham-Lewis, Interim IM&T Director attended for this item.

3.2   He explained that we were on track to go live with applications via the new system on Wednesday 9th November.

3.3   The core data migration took place on the 7th and 8th and additional migrations will occur between now and the New Year.

3.4   Interim support has been found to account for the departure of our Lead Systems Analyst.

3.5   The project is now RAG rated green.

4.   National Training Contract

4.1   Brian Rock updated the programme board on the work that has been ongoing in relation to the national training contract.

4.2   Elisa Reyes Simpson, Associate Dean for Academic Governance and Quality Assurance explained that the Portfolio review continues and they are awaiting financial data before making further decisions.

4.3   Karen Tanner, Deputy Director and Associate Dean for Learning and Teaching advised that meetings had begun with relevant staff across the Trust that had expertise in the areas identified as potentially being suitable for educational consultancy. These are; primary care, trauma and resilience and vulnerable children.

5. **National Mental Health Training Hub**

5.1 Brian Rock advised that talks with other providers that may work with the Trust on the National Mental Health Training Hub were continuing.

5.2 A kick off meeting is planned for before Christmas at which priorities, goals and outcomes, governance arrangements will be discussed.

6. **Student Recruitment**

6.1 BR presented a paper on student recruitment which included the final numbers for 2016/17 and the results of a survey carried out to staff regarding the recruitment cycle.

6.2 We have ended the cycle with 555 students (excluding associate centres), which is a 15% increase on 2015/16).

6.3 The new prospectus has been delivered and potential students can now request paper and hard copies.

6.4 A more in depth analysis of the 2016/17 cycle and the lessons learnt will be brought to the TEPMB in December.

7. **Alumni**

7.1 BR explained that the work with our alumni has now begun with former students receiving a message from Paul Jenkins and himself.

7.2 The first event will be held later this month with a seminar being delivered by current staff and alumni: Broken Attachments.

7.3 The programme board discussed the purpose of the alumni function which it was agreed was not to raise funds but rather to promote our work.

8. **Honorary Doctorates**

8.1 BR explained to the programme board that each year the Trust awards two honorary doctorates at its graduation ceremony with the University of East London.

8.2 He will prepare a briefing paper on the potential nominees and circulate to the members of the programme board. It will then be circulated to the Board for approval.

Brian Rock
Director of Education and Training/Dean of Postgraduate Studies
11ᵗʰ November 2016

T&E Report

Board of Directors : November 2016

Item : 16

Title : Clinical Quality Safety and Governance Committee Minutes

Summary:

These are the draft minutes from the quarter 2 meeting of the CQSGC meeting held on the 7th November. As there were no NEDs in attendance, the meeting was non-quorate. The Board is therefore invited to review the action plans emanating from this meeting and the overall RAG Rating of each work stream.

This report has been reviewed by the following Committees:
* EMT, 15 November 2016

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

For : Discussion and Approval

From : Dr Rob Senior, Medical Director

CQSG

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CQSGC MINUTES FROM A MEETING
HELD AT 11:00, TUESDAY 1st NOVEMBER 2016, BOARDROOM

Members	Present?
Rob Senior, Medical Director (& CQSGC Chair) (RS)	Y
Paul Burstow, Trust Chair (PB)	N
Dinesh Bhugra, Non-Executive Director (DB)	N
Anthony Levy, Public Governor (AL)	Y
George Wilkinson, Public Governor (GW)	Y
Paul Jenkins, Chief Executive (PJ)	Y
Terry Noys, Deputy Chief Executive and Finance Director & SIRO (TN)	Y
Jonathan McKee. Deputy Senior Information Risk Owner (JMK)	Y
Louise Lyon, Director of Quality and Patient Experience (LL)	Y
Sally Hodges, CYAF Director (SH)	Y
Julian Stern, Director of Adult and Forensic Services (JS)	**Y**
Caroline McKenna, Associate Medical Director (CMK)	N
Elisa Reyes Simpson, Associate Dean for Academic Governance and Quality Assurance (ERS)	Y
Marion Shipman, Associate Director Quality and Governance (MS)	Y
Irene Henderson, Clinical Governance & Quality Manager (& CQSGC Secretary) (IH)	Y

SUMMARY OF NOVEMBER ACTIONS

AP	Item	Action to be taken	By	Deadline
4	C/F	SH to work with PPI to gain patient feedback in relation to CCTV signage	SH	Q3 Meeting February 2017
4	C/F	JMK to investigate and report back on all contractor compliance with IG training	JMK	Q3 Meeting February 2017
5		IMT Strategic: JMK & ERS to explore with DET resolution in relation to trainees taking secure data off site.	JMK & ERS	Q3 Meeting February 2017
5		IMT Data Loss Protection: Invite IMT Interim Director to produce updated IMT Security data loss protection report for Q3 and invite IMT Interim Director to CQSGC Meeting	IH	Q3 Meeting February 2017
6		CQC Update: CMK to produce a systematic overview, across a year, to see real trends, which we can disaggregate from the quality report.	CMK	Q3 Meeting February 2017
7		Clinical Outcomes: LL to add an appendix to next CQSGC report in relation to completion timescales for the integrated quality improvements reported via the November Board.	LL	Q3 Meeting February 2017
8	1	Sign up to Safety: MS to update plan to include lines of accountability	MS	December 2017
8	4	Sign up to Safety – Knowledge of Self-harm and Suicide: MS & CMK to discuss inclusion of voluntary sectors, GPs, etc.	MS & CMK	December 2017
8	4	Sign up to Safety – MS to check if the updated plan	MS	December 2017

CQSG

		requires formal Board approval.		

Apologies for absence:

1 Caroline McKenna. Dinesh Bhugra and Paul Burstow

2 Chair's opening remarks

RS stated as neither of the Non-Executive Directors was present, the meeting was not quorate. After some discussion it was agreed that the meeting would go ahead and be minuted with actions, and then these minutes and actions would need to be approved by the Board.

RS noted it has been difficult for DB to attend many meetings. PJ confirmed that Ian McPherson has stepped down as a Non-Executive Director and it was noted that the Board would need to appoint a number of new NEDs to committees.

RS confirmed the workstream reports being presented today were covering Q2 2016-17.

3 Minutes from the last meeting

The previous minutes were reviewed and accepted as a true record with the following amendments:

❖ George Wilkinson's attendance was corrected to Y.
❖ Julian Stern's title was corrected.
❖ ICD10 target completion date now obsolete as the Trust is exempt.

4   Matters arising

It was noted that not all actions have been addressed via the workstream reports so the leads gave the following verbal action updates prior to presenting their reports.

AL also noted that there appears to be slippage in many action target completion dates and that should be addressed.

ACTIONS UPDATE from Q1 MEETING

AP	Item	Action to be taken	By	Deadline
2	5a	MS to investigate and improve the 'healthy options' provided by the vending machine. **UPDATE: MS confirmed Paul Waterman is due to meet with the suppliers to investigate and improve the healthy options available.**	*MS*	**Complete**
5	5b	LL agreed to investigate how and if any data captured on paper is stored prior to upload. **UPDATE: LL confirmed all GIDS patient data captured paper is scanned directly on the PC and then paper version is destroyed.**	*LL*	**Complete**
6	6	MS to check signage in relation to CCTV at the Tavistock and all external sites. **UPDATE: MS confirmed the limited signage had been previously agreed. It was noted that this was an IG matter and JMK confirmed the Trust has met this standard. The Trust may wish to explore the benefits of adding additional signage; SH suggested gaining patient feedback and MS agreed to work with the PPI team to get patient feedback and if necessary then take any appropriate proposals to the EMT.**	*MS* SH	**Complete**

7	7	LL agreed to take this the Data Analysis and Reporting Committee (DARC) for a decision on ICD10 coding and will report back to this workstream. **UPDATE: LL confirmed we are now exempt from mandatory report on ICD10 coding but that many feel it is considered to be clinically beneficial for us to use ICD10 coding, if done correctly. It was noted it would also enable bench marking with other providers. LL confirmed ICD10 is under consideration by the Data Analysis and Reporting Committee (DARC) for a proposal re training and implementation.**	*LL*	**Complete**
8	7	SY agreed to amend the rating to amber for the following two areas: Clinical Information Assurance and Corporate Records.	*SY*	**Complete**
9	8	Louise agreed to check the TADS data for any information or evidence on attempted suicides. **UPDATE: LL confirmed that she has requested any research data in relation to suicide or attempted suicide alongside the long term follow ups after treatment to assist patients' at risk of relapse.**	*LL*	**Complete**

REPORTS FROM WORK STREAM LEADS

5   INFORMATION GOVERNANCE WORKSTREAM

JMK introduced his report with a current overall rating of red and highlighted the following areas:

- **Strategic**
  NHS Digital is to introduce a new basic mandatory system but there were difficulties embedding it, so we may need to have an interim **JMK**

plan if the new system is not functioning in time. RS suggested we may have to use the old system in the meantime, if it remains available.

AL asked if contractors, such as physical estates workers, are required to complete IG training. It was noted that the Trust only uses contractors from an approved list, so offered this limited assurance of compliance, but it was not clear whether IG training was a requirement of such contractors. JMK agreed to find out and report back.

JMK acknowledged that all staff who come via HR will have undertaken IG. However, those employed on a consultancy basis not through HR may not have completed the training.

- **Data Protection**
  There was an issue with trainees taking recordings of patient sessions off site highlighted by the Caldicott Guardian. JMK and ERS are working with the Caldicott Guardian and DET colleagues for a resolution and will report back. RS asked what instructions are currently given to trainees, and ERS confirmed that they are clearly told not to take recordings out of the building. **JMK & ERS**

- **IMT Security - data loss protection**
  The purchased software to provide this level of IMT security is currently only functioning in audit mode and the Director of IMT is working to resolve this as a matter of urgency. There was some discussion around how the Trust would function if we suffered a complete IT system failure and it was agreed that all services should have an updated business continuity plan (BCP) that now includes our work with the electronic patient record. AL asked if there is adequate protection assurance in relation to the ever increasing cyber-attacks. JMK noted that Caldicott 3 launched in summer, highlighted the expectation that the safety of patient data be treated as a patient safety issue and be afforded the same level of scrutiny as finance. **IH**
  PJ asked for the Director of IMT, David Wyndham Lewis, to be invited to provide a report to the next CQSGC for Q3.

- **Secondary Use data**
  JMK explained that first use data is all data used in direct patient care and secondary use data is all the rest of the data we use across the Trust for management purposes etc. JMK noted that there has been some progress in the production of evidence towards the standard of secondary data use but that we are not quite there and confirmed that the ICD10 clinical coding had been removed from the mandatory requirements but may be reintroduced for clinical reasons, as noted in the Clinical Quality and Patient Experience work stream report.

- **Clinical Information assurance**
  JMK noted the Trust's work was considered exemplary and was twice referenced (for archiving and document review panel) in the new national guidance:

- **Corporate records – Freedom of Information Requests (FOIs)**
  JMK reported excellent news in that the Trust has for the first time achieved a 100% response rate for all received FOIs.

RS asked if the Q2 report should be made amber but JMK explained that although the Trust did relatively well in most areas, NHS Digital deemed performance overall as "unsatisfactory" as the requirements in the clinical data quality area had not been met and this would not change until the work to complete this had been done.

The committee accepted an overall rating of red for Q2.

6 PATIENT SAFETY AND CLINICAL RISK

CMK was not present so RS introduced this work stream report noting the overall rating for Q2 as amber. IH highlighted the increase in numbers incidents of violence, which were mostly at Gloucester House school, and noted that this was expected due to the nature of the school pupils and the time of year which meant the children were settling in and getting used to new staff etc.

Serious incidents:
AL asked in relation to serious incidents (SIs), if the Trust has an adequate system in place for lessons learned, which he would like to see include near misses, which might never actually reach one of these reports. He also asked how the Board receives this assurance.

RS cited the recent CYAF patient suicide and briefly explained the process, in that he appoints a senior investigator who produces recommendations to enable the Director to produce an action plan, which goes back to the team, and where appropriate is shared across the Trust. We monitor this dissemination to ensure where practices have changed, that the changes have been embedded in clinical services, eg case reviews or supervision. RS also confirmed that the Board receives assurance on this via the Patient Safety and Clinical Risk work stream reports.

PJ stated that if we had longer historical timelines of data to review it would give us a much clearer picture of whether clinical practice has

changed in light of lessons learned and also provide us with the evidence of these changes. RS stated that we now have a part time clinical audit officer who should be able to assist with this going forward.

CQC UPDATE:
RS also noted that the CQC would be coming again before the 27th November for an "unannounced" visit. LL provided a brief update and explained that the Trust had indicated we would welcome this second inspection now, rather than to wait for the next CQC inspection in 3 years' time. This gives the Trust an opportunity to complete the MUST DOs on the CQC action plan and also to address the SHOULD DOs within the plan, and possibly move our safety rating of 'needs improvement' to 'good'. LL confirmed the CQC would specifically be looking for serious improvements on the MUST DOs:

- Waiting room arrangements for children
- Crisis planning for adults
- Case records management

All these relate solely to our services in the following teams, The Portman Clinic, City & Hackney Service, Fitzjohns, Trauma and Lyndhurst Units. JS stated that much work has been undertaken in these units to ensure these items have been addressed and he would be extremely disappointed if the CQC don't find significant improvements in these areas.

PJ asked for CMK to produce a systematic overview, across a year, to see real trends, which we can disaggregate from the quality report. This could provide an annual basis for looking at systemic issues, near misses etc.

CMK

Revalidation:
AL asked if we have adequate assurance that doctors on honorary contracts are fully aware and adhering to our policies and procedures where appropriate to their services. RS stated that we have improved our performance in this area and that all external doctors, who pay an annual fee to join the Trust revalidation programme, are invited to mandatory training and have to provide evidence of continued professional training and development. JS also added that all of the external doctors are aware of the requirements and are expected to follow them.

The committee accepted an overall amber rating for Q2.

CLINICAL QUALITY AND PATIENT EXPERIENCE WORKSTREAM

LL introduced her work stream report and stated it is still a work in progress trying to draw all three areas together for coherent reporting and that there have been some difficulties in getting the reports completed for deadlines, when the data has not yet fully available. LL

confirmed the introduction of the information dashboards will enable this report to be collated in a timelier manner.

LL highlighted the following areas in her report:

- **Data completeness, e.g. ethnicity**
  LL noted that we need to ensure ethnicity data collection which is essential for our equalities work and there is currently a piece of work being led by the Data Quality Manager to address this.

- **Physical Health Form**
  Completion of this form is still limited and it is essential we increase the completion rate as it is also one of our CQUINS. AL asked if clinicians are being urged to complete this form even if they feel it may be clinically inappropriate during the sessions. JS said that clinicians handle this form quite subtly to ensure it does not interfere with treatment. SH also acknowledged that we are mandated to complete the physical health form for all patients over 14 years old.

- **Clinical Outcomes**
  LL confirmed the Goal Based Measure (GBM) completion rate is good. However, we are required to reach an improvement rate of 70% for the CORE measure which is extremely high. LL suggested we need to do more analysis to see how services are doing in relation to outcomes. LL also stated that clinicians must ensure they enter accurate and timely data on CareNotes, but that the Trust needs to monitor staff sensitively to ensure they are coping and to ensure we attend to staff morale.

  There was a brief discussion around waiting times and SH confirmed that Camden CAMHS waiting times had improved and PJ stated that we need to ensure our services are streamlined and accessible for patients and staff.

  AL asked what the timescale was for the integrated quality improvements and LL confirmed they would be presented to the November Board. LL said we need to ensure the improvements are useful to clinicians, which will in turn translate in to help for our patients. RS asked LL to add this as an appendix to her next CQSGC report.

  LL

- **CQC Action Plan**
  LL noted that although the committee had already discussed the CQC's forthcoming visit, she also added:
  - All MUST DOs have been completed
  - All SHOULD DOs are all planned to be completed
  - Audits have been planned to provide assurance
  LL confirmed that the CQC are impressed with our plans for

completion of both MUST DOs and SHOULD DOs.
RS requested that once the CQC compliance has been agreed, that LL move any outstanding action plans to the appropriate work streams to ensure they are completed.

The committee accepted an overall rating of amber for Q2.

CORPORATE GOVERNANCE AND RISK WORKSTREAM

MS introduced her work stream report and noted the following areas:

- NHS Improvement – seeking to reduce our green rating if we continue to overspend on our Agency Cap. MS confirmed HR are aware of this and a plan is in place.
- There are five new metrics being introduced in April 2017 and the implications of these are currently being considered.
- HR now have a plan in place to roll out clinical risk training. They will be cleansing data to provide data accuracy and the Director of HR assures this exercise will be completed by the end of Q3. HR also confirm our staff turnover of 18% is high and the HR Director plans to introduce exit interviews among other strategies. RS asked if it was clear which staff groups were involved and MS confirmed she will ask the HR Director to bring this item back to the EMT.
- EPPR Report – The focus this year is on BCPs and it was noted that all services across the Trust need to ensure their BCPs are in place and adequate to enable their services to function in specific emergency situations.

JMK asked for confirmation whether ICD10 clinical coding would be applied to the Trust from 2017 given it had been exempted. ICD10 had been mentioned in three separate reports, each detailing slightly contradictory things. LL explained that the Trust received an exemption from recording and reporting ICD10 coding. However, since then, some clinical teams have agreed that we should in fact use ICD10 coding for purposes of benchmarking and comparison with other services. MS stated that it was in the NHS Improvement metrics being introduced in April 2017, and the Trust Secretary is checking whether this would actually apply to the Trust. JS noted that it would require comprehensive training to ensure the data collected is accurate and useful.

RS acknowledged that there are many areas within the Clinical **LL** Governance and Risk work stream, which are already being considered elsewhere as the activity is happening elsewhere and asked MS to update her commentary to reflect this and avoid duplication.

JMK asked why project risks were not included in the risk register, as requested by the IG workstream, specifically the risks in relation to the

CQSG

IMT strategy, to ensure the Board receives a full list of all risks. MS agreed to update the risk register to include all project risks. MS also agreed to amend the operational risk register Q2 rating from green to amber in relation to the inclusion of project risks.

TN asked if we should be considering action plans for internal audits here. RS stated that he attended the Audit Committee annually to give assurance on the work of the CQSGC. PJ stated that this committee should only consider those relevant to the CQSGC as the Audit committee already considers reports for all audits and monitors the completion of actions.

The committee accepted an overall rating of amber for Q2.

SIGN UP TO SAFETY CAMPAIGN

MS introduced a draft plan for the Sign up to Safety campaign with proposed completion dates noting there are four main areas for consideration:

1.   Detect and managing e-safety risks in young people
AL asked if the Trust has a E-Safety champion, given the fast pace of technology and cyber risks and MS confirmed that E-safety risks are held by Richard Graham. SH asked if whoever is accountable for each area be added to the plan for clarity and MS agreed to update the plan adding the accountable leads.

2.   Improve patient's physical health
AL asked if clinicians were being asked to complete physical health forms rigidly including if the clinician feels it may interfere with the therapeutic arena. JS confirmed it is often not appropriate to complete the physical **MS** health form during intricate treatment plans and it is being dealt with very subtly so it doesn't impact negatively on the treatment.
SH also noted it is mandatory for us to complete the physical health form for all patients over the age of 14.

3.   Improve domestic violence and abuse management
It was agreed there was further work to be done in ensuring that systems were able to capture the required data; that staff were aware of the mandatory requirements in terms of ensuring data capture and ensuring patient safety.

4.   Improve clinician knowledge of self-harm and suicide
AL noted that there is mention of work with patients, families and carers, and asked if we could include GPs, referrers, voluntary sector partners etc. LL noted this omission and MS agreed to discuss with CMK.

MS
&
JS asked for a correction to be made to the first paragraph to note that **CMK**
AFS services are also involved in providing specialist mental health services, as well as CYAF and MS agreed to make the correction.

RS clarified that the plan's implementation will be overseen via the Patient Safety and Clinical Risk workstream (PSCR). PJ confirmed that the plan would be approved by the EMT; it should then go to the Board for approval only if required. MS to check whether formal Board approval is mandated, otherwise this would be approved at the EMT. MS confirmed once the plan has been completed and signed off by the Board it would be published on the Trust website.

AOB:
There was no other business raised.

Notice of future meetings:
11am, Tuesday 7th February 2017
11am, Tuesday 2nd May 2017   **MS**
11am, Tuesday 5th September 2017
11am, Tuesday 7th November 2017

                                                              MS

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

Board of Directors : November 2015

Item : 17

Title : Deputy Chair recommendation, NED Committee
memberships and Links

Summary:

1. Deputy Chair recommendation, to approve
2. Changes to Committee ToR, to approve.
3. NED committee memberships and links, to approve.

This report focuses on the following areas:

- Corporate Governance

For : Approval

From : Gervase Campbell, Trust Secretary

Page 1 of 3

Corporate Governance

1. NED Roles, Committee Memberships and Links

1.1 Introduction
1.1.1 As Dr McPherson has left the Trust we need to appoint a new Deputy Chair. This is an appointment for the Council of Governors to make, and the Board are asked to make a recommendation to be taken to the Governors at their December meeting.

1.1.2 NED Roles, Committee memberships and Committee Chairmanships were last agreed by the board in November 2015. With the appointment of a new NED to the Board these have been reviewed and changes made, including changes to the number of NEDs on committees.

1.2 Deputy Chair of the Trust
1.2.1 We propose to recommend to the Council of Governors that they appoint Ms Edna Murphy to serve as Deputy Chair of the Board of Directors.

1.2.2 The Council will be asked to appoint the Deputy Chair at their December meeting.

1.3 Changes to Terms of Reference of Board Committees
1.3.1 We propose that the membership of the Clinical Quality, Safety and Governance Committee (CQSG) increase from two to three NEDs.

1.3.2 We propose that the membership of the Training and Education Programme Management Committee reduce from four to two NEDs.

1.3.3 We propose that the membership of the Strategic and Commercial Committee (SCC) reduce from three to two NEDs.

1.3.4 In addition we propose that the Chair of the Trust become a roving member of all the Board committees, to attend at least one meeting of each over the course of each year.

1.3.5 The Terms of Reference of these committees will be updated to include these changes.

1.4 NED Committee memberships
1.4.1 We propose that Ms Helen Farrow should join the SCC now to attend their January meeting as a member, and take on the role of Chair at the conclusion of that meeting.

1.4.2 Details of all other NED memberships and links are listed in **Appendix A**.

1.5 NED Links
1.5.1 The Board is asked to **approve** these links, memberships and roles as detailed above and in Appendix A.

1.6 Approval
1.6.1 The Board of Directors is asked to approve:

Page 2 of 3

- The recommendation to the Council that Ms Murphy be appointed as Deputy Chair.
- The changes to the committee terms of reference detailed above.
- The Committee memberships detailed in Appendix A.
- The NED links detailed in Appendix A.

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Director Links to Trust Work

Areas where NED involvement is mandatory
(nb - where membership of committees is large only key Executive Director link is given)

Board Committees	Name	Title	Responsibility
Audit Committee	David Holt	Non-Executive Director	Committee Chair
(3 NEDs)	Helen Farrow	Non-Executive Director	Member
	Edna Murphy	Non-Executive Director	Member
	Terry Noys	Finance Director	Attendance
Strategic and Commercial Committee	David Holt, then Helen Farrow from 18th January 2017		Committee Chair
(2 NEDs)	David Holt	Non-Executive Director	Member
	Helen Farrow	Non-Executive Director	Member
	Paul Jenkins	Chief Executive	Member
	Terry Noys	Finance Director	Member
Charitable Fund Committee	Paul Burstow	Trust Chair	Committee Chair
(1 NED)	Paul Jenkins	Chief Executive	Member
	Terry Noys	Finance Director	Member
Clinical Quality, Safety & Governance Committee	Rob Senior	Medical Director	Committee Chair
(CQSG)	Jane Gizbert	Non-Executive Director	Member
(3 NEDs)	Edna Murphy	Non-Executive Director	Member
	Dinesh Bhugra	Non-Executive Director	Member
	Paul Jenkins	Chief Executive	Member
	Julian Stern	Director of AFS	Member
	Sally Hodges	Director of CYAF	Member
	Louise Lyon	Director of Quality & Patient Experience	Member
Executive Appointment and Remuneration Com	Paul Burstow	Trust Chair	Committee Chair
(all NEDs)	Dinesh Bhugra	Non-Executive Director	Member
	Jane Gizbert	Non-Executive Director	Member
	David Holt	Non-Executive Director	Member
	Helen Farrow	Non-Executive Director	Member
	Edna Murphy	Non-Executive Director	Member
Trust Committees	**Name**	**Title**	**Responsibility**
Training & Education Programme Management	Paul Jenkins	Chief Executive	Committee Chair
(2 NEDs)	Edna Murphy	Non-Executive Director	Member
	Dinesh Bhugra	Non-Executive Director	Member
	Chris Caldwell	Nursing Director	Member
	Brian Rock	Director of Educationa and Training/ Dean	Member
Gloucester House The Tavistock Children's Day	Sally Hodges	Director of CYAF	Trust Lead

Director Links to Trust Work

Link Areas	Name	Title	Responsibility
Unit Steering Group	Jane Gizbert	Non-Executive Director	Member
Safeguarding Committee;	Sonia Appleby	Consultant Social Worker	Clinical Lead
Child and Adult Protection	Helen Farrow	Non-Executive Director	Member
	Rob Senior	Medical Director	Trust Lead
Clinical Excellence Awards Committee	Paul Jenkins	Chief Executive	Committee Chair
	Paul Burstow	Trust Chair	Lay Member
	David Holt	Non-Executive Director	Lay Member
Research & Development Committee	Eilis Kennedy	Director of Research & Development	Trust Lead
	Dinesh Bhugra	Non-Executive Director	Non-Executive Lead
Quality Stakeholders Group	Jane Gizbert	Non-Executive Director	Non-Executive Lead
	Louise Lyon	Director of Quality, Patient Experience and AFS	Trust Lead
Link Areas	Name	Title	Responsibility
Adult and Forensic Services (AFS)	David Holt	Non-Executive Director	Non-Executive Lead
Children, Young Adults and Family Services	Helen Farrow	Non-Executive Director	Non-Executive Lead
Training & Education Directorate	Dinesh Bhugra	Non-Executive Director	Non-Executive Lead
	Edna Murphy	Non-Executive Director	Non-Executive Lead
Communications	Jane Gizbert	Non-Executive Director	Non-Executive Lead
	Laure Thomas	Director of Communications and Marketing	Management Lead
Complaints and Whistleblowing	Amanda Hawke	Complaints Manager	Management Lead
	Marion Shipman	Associate Director of Quality and Governance	Management Lead
	Edna Murphy	Non-Executive Director	Non-Executive Lead
Finance and Counter Fraud	Terry Noys	Deputy CEO & Finance Director	Trust Lead
	David Holt	Non-Executive Director	Non-Executive Lead
	Gemma Higginson	Local Counter Fraud Specialist	RSM Risk Assurance Services
Estates and Security Management	Paul Waterman	Estates and Facilities Manager	Trust Lead
	David Holt	Non-Executive Director	Non-Executive Lead
Legal Issues	Gervase Campbell	Trust Secretary	Trust Lead
	Edna Murphy	Non-Executive Director	Non-Executive Lead
Data/Informatics/IT	Terry Noys	Deputy CEO & Finance Director	Trust Lead
	Jane Gizbert	Non-Executive Director	Non-Executive Lead
HR	Craig DeSousa	Director of Human Resources	Trust Lead
	Paul Burstow	Chair	Non-Executive Lead

Name	Committee/Area	Responsibility
Paul Burstow	Ex-officio all Board Committees attending in rotation	
	Charitable Fund Committee	Chair
	Executive Appointment & Remunerat	Chair
	Clinical Excellence Awards Committee	Member
	Link area: Human Resources	Link
	Link area: Equalities Committee; Disability Issues; Human Rights; MHA	Link/ Member
Dinesh Bhugra	Training & Education Programme Ma	Member
	CQSG	Member
	Executive Appointment & Remunerat	Member
	Research and Development Committee	Member
	Link area: T&E Directorate	Link
	Link area: International Business Dev	Link
Helen Farrow	Audit Committee	Member
	SCPB	Chair
	Executive Appointment & Remunerat	Member
	Safeguarding and Child and Adult Pr	Member
	Link area: CYAF	Link
Jane Gizbert	CQSG	Member
	Executive Appointment & Remunerat	Member
	Quality Stakeholders Group	Member
	Link area: Gloucester House Steering	Link
	Link area: Communications	Link
	Link area: Data/Informatics/IT	Link
	Link area: FDAC and FNP	Link
David Holt (SID)	Audit Committee	Chair
	SCPB	Interim Chair
	Executive Appointment & Remunerat	Member
	Clinical Excellence Awards Committee	Member
	Link area: Adult and Forensic Services	Link
	Link area: Finance and Counter Fraud	Link
	Link area: Estates & Security Mngt	Link
Edna Murphy	Audit Committee	Member
	Training & Education Programme Ma	Member
	CQSG	Member
	Research and Development Committee	Chair
	Executive Appointment & Remunerat	Member
	Link area: T&E	Link
	Link area: Complaints and whistleblo	Link
	Link area: Legal issues	Link

Board of Directors: November 2016

Item : 18

Title : Safety Improvement Plan 2016-2019

Purpose:

The Board approved Trust sign up to the national 'Sign up to Safety Campaign' in October 2015. This commitment and our actions in response to the five Sign up to Safety pledges, was signed by the Chief Executive. In signing up to the Campaign we committed to turning our proposed actions into a Safety Improvement Plan, showing how we would seek to 'save lives and reduce harm for patients' over the next three years.

The following plan outlines the four programmes of work the Trust has committed to implement.   These also align to our Trust Quality Priorities.

The Board of Directors is asked to approve the following Safety Improvement Plan.

This report has been reviewed by the following Committees:
- Management Team, 15th November 2016
- Clinical Risk Safety and Governance Committee, 1st November 2016

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

For : Approval

From : Marion Shipman, Associate Director Quality and Governance

Safety Plan

Tavistock and Portman NHS Foundation Trust

Sign up to Safety Campaign

Safety Improvement Plan
2016-2019

1.0 Introduction

The focus on quality of care and patient safety remain central to the Tavistock and Portman NHS Foundation Trust (the Trust) in providing specialist mental health services and integrated health and social care services for children and families across Camden and more widely. Central to this focus is the commitment to improve mental health and emotional well-being, and a belief that high quality mental health services should be available to all who need them.

This Safety Improvement Plan (SIP) builds on and integrates with our Clinical Quality Strategy and Annual Quality Report, and complements our established governance and safety infrastructure. The SIP sets out clear organisational aim statements as to how we will improve the health outcomes of our patients during the three year campaign period and in doing so will support the Trust's aim of providing equitable services to all patients.

The improvement plan will be a dynamic document that will respond to the data and information we routinely collect through our established patient safety reporting systems, staff and service user feedback and as we roll out this plan we support and develop a "just culture for safety".

2.0 Setting our aims

The Trust has developed its Clinical Quality Strategy (2016-19) from a range of National, Regional and Local directives and initiatives, but more importantly it has been tailored to meet the local needs of the service users who receive care across the Trusts footprint. This has been done through an analysis of the Trusts patient harm data, national statistics and consultations with service users and staff. We therefore believe that core aims outlined in the Clinical Quality Strategy will drive the SIP.

These are:

- Ensuring that all service users are safe and protected from avoidable harm and abuse
- Providing services with care, treatment and support that achieves good outcomes and promotes good quality of life, based on best evidence.
- Organising services around the needs of the user – involving them and their carers in service design and delivery.
- Supporting staff to maintain and develop their skills and working within clear and effective governance structures to deliver safe, effective, responsive, caring and well led services.

These four core aims will cut across services provided by the Trust and we will work with and involve our health and social care partners where elements of services are provided by other organisations.

Safety Plan

3.0 Creating our Team

To develop a "just culture for safety", we need the engagement and involvement of all our staff, the people who use our services and the public. The starting point has been the pledges made by the Trust's Chief Executive and Executive Director of Clinical Governance and Quality in signing up to the "Sign up to Safety Campaign". From these pledges the following team has been established:

- Executive Lead – Louise Lyon, Director Quality and Patient Experience
- Sign up to Safety Campaign Lead – Marion Shipman, Associate Director Quality and Governance
- Projects and leads:
  - o Detect and manage e-safety risks in young people: Richard Graham
  - o Improve the physical health of patients: Tim Quinn
  - o Improve domestic violence and abuse management: Sonia Appleby / Sarah Helps
  - o Improve self-harm and suicide management: Caroline McKenna

Each of the leads for the four safety campaign work streams will lead a multidisciplinary group from across the Trust. We will look to co-opt membership from partner organisations where indicated and to support the involvement of service users. Each of the individual work streams will identify local clinical team champions to support and develop the safety improvement planning process into clinical teams.

4.0 Safety Improvement Governance Structure

The Trust Clinical Quality Safety and Governance (CQSG) committee receives reports and updates from four workstreams which report to the committee to ensure clinical effectiveness and monitoring of clinical performance. The committee is responsible for analysing and challenging the information reported. The purpose of the reports received is to promote safety and excellence in patient care; to identify, prioritise and manage risk arising from clinical care and to ensure effective and efficient use of resources through evidence based clinical practice.

To ensure that there are clear lines of accountability, the Safety Improvement Programme will be an integral part of the Trust's governance process and report into the Patient Safety and Clinical Risk Workstream and from there into the CQSG. These governance structures will afford the safety improvement plan access to the Board.

Two Directorate quality groups underpin the Trust's overarching governance framework providing the interface between Trust wide and service specific clinical governance issues. Ultimately, these groups support the delivery of quality services close to the point of care delivery. The Safety Improvement Programme and identified clinical team champions will link into this structure to support integration and learning.

5.0 Trust Governance Structure

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

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

Sign up to Safety

Safety Plan

6.0 Safety Improvement Plan

The Safety Improvement Plan below sets out the core aims that the Trust will be addressing over the 3 year plan. The aim is to launch the Safety Improvement Plan in November following review by the Trust Clinical Quality Safety and Governance Committee. Each individual lead will continue to work with the clinical teams to develop action plans to achieve the agreed goals.

	Core Aim	What does success look like? What is your goal statement?	What Measures?	What do we need to do for that success to be realised?	Timescales and update Oct 16	What resources do we need?
1	**Detect and manage-e-safety risks in young people**	Clinicians will be confident to detect and assess the impact of a young person's digital life on their health and well-being	• Baseline audit of completion of the Digital Life section of the Assessment Summary	Undertake baseline audit – Trust data	30 November 2016	Support from Clinical Audit administrator to design and run reports on Assessment Summaries.
		Clinicians will complete the Digital Life section of the Assessment Summary to a high standard.	• Baseline assessment of Team / clinician confidence/ skills as a guide to developing educational tools to improve confidence and skills in assessing young person's digital life.	Assess team / clinician confidence/ skills in completing digital life section of the Assessment Summary at pilot site (South Camden CAMHS) – Carenotes report and staff survey / focus group.	November 2016	Staff training support from informatics and Quality Team regarding completion of the Assessment Summary
		Areas of digital health risk will be addressed at each review summary.	• PPI qualitative feedback			
		Service Users will feel involved in developing clinical awareness of digital issues.	• Team / clinician confidence/ skills assessment post implementing educational tools.	Obtain patient feedback to inform educational tools	November 2016	
		Goal: Improve awareness among clinicians of the role of patients digital lives on mental health	• Communications plan • Audit completion of the Digital Life section of the Assessment Summary post implementing educational tools.	Develop educational tools following pilot team input including pre and post knowledge assessment tool and implement with pilot team.	December 2016	
				Deliver educational training and assessment with pilot team.	December / January 2017	

Action	Date
Develop a communications plan to raise awareness and understanding of Digital Life and impact on mental health issues.	December 2016
Reaudit pilot site completion of Digital Life section of Assessment Summary	February 2017 on January data
Embed educational tools for routine assessment of Digital Life information in the Assessment process.	February / March 2017
Review evidence, current outcome monitoring forms for Digital Life information and develop an extended proforma	March 2017

	Core Aim	What does success look like? What is your goal statement?	What Measures?	What do we need to do for that success to be realised?	Timescales and update Oct 16	What resources do we need?
2	**Improve the physical health of patients**	Clinicians will be confident to raise physical health issues with patients and also offer very brief smoking and alcohol advice. Clinicians will actively promote appropriate referral to the Physical Health Specialist Nurse (PHSN) or the Trust Living Well Programme. Clinicians will complete the Physical Health form to a high standard **Goal: Improve physical health of patients receiving treatment for mental health issues**	• Baseline and subsequent audit of Physical Health form completion with feedback to teams • Number of referrals to PHSN and Living Well Programme • Evaluation of Living Well Programme and physical health impact via participant survey • Programme uptake • Assessment of Team/ clinician confidence / skills around physical health issues and mental health as a guide to developing resources • Staff feedback on impact of the Programme on patient wellbeing	Monthly audits of physical health form completion with feedback to teams to help embed routine assessment of physical health information in the Assessment process Obtain staff feedback on Living Well Programme at Wellbeing Event Obtain patient / carer feedback through PPI meetings and reception 'tokens' Quarterly referrals to PHSN reported Number of Living Well Programme attendees reported quarterly. Raise awareness and understanding of the impact of physical health issues on mental health – Mind-Body Lecture Series Recruit and develop service level physical health champions across the Trust to support physical health work and	Started July 2016 June 2016 June 2016 Started Q1 2016 and ongoing Programme started October 2016 Oct 2016 – Jan 2017 September 2016 First meeting of physical health champions planned for Nov 16	Commitment from Trust Physical Health Lead clinicians to the project Quality Team support to design and run reports on physical health form completion. Patient, Public involvement Team expertise Staff training support from informatics and Quality Team regarding completion of the physical health form. Patient and staff briefings and information

clinician engagement		
Survey all participants attending the programmes		Jan – March 2017
Further develop Living Well Programme following evaluation for 2017		March 2017
Deliver Physical Health conference		July 2017

	Core Aim	What does success look like? What is your goal statement?	What Measures?	What do we need to do for that success to be realised?	Timescales and update Oct 16	What resources do we need?
3	**Improve domestic violence and abuse management**	There will be an increase in the number of assessed patients being asked the question about whether they have been exposed to domestic abuse and violence against a baseline assessment. **Goal: Improve identification, assessment and management where there is evidence of domestic violence or abuse**	• Number of referrals of victims to specialist agencies and MARAC • Number of safeguarding alert forms (SAFs) • Number of perpetrators referred to specialist agencies • Training in CAADA-DASH for Team Managers – feedback • Numbers and percentage of clinical staff trained in Level 2/3 Domestic Violence and Abuse Training	Train the Trainer CAADA-DASH tool training to be undertaken by Named Professional for Safeguarding Children	May 2016	CAADA-DASH training completed by Named Professional Safeguarding Children
				Baseline Domestic Abuse Audit	June 2016	Commitment from Trust Safeguarding Lead (Medical Director) to the project
				Engage with clinicians across the Trust: - Establishing core training on domestic violence and abuse and management for staff requiring level 2/3 adult and children safeguarding training - Delivering CAADA-DASH training for Team managers	Level 2 and Level 3 training delivery April 2016 – March 2017	Informatics support Support from the Safeguarding supervision group
				Quarterly reports of referrals / alerts	Sept 2016 – March 2017 Commenced for Q1 (Apr-June) 2016 and ongoing	
				Embed SAF processes within clinical practice through directorate feedback by Named Professional for Safeguarding Children	September 2016 and ongoing	

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	Core Aim	What does success look like? What is your goal statement?	What Measures?	What do we need to do for that success to be realised?	Timescales and update Oct 16	What resources do we need?
4	**Improve clinician knowledge of self-harm and suicide**	Clinicians will understand specific risk factors for self-harm and suicide	• Baseline and subsequent audit of completion of recording risk of suicide and self-harm on assessment and review forms	Baseline audit of completion of recording risk of suicide and self-harm on assessment	Self harm and suicide Trust audit completed in Sept 2016. Action plans being developed within directorates October 2016.	Commitment from Associate Medical Director Patient Safety & Portman Director
		Clinicians will confidently carry out competent risk assessments for self-harm and suicide	• In depth examination of a sub-sample of patient records to review in more detail the quality of risk assessments for suicide and self-harm	Mandatory training for clinicians in assessing and managing risk of suicide and self-harm every three years	Introduced from Sept 2016. Training delivered Sept/Oct CYAF, Portman	Commitment from the Medical Director
		Clinicians will complete the clinical risk assessment form to a high standard	• Develop a test of clinician's knowledge of assessing risk of suicide and self-harm post training e.g. multiple choice questionnaire administered via Survey Monkey.	Develop clinician's multiple choice questionnaire to assess pre and post knowledge.	November 2016	Informatics support
		Clinicians will assess and record risk of self harm and suicide at all patient review meetings		Review clinical risk policy to ensure preventative actions are taken.	31 December 2016	
		Goal: Improve clinician knowledge of self-harm and suicide		Engage with clinician's to determine level of knowledge	Explore further at Team Leaders event 6th December 2016.	
				Review and update the Trust Prevention of Suicide Procedure to include learning and recommendations from national strategy.	31 March 2017	
				Involve patients, family and carers in identifying concerns and key factors in determining risk.	January 2017	

	Action	Date
	Review Clinical Risk Assessment Procedure and ensure implementation plan is in place.	December 2016
	Re-audit completion of recording risk of suicide and self-harm on assessment	March 2017

Board of Directors : October 2016

Item : 19

Title : Single Oversight Framework

Purpose:

On the 1st October the Risk Assurance Framework was replaced by the Single Oversight Framework (SOF). Under the SOF there is no requirement to make quarterly governance statements and NHS Improvement will use national datasets to which we already contribute to judge our performance on many of the metrics they will consider. They are looking at a slightly different set of indicators under the SOF and some of these will require work (see section 3.3).

This report explains the scoring under the new system and is given to provide assurance on our performance on the metrics being assessed by NHS Improvement. We currently fall within segment 1 under the shadow, segmentation which NHS Improvement published in October. This means no support needs have been identified and the Trust has maximum autonomy. We have assessed our own performance as green overall, with some concerns for the future regarding the new 'priority' performance data completeness metrics which come into play in April 2017, and over our current agency spend.

This paper was reviewed at the Executive Management Team in November. Members confirmed that we are not aware of any risk to compliance with any conditions of our licence.

This report focuses on the following areas:
- Risk
- Finance
- Quality

For : Noting

From : Trust Secretary

Single Oversight

Single Operating Framework

1.   Introduction

1.1   The Single Oversight Framework is designed to support NHS Improvement's 2020 objectives: to help providers attain/maintain a CQC 'good' or 'outstanding' rating, reduce the number of trusts in special measures, and achieving aggregate financial balance from 2017/18.

1.2   The five themes of the Single Oversight Framework are:
1. Quality of Care
2. Finances and Use of Resources
3. Operational Performance
4. Strategic Change
5. Leadership and Improvement Capability

1.3   The Single Oversight Framework is based on the principle of earned autonomy, and NHS Improvement will segment the provider sector according to the scale of issues faced by individual providers.

- If no support needs are identified in any of the five themes the provider will be in segment 1 with maximum autonomy.
- If some support needs are identified providers will be given targeted support within segment 2.
- Significant concerns mean a breach of licence conditions and lead to mandatory support in segment 3, and major/complex concerns mean special measures in segment 4

1.4   In October NHS Improvement published a shadow, or indicative, segmentation of providers and we were rated as segment 1.

2.   Identifying Potential Support Needs

Where possible, and especially for operational performance, NHS Improvement will use nationally collected and evaluated datasets rather than require bespoke data submissions. There will still be a requirement to make quarterly financial submissions. Sources of data are shown in the table below:

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	In-year	Annual/ less frequently	Ad hoc
Quality of care	In-year quality information to identify any areas for improvement (see Appendix 2)	Annual quality information	Results of CQC inspections CQC warning notices, fines, civil or criminal actions and information on other relevant matters
Finance and use of resources	Monthly returns	Annual plans	One-off financial events (eg sudden drops in income/ increases in costs) Transactions/mergers
Operational performance	Monthly/quarterly(in some cases weekly[2]) operational performance information (see Appendix 3)		Any sudden and unforeseen factors driving a significant failure to deliver
Strategic change	Delivery of sustainability and transformation plans (STPs) Progress of any new care models, devolution plans	STPs	Any sudden and unforeseen factors driving a significant failure to deliver
Leadership and improvement capability	Third-party information with governance implications[1] Organisational health indicators - staff absenteeism - staff churn - board vacancies	Staff and patient surveys Third-party information with governance implications[1]	Findings of well-led reviews Third-party information with governance implications[1]

[1] eg reports from quality surveillance groups (QSGs), GMC, ombudsman, CCGs, Healthwatch England, auditors, Health and Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges
[2] Where necessary

Within each of the five themes there are triggers which NHS Improvement uses to assess potential support needs and determine which segment a provider sits in:

2.1 **Quality of Care:** A CQC assessment of inadequate or requires improvement will represent a support need. This will be supplemented by other indicators in-year, such as concerns arising from trends in quality indicators.

2.2 **Finance and use of resources:**

NHS Improvement will use five (to begin with) financial metrics to assess performance. In these metrics scoring 1 is best, and 4 is worst. A score of 4 in any individual metric, or of 3 or 4 on average across them, will trigger a concern. Details are given in section 3.2

NHS Improvement will also look at broader value for money considerations, using evidence such as management consultancy spend, paybill growth, consolidation of back office services, and national benchmarking.

Single Oversight

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2.3 Operational Performance

The triggers here are:

- for a provider with one or more agreed Sustainability and Transformation Fund trajectories against any of the metrics listed in Appendix 3 to the SOF: it fails to meet any trajectory for at least two consecutive months
- for a provider with no agreed Sustainability and Transformation Fund trajectory against any metrics: it fails to meet a relevant target or standard in the list of metrics given in Appendix 3 of the Single Oversight Framework for at least two consecutive months
- where other factors (eg a significant deterioration in a single month, or multiple potential support needs across other standards and/or other themes) indicate we need to get involved before two months have elapsed.

2.4 Strategic Change

In the future NHS Improvement will develop a way to consider the extent to which organisations are working with partners to achieve the agenda in the 5YFV. In the interim they will consider provider's contribution to developing and delivering STPs. No specific metrics or details have been given.

2.5 Leadership and improvement capability

Providers should demonstrate three main characteristics:

1. Effective boards and governance – Metrics will include: staff/patient surveys, organisational metrics, agency spend, delivering WRES, CQC well-led assessments.
2. Continuous improvement capability – No details available.
3. Use of data – Organisations are required to collect use and submit robust data. No details are available yet on how this will be judged.

3.   Current Performance

3.1   Quality of Care

3.1.1   The Trust was registered by the CQC on 1 April 2010 with no restrictions. Actions continue to ensure that this status is retained; assurance is considered at the quarterly meetings of the CQSG Committee.

3.1.2   The Trust remains compliant with the CQC registration requirements.

3.1.3   Following the CQC inspection in January, their report was published at the end of May, and has been fully discussed by the Board. The overall rating was Good; ratings for four of the five domains were also Good, while the rating for safety was Requires Improvement.

An action plan covering all five domains has been approved and is being implemented; the CQSG Committee will continue to monitor the progress and completion of these actions.

3.2   Finance and Use of Resources

3.2.1   NHS Improvement will use five financial metrics to assess financial performance, scoring each metric from 1 (best) to 4 (worst), and averaging the metrics to derive a 'use of resources' score. Scoring a 4 overall, or a 3 or 4 in any individual metric, will trigger a potential support need.

3.2.2   Our current score for each of the metrics is 1, except for agency spend where we score 3. Overall our average 'use of resources' score is 1.4, which NHS Improvement rounds to 1.

3.2.3   The five metrics and details of the scoring given in the table below:

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	**Capital service capacity**	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	**Liquidity (days)**	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	**I&E margin**	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	**Distance from financial plan**	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	**Agency spend**	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

3.2.4   **Capital service capacity-** This measures the degree to which our generated income covers our financial obligations (Public Dividend Capital). At the end of September the Revenue available for Capital Service Cover was £1,927k which is 6.62 times greater than our PDC of £291k. The Trust achieved the top rating of 1 as 6.62 is larger than the 2.5 requirement. There is a cushion in the surplus of £1,201k before the rating falls to 2.

3.2.5   **Liquidity-** This measures to what extent our net assets (in days) could cover the average operating expenses per day. After quarter 2 we

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Single Oversight

achieved a rating of 1 with 8.8 days of cover against a target of 0.

3.2.6 **Income & Expenditure (I&E) margin-** This measures whether I&E surplus is greater than 1% for the highest rating of 1. As our surplus is £1,180k generated from £24,611k operating income the margin is 4.79% which equates to a rating of 1. The surplus would have to reduce by £938k to reduce the rating to 2.

3.2.6 **Distance from financial plan -** At the end of quarter 2 the I&E margin of 4.79% is ahead of the planned margin of 1.76% by 3.03% which results in a rating of 1. A reduction of £778k in the surplus would reduce the rating to 2.

3.2.7 **Agency cap** – the current cap is £728k for the year. Agency staff expenditure was £467k after 6 months, which is 28% over the cap set by NHS Improvement. This means a score of 3 for this metric. It is essential that we do not exceed the cap by more than 50%, which would mean a score of 4 and act as a trigger for concern.

3.3 Operational Performance

3.3.1 The target is 95% completeness on six data metrics within the Mental Health Services Data Set (MHSDS), and from April 2017, 85% completeness on 5 'priority' metrics from the MHSDS.

3.3.2 Current statistics confirm that we are still meeting and generally exceeding the data identifiers target: see table below.

	Target (%)	Month 5, provisional	Month 4, final
Valid NHS number	95	99.6	99.7
Valid Postcode	95	99.5	99.6
Valid Date of Birth	95	100	100
Valid Organisation code of Commissioner	95	99.7	99.7
Valid Organisation code GP Practice	95	99.8	99.8
Valid Gender	95	100	100

3.3.3 We do not currently meet the targets on the five additional "priority" metrics within the MHSDS, which come into force in April 2017.

	Target (%)	Month 5, provisional	Month 4, final
Ethnicity	85	77.2	
Employment Status (for adults)	85	29.0	

Page 6

School Attendance (for CYP)	85	(25.0)	
Accommodation status (for adults)	85	28.0	
ICD10 coding	85	-	

Informatics is undertaking a schedule of work against each of the measures listed above. A current status on each can be found below:

Ethnicity – as with all the above data items the necessary function is already available in Carenotes to collect this data. A report has been set up to allow services to report on completeness of this field to allow service leads to drive completion. A communication exercise is being undertaken to prompt staff to complete this field correctly (i.e. if a patient does not wish to state their ethnicity to enter this into the system as a response and not to leave the field blank in error or select other incorrect options).

Employment status – the function to collect this data already exists within Carenotes however uptake and usage is poor. A communication exercise will be undertaken to enforce the requirement for completion of the field with Trust staff working within Adult service lines. Reports are already available on reporting services regarding completeness of this data item and are accessible to service leads.

School attendance – Informatics are seeking clarification on this requirement from NHS Digital. Once that is received a plan for implementation will be developed. Informatics think it is likely that metric means "is the child registered with a school", in which case our current result is 25% complete.

ICD10 Coding - We have not actively collected ICD10 in the past as it is not directly applicable to the mechanisms of care undertaken at this Trust. We have an existing exemption from NHS Digital over this measure with regard to the Information Governance Toolkit. NHS Improvement have confirmed that this exemption will also be applied to the Single Oversight Framework.

3.4 Strategic Change

3.4.1 We are fully engaged with the Sustainability and Transformation Planning process within North Central London. The STP was submitted on the 21st October.

3.5 Leadership and improvement capability

Single Oversight

3.5.1 The CQC rated us 'good' under the well-led domain this year.

3.5.2 The national staff survey put us in the upper quartile for NHS Trusts.

3.5.3 Patient surveys- our Experience of Service Questionnaires (ESQ) data shows very high patient satisfaction.

3.5.4 We are currently breaching the agency spending cap. Controls have been put in place over future agency use, and plans are being developed to reduce the current spend.

3.5.5 Delivering Workforce Race Equality Standard – there has been small but positive movement but significant work still needs to be done.

3.5.6 Use of data – the implementation of CareNotes has significantly increased the capacity of the Trust to gather and use data, and the optimisation programme is delivering improvements in our ability to use that capacity.

4 **Other matters**

4.1 The Trust is required to report any incidents, events or reports which may reasonably be regarded as raising potential concerns over compliance with our licence. Examples where such a report would be required include unplanned significant reduction in income or significant increase in costs; discussions with external auditors which may lead to a qualified audit report; loss of accreditation of a Commissioner Requested Service; an adverse report from internal auditors; or patient safety issues which may impact compliance with our licence.

4.2 There are no events, incidents, or reports which may reasonably be regarded as raising potential concerns over compliance with our licence

Gervase Campbell
Trust Secretary
7th November 2016

Board of Directors : November 2016

Item : 20

Title : Proposed revised Data Quality Policy

Summary:

The policy has been substantively rewritten, and as policy is a matter reserved to the Board, it must be approved by The Board. It addresses the Board's strategic plan to improve data quality. The executive is following through by operationalising the policy.

This report has been reviewed by the following Committees:
- Executive Management Team, September
- Data Analysis and Reporting Committee (DARC), September

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

- Quality
- Patient / User Experience
- Risk

For : Approval

From : Deputy SIRO and Governance Manager

Data Quality Policy

Version:	2
Approved by:	
Date Approved:	
Lead Manager:	Associate Director Quality and Governance
Consultation	Director Quality and Patient Experience, HR Director, IM&T Director, Finance Director, Commercial Director, DET Director, AF Director, CYAF Director, Governance Manager, Head of Contracts, AF Head of Admin, CYAF Head of Admin., DARC.
Lead Director:	Director Quality and Patient Experience
Date issued:	
Review date:	

Is this policy current? Check the intranet to find the latest version!

Contents

Data Quality Policy

Data Quality Policy

1   Introduction

The importance of having data of the highest quality on which to base its decisions, whether clinical, managerial, or financial, is recognised by the Trust. The importance of having robust systems, processes, data definitions and systems of validation in place to assure data quality is part of this process. The quality of data can affect the reputation of the Trust and may lead to financial penalty in certain circumstances, e.g. failing to meet contractual requirements such as Key Performance Indicators (KPIs), Commissioning for Quality and Innovation targets (CQUINs) and other reportable outcome measures.

Information accuracy is a legal requirement under the Data Protection Act and Public Records Act.

Complete and accurate data are essential to support effective decision making across the spectrum of Trust functions, including:

- Patient Care – in the delivery of effective, relevant and timely care, thereby minimising clinical risk.
- Good Clinical Governance – a pre-requisite for minimising clinical risk and avoiding clinical error and misjudgement.
- Disclosure – ensuring that clinical and administrative information provided to the patient and authorised health partners, including external partners is of the highest quality.
- Business planning – ensuring management can rely on the information to make informed and effective business decisions.
- The measurement of activity and performance to ensure effective distribution and use of Trust resources.
- Regulatory reporting – to ensure compliance with the standards and targets as laid down in measures such as CQUIN, IG Toolkit and Monitor Assessments.
- Good corporate governance – which, as above, has data quality as a pre-requisite to ensure effective business management.
- Legal compliance – ensuring that the Trust conforms to its legal obligations as laid down in relevant legislation, such as Data Protection Act.
- Education and Training – in the development and delivery of quality education and training provision and the effective administration of the student journey.

2   Purpose

The purpose of this policy, is to provide general principles for the management of all data and guidance. This is to ensure that the Trust can take decisions based on accurate and complete data and can meet its various legal and regulatory responsibilities.

3   Scope

This policy is applicable to:
- All data held and processed by the Trust.
- All data must be managed and held within a controlled environment and to a standard of accuracy and completeness. This applies to data regardless of format.

    This policy must be applied by all permanent, contract or temporary staff, clinical and non-clinical and all third parties who process Trust data.

4   Definitions

Data quality is a measure of the difference between data collected on information systems or manually, against the true experience of the subject (eg for patient data), or the true occurrence of an event (e.g. for financial data).

Data validation is defined as systems and processes employed to verify the accuracy and completeness of data that is collected.

5   Principles of Data Quality

Data quality can be said to be 'high' if the data accurately portray exact details and/or events that actually took place. Measuring data quality can be vexatious and problematic, which is why the following principles should be considered when doing so.

5.1   Accessibility

Information can be accessed quickly and efficiently through the use of systematic and consistent management in electronic (and physical) format. Access must be appropriate so that only those with a lawful basis and legitimate relationship to the data may view, create or modify them.

5.2   Accuracy

Data (and information) are accurate with systems, processes and practice in place to ensure this. Any limitations on accuracy of data must be made clear

to its users and effective margins of error need to be considered for calculations.

5.3 Completeness

Completeness can have a real impact on the quality of data. The evaluation of data quality must monitor for missing, incomplete or invalid information as well as identification of future or occurring causes and the associated risks.

5.4 Relevance

Data captured should be appropriate for the intended purpose and never excessive.

5.5 Reliability

Data and information must reflect a stable, systematic and consistent approach to enhance reliability. Review and enforcement of collection methods of data must be considered to ensure a positive impact on the quality or content of any information produced.

5.6 Timeliness

Data should be recorded as close as possible to being gathered and should be accessed quickly and efficiently, in line with the Data Protection Act.

5.7 Validity

Validity is supported by consistency over time, systems and measures; data must be collected, recorded and utilised to the standard set by relevant requirements or controls. Any information collection, use or analytical process must incorporate an agreed validation method or tool to ensure the standards and principles outlined above are met. Validation tools will support routine data entry and analysis, as well as supporting the identification and control of duplicate records and other errors.

6 Duties and Responsibilities

6.1 Chief Executive

The Chief Executive (CE) has overall responsibility for data quality systems and processes in the Trust. The CE is responsible for signing the statement of assurance of clinical data quality included in the annual Quality Report.

> The responsibility for data quality is delegated through the Trust management structure, with specific responsibilities allocated as below.

6.2 Senior Information Risk Owner (SIRO)

The Trust's Senior Information Risk Owner (SIRO) is a director appointed by the Board of Directors (BD) who takes ownership of the organisation's information risk policy and acts as the advocate for information risk on the Board. The SIRO reports to the BD through the Clinical Quality, Safety, and Governance Committee.

6.3 **Finance Director** The Finance Director is responsible to the Board for assurance that systems and processes for finance data quality are in place and working effectively, and alerting the Executive Management Team (and the Board of Directors, if appropriate) of any significant risks to finance data quality.

6.4 Director of Quality and Patient Experience

The Trust's Director of Quality and Patient Experience is responsible to the Board for assurance that systems and processes for clinical data quality are in place and working effectively, and alerting the Executive Management Team (and the Board of Directors, if appropriate) of any significant risks to clinical data quality.

6.5 Associate Director of Quality and Governance

The Associate Director has operational responsibility for all clinical data quality reports. The Associate Director will liaise with internal and external stakeholders to streamline and reduce the collection burden wherever possible.

6.5 Governance Manager

The Governance Manager has responsibility for the strategic and operational management of information governance, and for providing subject matter expertise in this area. The manager will assess quality of data related evidence submissions for the IG toolkit submissions.

6.6 Clinical Governance Manager

The manager will lead on the management of data for clinical audit, patient safety, safeguarding, PREVENT, CHANNEL, and will monitor clinical incident data for clinical risk and revalidation management purposes.

6.7 Data Quality Manager

The Data Quality Manager is responsible for providing guidance and support across a range of clinical data collection processes and advises on data quality improvements or changes necessary for reporting on the current and developing performance measures, such as CQUINs and KPIs.

6.8 Directors

Directors are responsible for the collation and validation of data in their respective directorates, alerting the Executive Management Committee (and the Board of Directors, if appropriate) of any significant risks to the data quality. Areas of responsibility are as follows:

Dataset	Data Quality Assurance Lead
Financial data	Director of Finance
IM&T data	Director of IM&T
Patient data (electronic and paper records)	Directors of CYAF and Adult and Forensic services
HR records	Director of HR
Membership records data	Trust Secretary
Staff administration records	All Directors
Education and Training data	Director of DET

6.9 Managers

Managers are responsible for ensuring the quality of data within their teams, adhering to this policy and implementing the associated Data Quality Management Procedure.

6.10 Head of Informatics

The Head of Informatics is responsible for developing and validating reports based on commissioning and management requirements. The post holder also advises on tools and processes to monitor and measure the level of data quality within the Trust's electronic patient system. This responsibility extends to providing an early warning system of potential risks and actively monitoring and commentating on performance trends. The post holder works closely with the Data Quality Manager and Head of Contracts.

6.11 Chief Clinical Information Officer

The CCIO is a clinician responsible for developing information in support of better care. The CCIO will provide clinical and professional leadership to clinicians, informatics and the Quality Directorate to help ensure that the Trust delivers safe, effective, evidence-based and accessible services and systems to meet the health and care knowledge and information needs of patients and services users. The CCIO will also improve accountability and strengthen governance of the quality of the Trust's data by reviewing the Trust's performance in secondary use assurance.

6.12 Head of Contracts

The post holder is responsible for 'sense-checking' any data and information that will be reported to commissioners, as well as providing robust definitions

and assurance of commissioning and reporting requirements.

6.13   All Staff

All staff have a responsibility to ensure the data they enter onto any system – electronic or manual is of good quality and follow Trust and local procedures for the validation of data.

7   Procedure for data quality management

Each director/manager listed in section 6 will publish procedures, or standard operating procedures, as indicated in order to discharge this policy in their domain.

8   Training

The importance of data quality will be included in:
- the Trust's mandatory training (INSET) and induction programme, as part of the IG presentation;
- bespoke Outcome Monitoring training provided by the Quality Team (clinical data);
- general CareNotes training offered by the Informatics department (clinical data).

Training issues with systems and/or other specific processes should be addressed on an individual basis as they arise.

9   Process for monitoring compliance with this policy

Data quality is ultimately the responsibility of department leads where the specific data are being generated. Processes for ensuring high data quality will differ between teams and should be implemented and reviewed locally.

Clinical data quality oversight is via the Quality Team which reports to the Data Quality Review Group (an operational group), which in turn reports to the DARC committee who are accountable to the Executive Management Team. The DQRG is responsible for escalating issues of clinical data that have strategic significance.

Assurance of management information systems, including assurance of data quality performance against the IG toolkit standards, is considered by the EMT and overseen by the Information Governance Work Stream of the Clinical Quality, Safety and Governance Committee on a quarterly basis. The Associate Director of Quality and Governance will

Data Quality Policy

provide a draft quarterly report to the CCIO for consideration and feedback, before submitting it to the IG work stream.

The CQSG reports to the Board of Directors quarterly and flags clinical data quality risks via reports and via the operational risk register. The CQSG also assures the quality of the draft Annual Quality Report in advance of presentation to the Board for approval.

Independent audit of all aspects of the Trust's business, including data quality are subject to periodic internal and external audit reviews. Findings and recommendations from these audits and subsequent action plans to address deficiencies are monitored by the Executive Management Team. These are overseen by the Audit Committee, which reports directly to the Board.

10   References

Data Protection Act: http://www.legislation.gov.uk/ukpga/1998/29/contents

NHS Information Governance Toolkit: https://nww.igt.hscic.gov.uk/

11   Associated documents[1]

This policy should also be considered in conjunction with all the policies and legislation, especially those highlighted below:

Health records management procedure
Health records audit procedure
Confidentiality Code of Conduct
Data Protection Procedure
Information Asset Acceptance and Registration Procedure
Information Governance Policy
Risk Management Strategy and Policy
Corporate and DET Records Procedure
Records Retention Schedule

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

12   Data Pathways

Diagram of data flows within the Trust with simplified validation and resolution procedures.
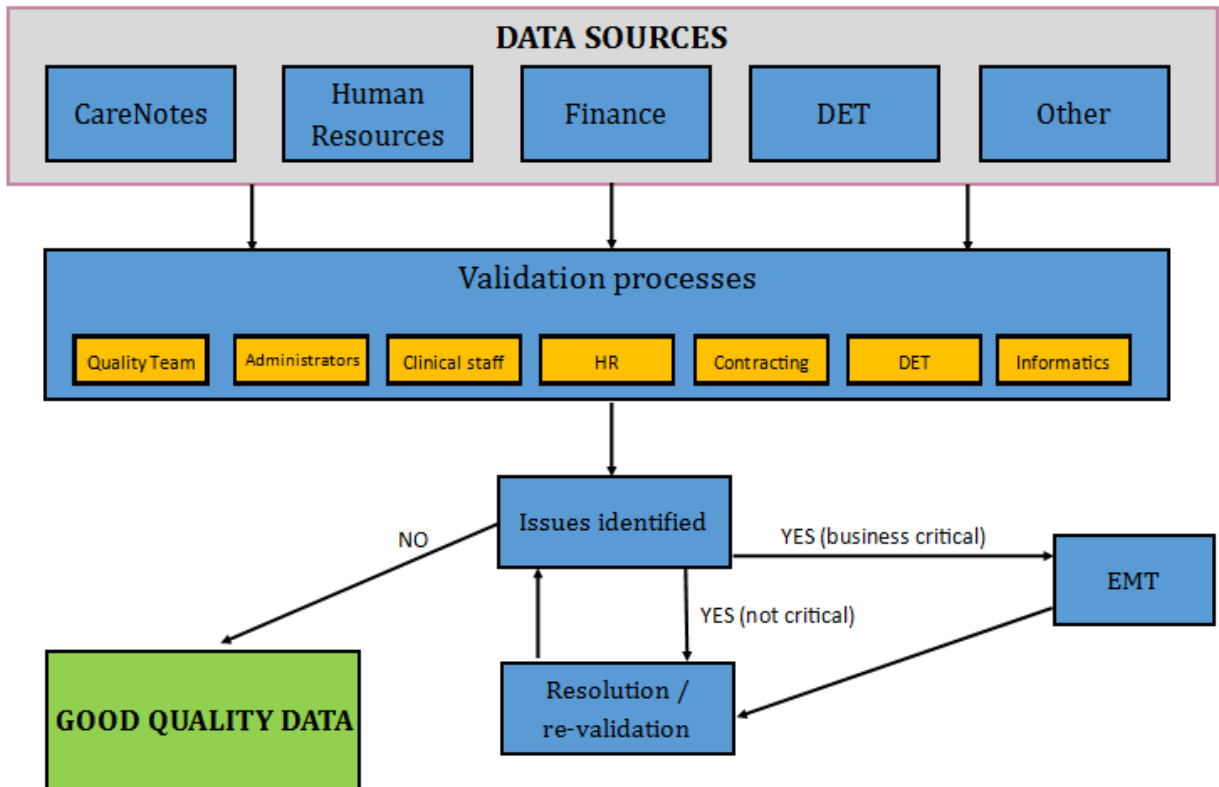
13   Appendix: Equality Analysis for Policies and Procedures

Completed by	Lee Chesham
Position	Data Quality Manager
Date	29 Jul 16

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.

If the answer to *any* of the questions was yes, then undertake the following analysis:

	Yes	No	Comment
Do policy outcomes and service take-up differ between people with different protected characteristics?		X	
What are the key findings of any engagement you have undertaken?			Wide consultation including Data Quality Assurance Leads and DARC. Approval of the policy.

If there is a greater effect on one group, is that consistent with the policy aims?		X	
If the policy has negative effects on people sharing particular characteristics, what steps can be taken to mitigate these effects?		X	
Will the policy deliver practical benefits for certain groups?		X	
Does the policy miss opportunities to advance equality of opportunity and foster good relations?		X	
Do other policies need to change to enable this policy to be effective?	X		Yes, Each director/manager listed in section 6 will need to publish procedures, or standard operating procedures, as indicated in order to discharge this policy in their domain.
Additional comments			

If one or more answers are yes, then the policy may unlawful under the Equality Act 2010 –seek advice from Human Resources (for staff related policies) or the Trust's Equalities Lead (for all other policies).

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

Board of Directors : November 2016

Item : 21

Title : Register of Interests

Summary:

The Directors' Register of Interests if presented for approval.

This report focuses on the following areas:

- Governance

For : Approval

From : Trust Secretary

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Register of Directors' Interests 2016/17

1.   Introduction

All existing Directors shall declare relevant and material interests forthwith and the Trust shall ensure that those interests are noted in the *Register of Directors' Interests*. Any Directors appointed subsequently shall declare their relevant and material interests on appointment. At the time the interests are declared this shall be recorded in the minutes of the Board of Directors meeting as appropriate. Any changes in interest shall be officially declared at the next meeting of the Board of Directors following the change occurring. It is the obligation of the Director to inform the Trust Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest and the membership. If a Director has a doubt about the relevance or materiality of any interest this should be discussed with the Trust Chair.

2.   Declaration

Board Member:	Interests Declared:
Prof Paul Burstow (Trust Chair)	• Managing Director, Indy Associates Ltd. • Trustee, The Silver Line • Trustee, Action on Smoking & Health (ASH)
Mr Paul Jenkins (Chief Executive)	• Member, and previous CEO, Rethink Mental Illness • Trustee, Joseph Rowntree Trust and Joseph Rowntree Housing Foundation.
Prof Dinesh Bhugra (NED)	• Secretary, Porism Ltd • Director, dKb Consulting • President, World Psychiatric Association • President, Mental Health Foundation • Trustee, Care-IF • Trustee, Sane
Ms Chris Caldwell (Director of Nursing)	None
Ms Helen Farrow (NED)	None
Ms Jane Gizbert (NED)	None
Dr Sally Hodges (Director of CYAF)	None
Mr David Holt (NED)	• Non-Executive Board Member, Hanover Housing Association • Chair, Merton Regeneration Board (Circle Housing Association) • Chair of Audit Committee, NED, Whittington Health NHS Trust. • Deputy Chair, Ebbsfleet Development Corporation • NED, Planning Inspectorate

Ms Louise Lyon (Director of Quality & Patient Experience	• Chair, Tavistock Clinic Foundation
Ms Edna Murphy (NED)	• Senior Manager, University College London (UCL)
Mr Terry Noys (Deputy Chief Executive & Finance Director)	None
Mr Brian Rock (Director of Education & Training; Dean)	None
Dr Rob Senior (Medical Director)	• Married to Chair of City and Hackney CCG
Dr Julian Stern (Director of Adult & Forensic Services)	None

November 2016

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 29th November 2016, 14.00 – 16.30
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES

1.	**Chair's Opening Remarks** Prof Paul Burstow, Trust Chair		Verbal	-
2.	**Apologies for absence and declarations of interest** Prof Paul Burstow, Trust Chair	To note	Verbal	-
3.	**Minutes of the previous meeting** Prof Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	**Outstanding Actions** Prof Paul Burstow, Trust Chair	To note	Verbal	-
4.	**Matters arising** Prof Paul Burstow, Trust Chair	To note	Verbal	-
5.	**Trust Chair's and NEDs' Reports** Prof Paul Burstow, Trust Chair	To note	Verbal	p.9

Strategy

6.	**Trust Objectives – Success Criteria** Mr Paul Jenkins, Chief Executive	To approve	Enc.	p.10
7.	**Review of Board Assurance Framework** Mr Paul Jenkins, Chief Executive	To approve	Enc.	p.19
8.	**NCL Sustainability and Transformation Plan** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.42
9.	**Mission and Values Statement** Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.115
10.	**Draft Two Year Operational Plan** Mr Paul Jenkins, Chief Executive	To discuss	Late	-

Reports

11.	**Service Line Report – Gloucester House Day Unit** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.119
12.	**Chief Executive's Report** Mr Paul Jenkins, Chief Executive	To note	Enc.	p.129
13.	**Waiting Times Analysis** Marion Shipman, Associate Director Quality and Governance	To discuss	Enc.	p.132
14.	**Finance and Performance Report** Mr Terry Noys, Deputy Chief Executive and Finance Director	To discuss	Enc.	p.147

15.	**Training and Education Report** Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.156
16.	**Clinical Quality, Safety & Governance Committee Report** Dr Rob Senior, Medical Director	To approve	Enc.	p.159
Governance			
17.	**Deputy Chair Appointment, Current NED Links and Committee Memberships** Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.171
18.	**Sign Up to Safety Plan** Ms Louise Lyon, Director of Quality and Patient Experience	To approve	Enc.	p.177
19.	**Single Oversight Framework** Mr Gervase Campbell, Trust Secretary	To note	Enc.	p.189
20.	**Data Quality Policy** Ms Louise Lyon, Director of Quality and Patient Experience	To approve	Enc.	p.197
21.	**Declarations of Interest** Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.210
22.	**Notice of Future Meetings** • Thursday 1st December 2016: Council of Governor's Meeting, 2.00pm – 5.00pm, Lecture Theatre • Tuesday 6th December 2016: Leadership Conference, 9.45am – 1.45pm, Lecture Theatre • Tuesday 31st January 2017: Board of Director's Meeting, 2.00pm – 5.00pm, Lecture Theatre			
Close			