

## Board of Directors Part One

### **Agenda and papers**

of a meeting to be held in public

2.00pm–4.30pm  
Tuesday 25<sup>th</sup> April 2017

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



## BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 25<sup>th</sup> April 2017, 14.00 – 16.30  
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

### AGENDA

PRELIMINARIES				
1.	<b>Chair's Opening Remarks</b> Prof Paul Burstow, Trust Chair		Verbal	-
2.	<b>Apologies for absence and declarations of interest</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
3.	<b>Minutes of the previous meeting</b> Prof Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	<b>Outstanding Actions</b> Prof Paul Burstow, Trust Chair	To note	Enc.	p.7
4.	<b>Matters arising</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS				
5.	<b>Patient Story</b> Psychoanalytic Portfolio Student	To note	Verbal	-
6.	<b>Service Line Report: Psychoanalytic Portfolio</b> Ms Katie Argent, Portfolio Lead	To discuss	Enc.	p.8
7.	<b>Trust Chair's and NED's Reports</b> Prof Paul Burstow, Trust Chair	To note	Verbal	-
8.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.20
9.	<b>People Strategy</b> Mr Craig de Sousa, Director of HR	To approve	Enc.	p.23
10.	<b>Apprenticeships Levy Update</b> Dr Chris Caldwell, Nursing Director	To discuss	Enc.	p.57
11.	<b>Mental Health Workforce Development Collaborative</b> Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.62
12.	<b>Clinical Complaints and whistleblowing report</b> Ms Amanda Hawke, Complaints Manager & Ms Gill Rusbridger, Freedom to Speak Up Guardian	To discuss	Enc.	p.73
13.	<b>Smoke Free Policy</b> Ms Marion Shipman, Associate Director of Quality and Governance	To approve	Enc.	p.83
14.	<b>Draft Quality Report</b> Ms Louise Lyon, Director of Quality and Patient Experience	To discuss	Enc.	p.102

15.	<b>Dashboard Report Q4</b> Ms Julia Smith, Commercial Director	To discuss	Enc.	p.170
16.	<b>Quality Report Q4 narrative</b> Ms Marion Shipman, Associate Director of Quality and Governance	To discuss	Enc.	p.181
17.	<b>Waiting Times Quarterly Report</b> Ms Louise Lyon, Director of Quality and Patient Experience	To discuss	Enc.	p.189
18.	<b>IMT Q4 report</b> Mr David Wyndman Lewis, IT Director	To discuss	Enc.	p.210
19.	<b>Finance and Performance Report</b> Mr Terry Noys, Deputy CEO and Finance Director	To discuss	Enc.	p.213
20.	<b>T&amp;E Report</b> Mr Brian Rock, Director of E&T/ Dean	To note	Enc.	p.220
<b>CLOSE</b>				
21.	<b>Notice of Future Meetings:</b> <ul style="list-style-type: none"> <li>23<sup>rd</sup> May Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre</li> <li>27<sup>th</sup> June Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre</li> <li>25<sup>th</sup> July Board of Directors' Meeting, 2.00-5.00pm, Board Room</li> </ul>			



## Board of Directors Meeting Minutes (Part One)

### Tuesday 28<sup>th</sup> March 2017, 2.00 – 4.00pm

Present:			
Prof. Paul Burstow Trust Chair	Prof. Dinesh Bhugra NED	Dr Chris Caldwell Nursing Director	Ms Helen Farrow NED
Ms Jane Gizbert NED	Dr Sally Hodges Director of CYAF	Mr David Holt NED, SID, Audit Chair	Mr Paul Jenkins Chief Executive
Ms Louise Lyon Director of Q&PE	Ms Edna Murphy NED, Deputy Chair	Mr Terry Noys Deputy CEO and FD	Mr Brian Rock Director of E&T/ Dean
Dr Rob Senior Medical Director	Dr Julian Stern, Director of AFS		
Attendees:			
Mr Gervase Campbell, Trust Secretary	Mr John Ratchford, Comms officer (item 13)	Mr Craig DeSousa, HR Director (item 9,10)	
Apologies:			

#### Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to the minutes	GC	Immd.
2	11	Arrange annual event for interactive discussion of Serious Incident cases to share learning amongst all clinicians	RS	Sept.
3	11	Audit of similar cases to BB to be undertaken to check closure procedures were followed.	RS/SH	June.

#### 1. Chair's Opening Remarks

Prof. Burstow welcomed the directors to the meeting.

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

Apologies as above.

#### 3. Minutes of the Previous Meeting

**AP1** The minutes were approved with minor amendments

#### 4. Matters Arising

Action points from previous meetings:

OAP1 – (TC report to Board) – on today's agenda, completed.

#### 5. Trust Chair's and NEDs' Reports

Prof Burstow noted his attendance at the 2017 International Initiative on Mental Health Leadership (IIMHL), and the interesting comparisons in young people's mental health systems that had been discussed over lunch. Ms Murphy noted her visit to the Mental Health Network event. Ms Farrow described her visit to GIDS and the experience of the large team meeting held via video link. Prof. Bhugra noted that he was working with Ms Harris on a meeting with the Mental Health Institute of India in October, and a two day masterclass in Sweden that would be sponsored by the Trust, but at no cost to the Trust.

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

Mr Jenkins highlighted the visit of representatives of the Health and Education select committee, which was held in Regent's High School to showcase our joined up schools based working. He noted that the Trust would shortly take on the contract for West London GIC, and there would be a welcome event on the 3<sup>rd</sup> April. Mr Jenkins closed by noting that this was the last board meeting Mr Campbell would attend, and a replacement had been appointed: Ms Terri Burns, who would work jointly with Camden and Islington.

The Board **noted** the report.

## **7. Finance and Performance Report**

Mr Noys introduced the report by noting the Trust would meet the Control Total for the year. He noted that staffing costs were down overall in Education and Training, but costs for visiting lecturers had risen, partly due to a shortage of permanent staff but also due to courses overperforming and staff being taken on to cover the demand.

Ms Farrow noted that agency costs were currently 4%, but forecast to be 7% at year end. Mr Noys explained that they expected higher costs at the end of the year, and it only took a couple of high cost temps to push the percentage higher. Prof Burstow asked what management actions were being taken to address agency usage, and Mr Noys explained that all interim staffing requests had to be approved by the CEO and HR Director, and were well controlled. He noted that the assigned cap of 2% was very tight and they had approached NHS Improvement to request it be raised. Mr Jenkins added that controls had reduced the rate to the point it was no longer a risk to the Trust's rating, and it was expected to reduce further in the coming year.

The Board **noted** the report.

## **8. 2017/18 Revenue and Capital Expenditure Budget**

Mr Noys noted that the proposed budget met the increased Control Total of £950k set by NHS Improvement. Following discussions with Directors most of the required £2M efficiency savings had been found through a combination of savings and growth plans, but there was currently £400k that remained to be found. In addition £200k of income from new sources would need to be found, and whilst this had not yet been identified it was achievable based on the past performance of the Trust. He noted the risks outlined in section 8 of the report, especially the FDAC London contract which was worth £700k and was out to tender. Education and Training income was key to achieving the budget, and whilst they were in a better position than in the previous year, it would be a challenge. He noted that section 6 should read as Camden TAP's income was reducing, not being lost entirely.

Mr Holt asked about cash flow, and Mr Noys commented that whilst £1.5M was tight it was manageable, and assumed no draw down of additional funding, but they were still exploring the ITFF resource and had an overdraft facility.

Ms Farrow noted the required increase in student numbers, and asked how confident the directorate was of achieving them. Mr Rock agreed they would be stretched, but the increase was less than they had looked for in the previous year and a lot of work had been done to improve the recruitment cycle this year, as well as to ensure that growth could be targeted to those courses that gave the most contribution.

The Board **approve** the budget for 2017/18.

## 9. NHS Staff Survey

Mr DeSousa reported that there had been a significant increase in the response rate to the survey, which allowed interrogation of the data at a more granular level. There had not been much statistically significant change to results from previous years, and they continued to be good overall and good compared to other mental health trusts. There continued to be troubling results in additional hours worked, workplace stress, and bullying and harassment – these were concerns that were known to the Board and were highlighted at the recent Thinking Space event where clinicians spoke of an erosion of their time to engage in reflective practice. In bullying and harassment some steps have already been taken, including an overhaul of the procedure to make it less mechanistic in the hope of encouraging issues to be raised and dealt with effectively and quickly. HR would continue to work with managers in hotspots such as CAMHS Open Minded, some of the portfolios, and clusters within corporate functions.

The directors discussed the results in depth, exploring some of the contradictions such as low motivation, but high engagement and high recommendation of the Trust as a place to work. They applauded the granularity, but suggested consideration of the context of the results, such as the scale of restructuring that had occurred over the year in CAMHS Open Minded needed to be taken into account. Ms Lyon suggested that the results confirmed the importance of the Race Equality work the Trust has engaged in.

Mr Jenkins suggested that the results reflected a year of pressure on staff, which was something that came up time and time again in engagements with staff at all levels. The Trust had not lost the special level of engagement and identity, but there was pressure at the edges, and this was the perfect time for the introduction of the People Strategy, and for making staff issues more of more central concern to the organisation and to the Board. The importance of developing managers who could lead change and engage staff; the importance to follow up on the Board's commitment to diversity and BAME staff. Whilst there were elements of the pressure that were externally imposed and beyond control, it was more important than ever to tackle areas that were, such as data burdens, and to do so visibly.

The Board **noted** the report.

## 10. Draft Organisational Development and People Strategy

Mr DeSousa introduced the strategy, noting that it was the product of discussions and consultations with staff and stakeholders over the past year. It included the best of what was already being done within the organisation, brought out and systematised, combined with best practice from other organisations.

The directors discussed the strategy, and the importance of modelling expected behaviours within the Trust in particular the value of psychologically informed practice. . Given the pressure on staff already the Board asked for the strategy to include timescales to the action plan to enable realistic prioritisation. Mr Rock suggested that one of the aspects of work that was meaningful to clinical staff was time to develop skills, to engage in research or to publish, and these were also valuable to the Trust and should be supported. Dr Stern noted that the pressure for lower banded posts meant there were less opportunities for career progression, and Mr DeSousa commented that one way to try and address this was to develop career pathways across organisations within the STP. Dr Caldwell added that progression could also be horizontal and involve gaining capability and doing the existing job better, and this was of more concern to millennials who were now entering the workforce.

Prof Burstow summarised that the strategy needed to:

- Pull out and focus on bullying and harassment, and conduct further work to triangulate a range of sources of evidence about the level and nature of the issue to ensure the Board have a full understanding of the problem.
- Emphasise the use of psychologically informed models with regards to stress and wellbeing and ensure that the Trust models them in its own practice.
- Expand the piece on development of commercial skills, making this a more visible focus of the strategy, as this is an integral element to the Trust's overall strategy and relevant to the personal and professional development of all staff.

A final version of the People Strategy will be brought to the Board for approval.

The Board **noted** the report.

## 11. Serious Incident Reports

Dr Senior introduced two reports by noting that they were presented in the public section of the meeting for the first time to ensure greater transparency, and asked for the Board's approval for this approach in the future. He explained that the two cases had been through thorough formal investigations so that all possible lessons could be learnt, and asked if the action plans presented were proportionate and sufficient.

The directors discussed the importance of being transparent and agreed that the reports should always be taken in part 1 in the future, whilst noting that there

would be important questions of confidentiality and consent from those involved to consider.

**AP2**

The Board discussed case AA, where the finding was that the actions of the Trust did not substantially contribute to the tragedy. They agreed that there were important lessons to learn over communication, and in handling of complex cases, where complexity suggested not only the multi-agency nature of the referral but also to the importance of consideration of co-morbidity in assessment. There was a thorough discussion of how the learning from cases such as this is spread beyond the team involved to the whole Trust. Although there were various mechanisms in place, such as the clinical governance committees, the inductions and INSET events, and the Quality News newsletter, it was agreed that these were not sufficient and a more interactive forum where clinicians could discuss the actual, compelling, cases would embed the learning more deeply. It was agreed that Dr Senior would organise an annual half-day event for all clinicians to share learning from serious incidents.

**AP3**

Prof. Burstow asked about for further consideration to be given to putting the most experienced staff on the front end of the process to allow more nuanced decisions about escalation.

The Board discussed case BB, there was some concern over the way the case was closed and whether other cases at the time might have been treated in the same way, and it was agreed that an audit of the relevant cases would be undertaken.

The Board **noted** the reports.

## **12. Training and Education Report**

Mr Rock introduced the report, highlighting the international development work being done, and that Dr Caldwell would be taking on a leadership role with the National Workforce Skills Development Unit, and recruitment was in process for an Associate Director to lead the unit.

Mr Holt noted the increase in applications over this time last year, and asked whether it was likely to reflect an increase overall, and what the conversion rates were. Mr Rock suggested it was too early to tell if it was an early peak or would translate into an increase overall, and noted that the conversion rate of applications was 60%, climbing to 95% of those given an offer. He explained they were aiming to start interviews earlier, and Ms Murphy agreed that this was important, as the human connection kept people involved. Prof. Burstow asked that future reports include the previous year's figures to allow the Board to compare progress.

The Board **noted** the report.

## **13. Annual General Meeting proposal**

Mr Ratchford introduced the proposal to hold the AGM on the 4<sup>th</sup> October, and to focus on the gender identity work as the theme. The directors discussed whether

the AGM was best used to promote less know services, or to celebrate the work of higher profile teams, and decided that in this case it would be of great benefit to celebrate the gender identity work within the Trust, and to welcome the new GIC service publicly to the Trust.

The Board **approved** the recommended theme.

#### **14. Risk Strategy/Policy**

Mr Noys introduced the policy, which had been updated to include the suggestions from the February meeting. Ms Hodges noted that page 147 did not make clear that it referred to the clinical directors, and the director of E&T.

The Board **approved** the policy, with the changes suggested.

#### **15. Any Other Business**

The Board noted its future meetings

Part one of the meeting closed at 4.05pm

Action Point No.	Originating Meeting	Action Required	Director / Manager	Due Date	Progress Update / Comment
1	Jan-17	Develop Race Equality Strategy	Louise Lyon	Apr-17	Due May
2	Jan-17	Invite GIC staff to meet directors	Sally Hodges	Apr-17	Arranged for April lunch session
1	Feb-17	Include W/T plans in GICS Service Line Report	Polly Carmichael	May-17	
2	Mar-17	Arrange annual event for interactive discussion of Serious Incident cases to share learning amongst all clinicians	Rob Senior	Sep-17	
3	Mar-17	Audit cases similar to BB to check closure procedures followed.	Sally Hodges/ Rob Senior	Jun-17	





## Board of Directors : April 2017

**Item : 6**

**Title :** Service Line Report - Psychoanalytic Applied Portfolio

**Purpose:**

The purpose of this report is to provide the Board of Directors with an update of progress in relation to the Psychoanalytic Applied Portfolio, within the Directorate of Education and Training (DET).

This report has been reviewed by the following Committees:

- Management Team, 28 March 2017

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

- Quality
- Risk
- Finance

**For :** Noting

**From :** Katie Argent, Portfolio Manager, Psychoanalytic Applied

## Service Line Report – Department of Education and Training Psychoanalytic Applied Portfolio

### Executive Summary

#### 1. Introduction

- 1.1 The re-structuring of the Department of Education and Training in 2015 included the establishment of six portfolios and six corresponding Portfolio Managers in order to give a greater degree of operational coherence and strategic management to our comprehensive training programme. Each portfolio falls within the remit of one of two Associate Deans, and functions to oversee, lead and develop a portfolio of linked courses.
- 1.2 This is an unusual portfolio in that all the courses seek to extend students' understanding of emotional development and human interaction, including in the workplace, while not in themselves offering a professional or clinical qualification. All of the courses provide students with a psychoanalytic way of thinking and an understanding of observation as a primary tool in making sense of experience. Many of our students undertake these courses to enhance their current working roles; some already have in mind that they will want to go on to apply to a clinical training. How and what students learn on these courses critically informs the culture of the psychoanalytic trainings they may move on to and so feeds in to the developing culture of psychoanalytic clinical practice in the Trust and elsewhere.
- 1.3 The Psychoanalytic Applied Portfolio has 11 long courses within it and in addition to the Tavistock Centre includes 10 national and Italian associate centres or alternative centres of delivery. Its long courses lead to an academic award or a Trust award. The portfolio also delivers a range of CPD courses and several long course units have recently been developed to run as CPD stand-alones. The staffing consists of one portfolio manager and 10 course leads, assessment or liaison tutors.

#### 2. Areas of Risk and/or Concern

- 2.1 **Income, student numbers and teaching groups:** for all portfolios, maximising income is essential and requires course leads continuously to review student numbers and teaching group size. This requires careful management of relationships with our excellent visiting lecturers in order to hold onto their good will – we often cannot confirm to VLs that a seminar is going ahead until just before term begins. The uncertainty that accompanies recruitment risks alienating the good teachers who attract good students and at the same time

we risk under-populating seminars and losing income if we firm up teaching contracts too early.

- 2.2 **Meeting HEE priorities and risk to course viability:** the changing framework for HEE funding requires careful articulation of the ways in which course outcomes meet HEE priorities. Where a course does not meet HEE priorities, we have to ensure that it can self-fund in order to be viable. The Portfolio Review process has been instrumental in clarifying areas where HEE criteria are met and areas of concern. In this portfolio one very long standing course – M16 Psychoanalytic Studies, which was the first Psychoanalytic Studies course to run in the UK and is highly regarded by students and our external examiner, could be at risk without a robust financial strategy.
- 2.3 **Recruitment fluctuations between centres:** we have to pay attention to recruitment patterns, bearing in mind that recruitment can fluctuate and changes to government policy can influence this either way. Two long standing courses have already been suspended from the Tavistock's delivery programme in this portfolio in 2016-17 because of concerns about recruitment levels, and there has been uncertainty about whether these courses could continue to run in other centres if employers in these different areas have been prepared to fund fees and/or study time. The concern has been to keep interested commissioners on board nationally even if we cannot prudently run a course at the Tavistock.
- 2.4 **The funding picture for clinical trainings:** psychoanalytic applied courses often function in part as foundation courses for clinical trainings, so the clinical funding context has a significant bearing on applications. As Board members will know from previous reports, the current review of healthcare education funding is underway and it is unclear whether there will be changes to the funding for the clinical training in child and adolescent psychotherapy. Potentially any significant reduction in funding could have a detrimental impact on M7, which is the main introductory course for the child psychotherapy training and is the largest course running at the Trust with 10 other centres nationally and in Italy. At the moment uncertainty about this situation does not seem to be affecting M7 applications in a major way, though Year One numbers are slightly lower this year than in recent years.
- 2.5 **Financial obstacles for students:** At interview and while on the courses, students report to us that the main obstacle to applying to and seeing through courses is financial. In these constrained times, doing an applied or introductory course is a significant financial commitment and we have to ensure that the courses continue to meet students' learning needs and aspirations, helping students make best use of the new post graduate student loans where possible.

### 3. Proposed Action Plan

- 3.1 **Income, student numbers and teaching groups:** the current Portfolio Review provides a structure within which to look at seminar size and student numbers and to explore opportunities for sharing resources between courses where appropriate and practical and for making best use of TEL. Changes to the structure of four Psychoanalytic Applied courses have already gone some way to avoid duplication in teaching across courses as well as using TEL to deliver filmed lectures to associate centres. The Portfolio supports Course Leads in negotiating sensitive relationships with VLs and in considering further possibilities for TEL.
- 3.2 **Meeting HEE priorities and risk to course viability:** linking course learning outcomes to HEE priorities in a clear and accessible way helps potential students and their employers identify which courses will be most effective in enhancing individual professional development and workforce capacity. In this portfolio we have reviewed our publicity and website information to highlight HEE priorities such as developing workforce resilience and reflective practice, enhancing work with children, young people and families and work with trauma. We will be offering course specific open evenings in addition to the Trust days and evenings where tutors will be available to talk about the added value offered to students and their employers. M16, probably the course most at risk because it does not directly address workforce needs, already attracts a high proportion of overseas students and we are exploring the potential for offering placements to professionals from overseas coming to the UK and wanting to get an experience of direct therapeutic work, supported by the course, and for offering programme associateships to professionals wanting to undertake only part of the course – usually including an infant observation, and offering parts of the course via TEL.
- 3.3 **Recruitment fluctuations between centres:** we have clarified the potential for flexibility in terms of course delivery so that a course can be delivered in some centres but not necessarily at the Tavistock. This allows us to review delivery of courses without risking shooting ourselves in the strategic foot if a course paused in one centre sustains or regains popularity elsewhere. The review of associate and alternative centres of delivery (see 4.3) is highlighting the need to balance the strategic importance of albeit small courses with income implications.
- 3.4 **The funding picture for clinical trainings:** we continue to work with the Trust Chief Executive, Dean, Chair of the Association of Child Psychotherapists, Psychoanalytic Clinical Portfolio and Course Lead for the Child Psychotherapy Training to keep abreast of the funding environment in relation to clinical training and to explore ways of sustaining the training. We are alert to the impact on introductory courses were the situation to change significantly.

- 3.5 **Financial obstacles for students:** the Department takes inclusion very seriously and considerable thought is given to balancing the requirement for courses to generate income for the Trust with keeping fees as affordable as possible. Sometimes this includes reviewing whether a course needs to continue to run in a university validated form, or whether it would be more accessible and relevant if offered purely as a Tavistock course. For example, from 2017-18 it has been agreed that D65 Reflective Mental Health Practice Today will run as a Tavistock certificate course rather than as a university validated diploma; this will enable us to lower the fee considerably and will be far more relevant for mental health nurses, who for some time have already had an academic qualification as part of their nursing training.

The Department is providing guidance to students about government loans available now at postgraduate level, though only for students who do not already have a Masters level degree. There was uncertainty at the beginning of the academic year about whether Tavistock students could apply for loans because of the structure of our collaboration with University of Essex; after substantial analysis of comparative arrangements established by other organisations, Essex agreed that this could be available to Tavistock students.

## Main Report

### 4. Overview of the Portfolio

#### 4.1 Core identity and purpose

The core functions of the courses in the Psychoanalytic Applied Portfolio are both to provide, at different levels, a learning experience that equips people to better manage and enjoy their current work with children, adolescents, adults or families and, if appropriate and wanted, to provide a pathway towards further training at the Trust. For example, approximately 50% of students in any one cohort of M7 Working with children, young people and families: a psychoanalytic observational approach, go on to apply to M80, the clinical training for child and adolescent psychotherapy, while 50% make use of their learning within their current post or professional trajectory.

All the courses in this portfolio offer students an understanding of:

- key psychoanalytic ideas and approaches as a framework for thinking
- emotional development and communication
- working roles and dynamics

Some courses are more introductory than others, but all courses afford students the opportunity to:

- Extend their capacity to maximise satisfaction in their current working role
- Build emotional resilience through reflective practice
- Test the water in relation to a further clinical training

The nature of the courses is critical in achieving this in that they are:

- Experience led, valuing and developing student's own observations of themselves and others
- Taught by clinicians who bring their clinical experience to bear on the curriculum
- Taught in relatively small seminar groups as well as larger lecture formats, to enable students to develop courage and confidence in their observational and analytic capacity

The main courses in the Portfolio are:

- M7 MA/PG Dip/PG Cert Working with children, young people and families: a psychoanalytic observational approach
- M9 MA/PG Dip/PG Cert Working with infants and the early years: a psychoanalytic observational approach
- D1 MA/PG Dip/PG Cert Working in education: a psychoanalytic observational approach
- M33 MA/PG Dip/PG Cert Working with adolescents: a psychoanalytic observational approach
- M16 MA/PG Dip/PG Cert Psychoanalytic Studies
- EC1 Graduate Cert/Dip The emotional care of babies, children, young people and families

- D12 Tavistock Certificate Introduction to counselling and psychotherapy
- eD12 Tavistock Certificate Introduction to counselling and psychotherapy
- bD12 Tavistock Certificate Introduction to counselling and psychotherapy
- D18 Tavistock Certificate Understanding trauma: principles and practice
- D65 Tavistock Certificate Reflective mental health practice today

## 4.2 Overall vision and strategy

The Portfolio's vision and strategy is in accordance with the DET strategic objectives, which have been distilled into the following key thematic areas:

### (a) **Increase intake of Year 1 student numbers to 700 for 2017/2018**

Maximising student numbers is a focus for all course leads in this portfolio. Course Leads meet regularly with marketing and recruitment staff to ensure that website information is attractive and accurate, attend Trust open evenings and open days and offer course specific open evenings. Course Leads also make themselves available to individual potential applicants for phone conversations or email correspondence. All course leads have now been trained in the new MyTap (SITS) system which means they have oversight of recruitment figures and applications. They also work with DET staff to ensure that there is room availability in preparation for an increase in seminar size and they establish the availability of additional teachers who can step in if necessary. The recruitment of overseas students is particularly important for courses that do not meet the new HEE priorities: in this portfolio M16 Psychoanalytic Studies has highlighted this group of students as a recruitment priority because it needs to be self-funding.

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

This portfolio already has a considerable national reach developed largely through the commitment of child psychotherapists working in local clinics, strongly supported by DET, who became aware of the potential demand in their areas for courses to help non-clinical professionals develop a better understanding of emotional development and difficulties. Currently, in addition to the Tavistock Centre, there are eight national centres and three centres in Italy within this portfolio. These are:

Belfast : M7 and M9  
Birmingham: M7  
Bristol: M7 and M9  
Devon: M7  
Leeds: M33  
Liverpool: M7  
Oxford: M7



Pen Green (East Midlands): M7 (and D24 from Psychological Therapies Portfolio)  
Florence: M7 and M9  
Genoa: M7  
Milan: M7

Some of these centres are exploring the possibility of offering additional courses – see 4.3 below.

In addition, D12 Introduction to Counselling and Psychotherapy is offered as an elearning course, so can be undertaken from anywhere in the UK or abroad.

Consideration of TEL in relation to whole courses and units has been an important part of the Portfolio Review process in term of extending national geographical reach; another area of development is the delivery of courses or units as CPD via TEL internationally.

Alongside the potential for development indicated by the large number of national associate and alternative centres of delivery in this portfolio, there are considerable challenges. The challenges lie primarily in balancing strategic potential with economies of scale. A few of our long standing, committed centres offering extremely high standards of learning and teaching and producing excellent results are also very small. The Trust's move towards dealing with student administration through MyTap and an imminent change in financial systems for alternative centres of delivery in order to meet university requirements may be difficult for the smaller centres to manage.

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

The culture of the Psychoanalytic Applied Portfolio very much lends itself to the HEE objective of widening the training reach, especially in relation to the unqualified health and social care workforce. The underlying principle is that reflective capacity is fundamental to emotional resilience at work at all levels of an organisation. Students on these courses come from a wide range of work settings at all organisational levels: from perinatal and early years; primary, secondary and higher education; social care; health and mental health; youth offending and criminal justice; and community work. The long courses in this portfolio are all designed to support professionals working in their current role with children, families and adults; to extend their understanding of the interpersonal and institutional dynamics at work and of the emotional development of the children and adults they



encounter. The courses offer an experience of a therapeutic approach, not a clinical training or qualification. Within the portfolio there are courses at Tavistock Certificate level, at graduate level and post-graduate level. Even the post-graduate courses will accept applicants who do not have a traditional educational history so long as capacity to meet the demands of the course can be demonstrated.

All the long courses are experience-based, with an emphasis on developing observational skills, including observing oneself in interaction with others, as a basis for mobilising reflective capacity.

The CPD courses in this portfolio offer a range of opportunities for all levels of the workforce to access introductory short courses and have an experience of a way of thinking that can be helpful in itself while also functioning as a taster. Some CPD courses are drawn directly from the longer courses, others offer condensed or selected aspects of a longer course that can be delivered online, and others are self-contained but linked to the portfolio because of the applied psychoanalytic framework. One particular CPD course, CPD 64, is a long-standing one-term emotional awareness course for assistant level workforce members. It functions as an escalator to a graduate level course – EC1 – which in turn can lead to application to M7 or to courses in other portfolios. CPD 64 is funded by HENCL, and in effect provides bursaries for participants with payment going directly to the Trust. So within this one portfolio there is opportunity for students to progress from a taster course to an introductory modular course to a university validated MA or PG Dip/PG Cert course.

**(d) Additional strategic objectives: inclusivity**

Improving inclusivity in terms of the student demographic is a Trust-wide strategic objective and this is valued highly in DET as a whole. The courses in this portfolio often give students their first taste of psychoanalytic thinking and so the portfolio carries a responsibility for considering afresh the impact of reading and discussing psychoanalytically oriented texts and for reviewing what is required of us in terms of teaching technique. Staff discussion and discussions with students have foregrounded issues of race, sexuality, class and gender, among other aspects of difference, and courses have reviewed their curricula and approaches to teaching, asked their teaching staff to take a more active role in making sure that psychoanalytic texts are opened up to questioning in seminars and that reading lists are extended to take account of contemporary debates.

For the Trust, this portfolio brings people into Education and Training for the first time. In times of austerity, it might be

anticipated that undertaking a course that does not directly lead to a professional or clinical qualification would not be a popular choice. However, students tell us that the understanding of emotional life they gain, which can be challenging and uncomfortable as well as satisfying, is often transformational. They find the mixture of smaller seminar groups for observation and work discussion with larger lecture groups for theory helps them develop their ideas in a way they can take back to their work settings and apply to their professional practice with confidence. In Trust terms, once someone starts an applied course with us they are probably with us for a long time to come, doing more long courses and CPD.

**(e) National Workforce Skills Development Unit**

The new framework for the National Training Contract diverts a significant proportion of funding and resources to the new NWSDU. The Portfolio Manager has been involved in the NTC Implementation Group, in what until recently has been called the NTC Educational Consultancy Work Group and the NTC Educational Consultancy: Children and Young People/Forensic Programme.

**4.3 Progress to date and current position**

**Numbers:**

Two courses in this portfolio have seen a significant increase in applications and enrolment in the last year: EC1, which is a graduate level modular introduction to thinking about the emotional life of babies, children and their families; and the D12 group of courses, which are Tavistock Certificate face to face and online introductions to thinking about the emotional life of adults and about some factors involved in a therapeutic role. These increases have contributed to an overall Portfolio increase in Year One Tavistock enrolment of 19% from 2015-16 to 2016-17 (excluding courses not now running at the Tavistock).

One course, D65 Reflective mental health practice today, will run in an unvalidated form from next academic year. This was agreed in order to maximise uptake, taking account of the change in nurse training, which means that mental health nurses already have a degree and no longer need the Tavistock course to provide an academic qualification. It is anticipated that the new, lower fee will improve D65's competitiveness in the marketplace.

Two new CPD courses have grown out of existing long courses, D65 and D18 this year: an introduction to reflective mental health practice that is designed to be provided in a bespoke way outside the Tavistock at a workplace of the commissioner's choosing; and an introduction

to working with trauma delivered by Technology Enhanced Learning.

#### Yr 1 Tavistock enrolment 2016/17 – 19% increase on 2015/16

Course code	Enrolment 2015-16	Enrolment 2016-17
M7	46	42
EC1	11	17
M9	7	4
M16	12	8
D12/bD12	25	54
eD12	8	12
D18	7	8
D65	11	6
<b>Total</b>	<b>127</b>	<b>151</b>

#### Geographical reach:

Discussions started last year about developing a national centre at Pen Green Children's Centre, Corby. The centre was validated by Essex University last summer and we are in the process of offering open evening and taster sessions at the centre for a 2017-18 intake. The key long courses they plan to deliver are M7 and D24 from the Psychological Therapies Portfolio. In addition, there is likely to be interest in CPD courses for social care staff.

From 2017-18, EC1, The emotional care of babies, children, young people and families, will run in Leeds in partnership with NSCAP.

A group of child psychotherapists in Venice is considering putting in an application for approval to run M7 Working with children, young people and families: a psychoanalytic observational approach and an existing M7 centre in Milan wants to apply for approval to offer D1 Working in Education: A psychoanalytic observational approach.

The Commercial Engagement and Development Unit is in discussion with child psychotherapists in Cornwall and the South West about the potential for running CPD courses.

In relation to the challenges in terms of assessing the balance between strategic opportunity and economies of scale, a review process is already underway to develop sensible, realistic and transparent criteria for viability which would apply equitably to all centres. Centres are in discussion with the Trust about this.

The potential of TEL for further geographical reach is being mobilised by an elearning version of D18 as mentioned above and by the bespoke version of D65 which can be delivered anywhere in the country making use of blended learning. In addition, this portfolio has linked up with the Trust lead on international training developments, Rita Harris: one infant observation seminar with

students in China was established earlier this year using 'Go To' and is now going strong, with another two groups imminent.

**Workforce reach:**

Courses in this portfolio provide learning/training opportunities for a wide range of workforce levels, from unqualified assistant level staff to post-graduate MA level professionals. Courses both enrich current practice and offer pathways to further training. The burgeoning of TEL this year within the portfolio's long and CPD courses will improve access in 2016-17 for students at all levels with full time jobs and/or caring responsibilities as well as improving geographical reach.

**Inclusivity:**

In addition to the ongoing process of syllabus and reading list review and amendment, in 2016-17 course leads from this portfolio participated in DET training and workshops with a focus on LGBT issues in training. The course lead for M7 has established a monthly discussion group open to all Trust staff to encourage thinking about issues of difference, including an understanding of how difference in experience affects learning and teaching.

**National Workforce Skills Development Unit:**

The Portfolio Manager, will continue to contribute to NWSDU work streams in the coming year, bringing an understanding of the value of applications of psychoanalytic thinking for workforce resilience and development.

Katie Argent  
Portfolio Manager Psychoanalytic Applied  
30 March, 2017

## Board of Directors : April 2017

**Item :** 08

**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. Gender Identity Clinic

- 1.1 The West London Gender Identity Clinic formally joined the Trust on 1st April. A very successful two day induction event was held for staff from the Clinic on 3<sup>rd</sup> and 4<sup>th</sup> April.

### 2. FNP 10<sup>th</sup> Anniversary

- 2.1 Paul Burstow, I and other colleagues attended an event to mark the 10<sup>th</sup> anniversary of the introduction of FNP in the UK. The event was well attended including staff and service users from different parts of the country and by key stakeholders from PHE and the Department of Health. The event highlighted the value attached to FNP and also the support it has for the way in which it has looked to adapt in the light of the 2015 RCT results to create a model more clearly aligned with UK systems and needs.

### 3. Five Year Forward View Refresh

- 3.1 NHS England published on 31<sup>st</sup> March an update on the 5 Year Forward View "*Next Steps on the NHS Five Year Forward View*". The document is important in setting out NHS England's, and NHS Improvement's, priorities for the next two years. The key points were:
- Reaffirmation of the principles of the 5 Year Forward View as the basis for the development of the NHS.
  - A clear acknowledgement that the NHS will need to manage within its existing resources and of the importance of eliminating the deficit. A number of areas, including North Central London, will be supported to develop a Capped Expenditure Plan to manage down the gap between current plans and their collective control totals.

- A focus on a number of areas for performance improvement: A&E, primary care, cancer and mental health.
- Some indication that in the short term the RTT standard on Waiting Times might be less of a focus. There are also similar statement in relation to the adoption of new medicines and a firm commitment to find a replacement for the current QOF payments for primary care.
- A focus on strengthening the role of STPs (now renamed as Sustainability and Transformation Partnerships) and some suggestion that Accountable Care Systems will be the model for developing services in the future although a clear statement that there is no expectation of a rapid shift to this as a contractual model.

3.2 I attended a briefing meeting on 6<sup>th</sup> April for all London provider CEs and CCG Chief Officers.

#### 4. STP Transformation Funding

4.1 Working with other partners in the STP we have been successful in securing two elements of national transformation funding for mental health. These are:

- £0.75m for an integrated IAPT pilot in Haringey and Islington with the Trust providing an element of training for physical health care staff.
- £1m for mental health liaison in UCH and North Middlesex.

Paul Jenkins  
Chief Executive  
18<sup>th</sup> April 2017





## Board of Directors : 25 April 2017

**Item : 9**

**Title : The Organisational Development & People Strategy**

**Purpose:**

The organisational development and people strategy was presented at the March Trust Board for initial discussion.

The Board suggested a number of amendments which have been incorporated in to the strategy document. The Board also asked that a delivery plan be worked up with a set of timescales and how the actions will be monitored and reported.

The final draft strategy is presented for approval and the delivery plan with timescales is appended.

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

*(delete where not applicable)*

- Workforce

**For : Approval**

**From : Craig de Sousa, Director of Human Resources**





# Organisational development and people strategy

2017-2020

Feel. Connect. Learn #mytavi

# Organisational Development and People Strategy 2017 – 2020

**DRAFT**

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## Foreword from Craig de Sousa, director of human resources

The Tavistock and Portman NHS Foundation Trust is built on a rich history and set of traditions which has led it to be a thought leader and specialist provider in psychoanalytic, psychodynamic and systemic approaches to mental health and education. Building on this rich history we need to ensure that our traditions and values remain relevant in the current health and social care context.



The Trust is unique in many ways and has grown a strong and prominent education and training directorate which is equipping the health and social care workforce with the skills needed to be resilient through challenging times.

Having joined the Trust in early 2016 I have had the opportunity to speak with a wide range of people about what is important about the Trust, what makes it a great organisation to work for and what is emerging on the horizon. I am very pleased to be part of the organisation and to share our organisational development and people strategy.

This strategy focuses on the skills and behaviours we will need to maintain our traditions, how we will attract talent into the organisation and how we will develop our current and future leaders.

# Executive Summary

The NHS has seen significant change in the last decade which has resulted in a number of opportunities and challenges for the system as a whole.

This strategy focuses on the skills, behaviours and the unique role that our staff will play to position our organisation in the wider and ever changing healthcare environment.

In order for us to continue to be a leader in clinical care, education and research we will focus our attention on four key strategic themes which were developed following conversations with our staff, students and service users including their families and carers.

Our strategic priorities for our organisational development and people strategy are to:

- attract, recruit and select talent in to the organisation;
- develop, promote, reward, recognise and support our existing staff;
- protect the physical and mental health and wellbeing of our staff;  
and
- respect and value diversity.

This document provides the strategic direction of travel over the coming years. The operational delivery of these commitments will be done through annual organisational development and people planning processes that will set out who is responsible for action; accountable for delivery; required to be involved; and those that need to contribute.

# Organisational Development and People Strategy

## Introduction

The NHS has seen significant change in the last decade which has resulted in a number of opportunities and challenges for the system as a whole. The current environment clearly will not be the same in another three years' time and with this in mind this document sets out the strategic direction of how we, as an organisation, will deliver our strategic ambitions; respond to the national policy direction; and harness the talent and contribution of our staff to continue to be a successful and viable institution.

This strategy focuses on the skills, behaviours and the unique role that our staff will play to position our organisation in the wider and ever changing healthcare environment. This document also aligns to our corporate strategic ambitions and sets out how we will equip and support our staff to deliver our corporate priorities so that we continue to be a leader in:

- clinical service delivery;
- education, training and consultancy; and
- research and development.

The strategy has been developed following conversations with a wide range of stakeholders including board members, senior managers, staff and our commissioners.



## Background

The Tavistock and Portman NHS Foundation Trust is a unique organisation built on a rich history that started from 1920 for the Tavistock Centre and 1933 for the Portman Clinic.

Clinically we are a thought leader across the healthcare system and a specialist provider in psychoanalytic, psychodynamic and systemic approaches to mental health.

Unlike other NHS organisations we provide a range of education and training programmes, delivered by our clinicians which are accredited academically. Working in collaboration with university partners, Health Education England and professional organisations we ensure our courses are relevant and distinctive providing a thriving and robust workforce to the health and social care sectors and beyond.

Our respected research also contributes to our unique brand. This helps us attract a wealth of talent and expertise that has built the organisation to where it is today and will be the golden thread that allows us to continue to be successful. It is important that we respect our traditions but also work collaboratively to co-design and make what is unique about our work contemporary to the current environment.

## Our mission, aims and values

### Our mission

For almost 100 years, the Tavistock and Portman clinics have embodied a distinctive way of thinking about and understanding mental distress, mental health and mental wellbeing. Working with children and families and adults 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 experience and places the person, their relationships and social context at the centre of our practice.

Our creative and skilled staff continue to build on these ideas, with new interventions, services and models of care that respond to contemporary challenges.

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

### **Our aims**

The Tavistock and Portman will:

- Continue to deliver and develop high quality and high impact patient services
- Offer training and education which meets the evolving needs of individuals and employers and helps transform the workforce in health, care and other sectors.
- Lead the development of new models of care and innovative approaches to addressing systemic issues in the delivery of care and other services.
- Be a national centre of thought leadership and research, contributing to the development of public policy.

### **Our values**

As an organisation:

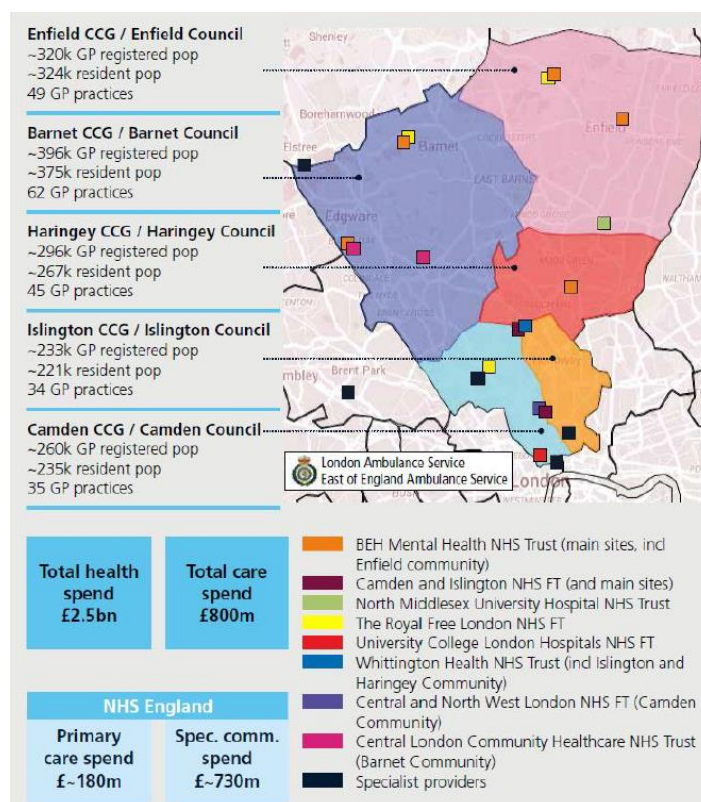
- We work with people with lived experience of mental distress to co-create and improve our services and inform our decision making.
- We are caring and compassionate.

- We are passionate about the quality of our work and committed to openness, the use of evidence and the application of improvement science.
- We value all our staff, are concerned for their wellbeing and seek to foster leadership, innovation and excellence in our workforce.
- We embrace diversity in our workforce and work to make our services and training as accessible as possible.
- We work with others who share our values and can enable us to achieve our mission.

We know as an organisation that there are many great things about working at the Tavistock and Portman but through many years of consistent staff survey results we are aware of behaviours we need to change. Through our values and this strategy we will commit to celebrating and protecting what is great about our organisation and ensure we stop less positive behaviours and practices.

## Our role within north central London

At the time of writing this strategy the healthcare system, as a whole, is fragmented and that in turn has had consequential impacts on both patients and service users. The sustainability and transformation plan (STP) sets out how we as competitor NHS organisations will collaborate across acute, community health, mental health and social care to improve patient and service user experience.

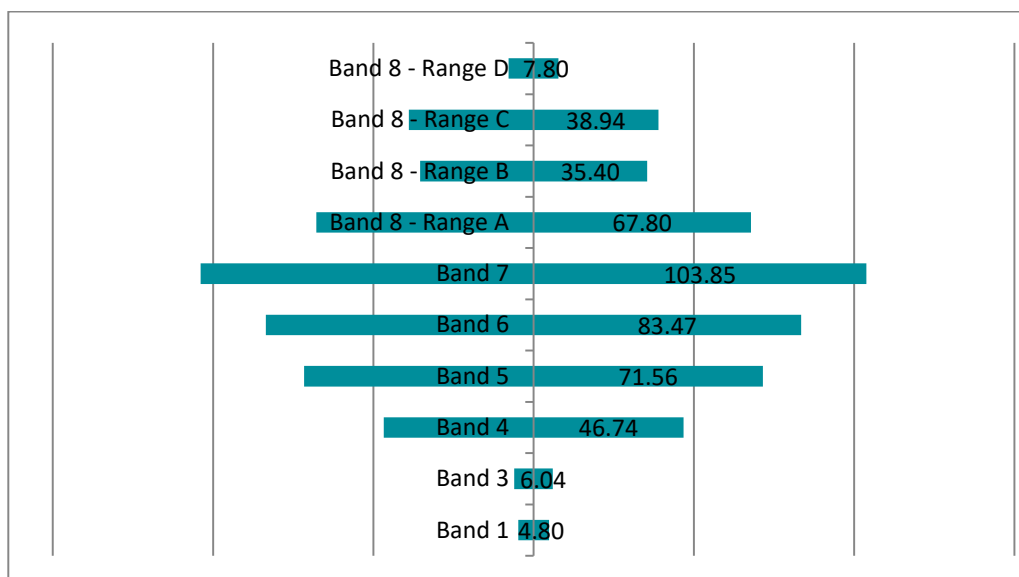


We have actively contributed to the north central London footprint STP and demonstrated our capability to work collaboratively with our two neighbouring trusts and much wider afield to develop a work plan that puts mental health very prominent in the direction of travel. Delivering the STP is now the focus and as an organisation we will need to equip our staff with the necessary skills to be **system leaders** to influence the way in which mental and physical health and care services are shaped.

## The Tavistock and Portman in context

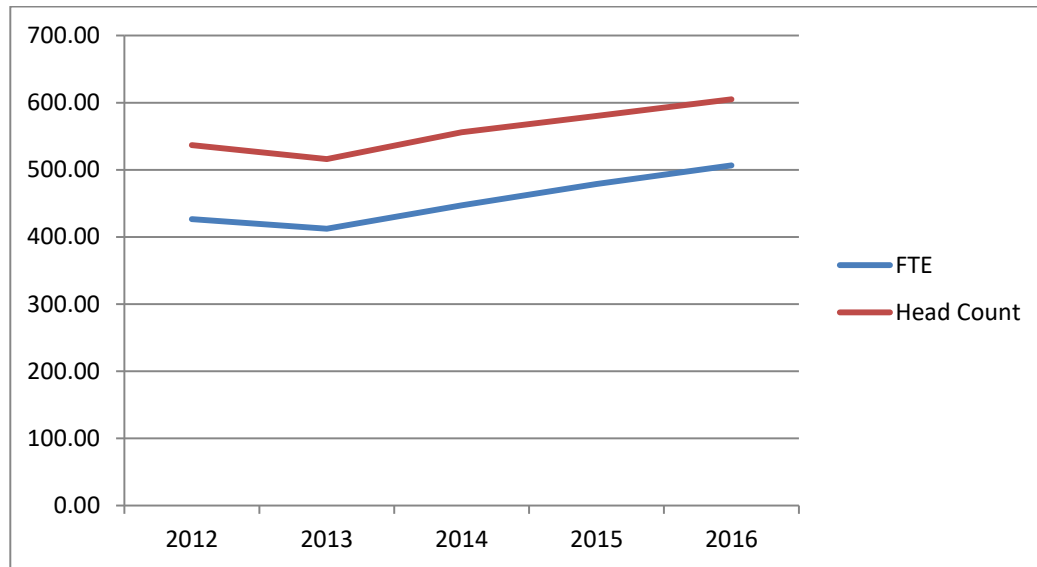
### Our skill mix and organisational profile

In 2016/17 the Trust employs just over 600 (515 FTE) staff at a number of locations across the capital and at a small number of sites further away. Our skill mix has changed quite a bit in the last five years and that presents us with both challenges and a number of great opportunities.



As an organisation we have grown in size and income as a result of development in our department of education and training, gender identity services, award of the Camden CAMHS services and a number of other smaller but equally important contracts.

	2012	2013	2014	2015	2016	Growth
FTE	426.33	412.24	447.01	479.04	515	18.82%
Head Count	537	516	556	580	605	12.66%



### Our contingent workforce

Our workforce metrics and indicators give us a clear view of staff that we employ and pay through the payroll but it does not recognise the important role that people like our bank staff, associates and visiting lecturers, play in delivering our corporate priorities. In 2016/17 there are just over 300 flexible workers that are engaged with the Trust.

### Relocation

For some time we have recognised that both the Tavistock Centre and Portman Clinic have reached capacity and challenge the way in which we need to deliver care, education and research. The Trust has committed to relocating to a new site in the coming years which will provide many opportunities to address the challenges we experience now and use a new building to address those.

This change will require a high level of staff engagement to ensure that we carefully plan the design of our new building and ensure that the issues that exist now, with our current estate, will not feature at our new site.

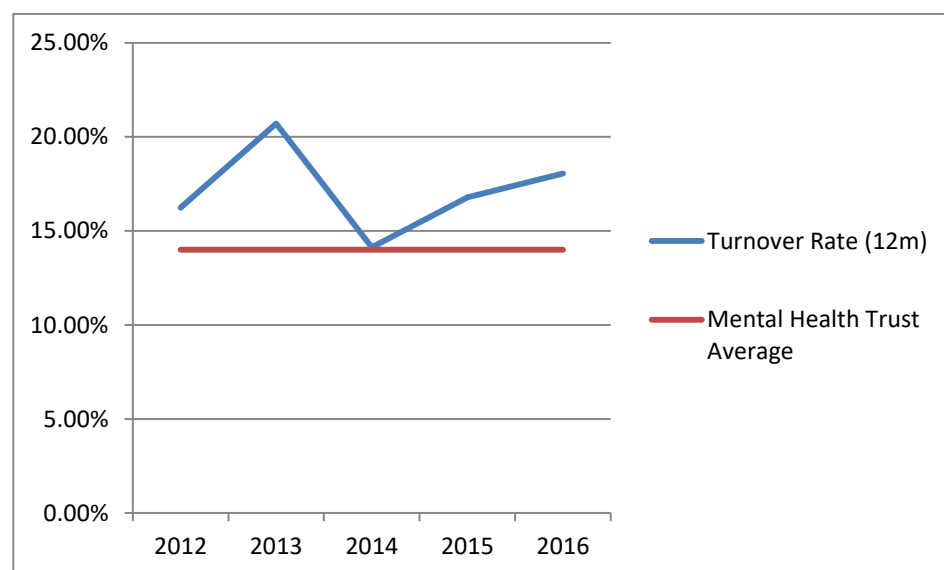
We also recognise that many long serving staff will have an emotional attachment to the building. We will use a range of organisational development approaches to support staff who are affected and help them manage the psychological loss.

## Turnover and stability

Throughout the lifetime of this strategy we will expect to see further growth as we continue to develop our gender identity services and pursue additional contracts to ensure that we remain sustainable.

When compared to other mental health trusts we have a higher than average percentage of staff who decide to leave the organisation. Having dived into the detail behind this we know that often for staff coming to join the organisation in bands 5 – 7 roles that the only natural way to progress is to leave the organisation and return later in their career journey.

	2012	2013	2014	2015	2016
Turnover Rate (12m)	16.24%	20.71%	14.13%	16.79%	18.05%



## Our organisational context in the wider system

The below strengths, opportunities, weaknesses and threats chart represents what we are likely to face over the coming years and what we need to prepare our workforce for.

### Strengths

- Strong financial position, compared to other NHS organisations
- Our role as a specialist mental health organisation
- A good CQC and QAA rating
- Higher than average engagement
- Our role as a thought leader in mental health
- Expertise in both clinical service delivery and delivering education

### Weaknesses

- Small in terms of both workforce and income
- Lack of succession planning for both clinical and education roles
- Volatile to external commissioning factors
- High turnover in lower graded roles
- Our ability to adapt to the external environment
- High levels of workplace stress and long working hours
- A lack of diversity across the organisation, specifically in Bands 8a and above

### Opportunities

- Ability to create career pathways within a small, contained organisation
- The department of education and training being an independent service line
- To build on our role as an 'honest broker' within our STP footprint
- Using our expertise in education and training to develop consultancy based support to the wider healthcare system
- Health Education England national contract renegotiation
- Using our partnership with Health Education England to position ourselves as a lead provider of mental health education
- Potential to develop international services
- Adult GIDS
- Charity income
- Acquisition and development of a new site for the Tavistock Centre and Portman Clinic

### Threats

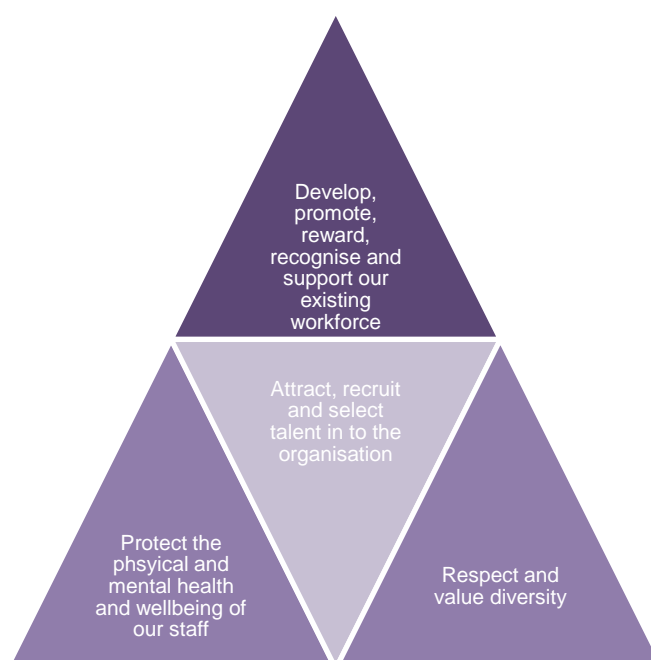
- Continued efficiency requirements
- Continued pay restraint across the wider public sector
- Loss or reduction in existing contracts
- The financial impacts of the Health Education England national contract renegotiation
- Significant workforce and funding challenges within social care
- A chronic shortage of housing across London
- Space issues within both the Tavistock and Portman clinics
- Brexit



## Strategic themes

In order for us to continue to be a leader in our field, we will focus our attention on four key strategic themes which were developed following conversations with our staff, students and service users.

Our strategic priorities for our organisational development and people strategy are to:



These strategic aims are interrelated and cannot operate in isolation of one another. Likewise our managers and leaders will be the drivers for implementing this strategy working collaboratively with the human resources directorate as a strategic business partner.

The following sections of this document set out the detail of each strategic aim and the key enablers to success.

## Attracting, recruiting and selecting talent

In order to be able to attract future talent in to the organisation we will need to have a clear understanding about our future staffing requirements and the skills that we will need to sustain and further

develop our services. We will do this through meaningful and service level led **workforce plans** that will look at the services we provide now and what we will need to do in the future. Our plans will need to focus on what we know exists, in terms of supply in the labour market, and how we will influence higher education providers to commission education placements to create our future clinicians.



By developing our workforce planning processes we will need to collaborate with the department of education and training to identify, early, our future clinicians and

develop **career pathways** that attract people with the skills we need at the right time and create a clear line of progression that will make a job at the Tavistock and Portman fulfilling, rewarding and maximises our opportunity to create innovative posts that span across the STP. We will also capitalise on the national priority to develop diverse roles that mix our internal approach with the national apprenticeship standards. In doing so we will make it an organisational priority not to create single points of failure and ensure that we have a comprehensive and regularly reviewed **succession plan** for our emerging and future leaders that harnesses our ability, as a small organisation, to allow staff to move across services and gain greater exposure to a range of clinical and academic settings.

All of this work will be incorporated into a comprehensive and professional recruitment package that maximises opportunities from technology and social media to **market our offerings**. Our marketing materials will need to effectively demonstrate what we have to offer and

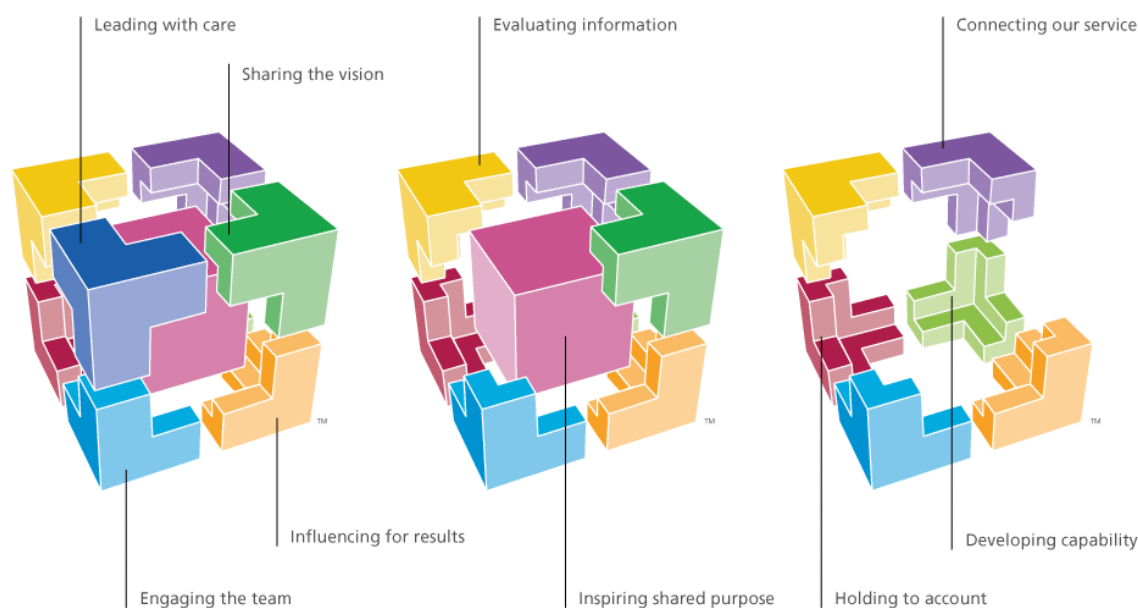
create a narrative that every individual can understand and encourage them to want to be part of a well led organisation.

## Developing, promoting and recognising our staff

### Leadership Development

High quality, collaborative leadership is one of the corner stones to delivering excellent patient care. NHS Improvement (2016) set out a national framework acknowledging the challenges within the current operating environment and what the national organisations will do to improve leadership capability and to ensure that compassionate care continues to be preserved.

As an organisation we will work to equip our middle managers and leaders with the right skills to deliver the national priorities and in doing so we will use the following nine dimensions as our framework to delivering effective, compassionate, safe and authentic leadership.



NHS Leadership Academy (2013:4)

By attracting talent in to the organisation we need to ensure that we invest in our workforce and ensure that our staff are equipped with the skills and opportunities to have a fulfilling career with the Trust. We have, for many years, offered a comprehensive range of education and development programmes but have often done this in a tactical rather

than strategic way. Through this strategy we will use intelligence from a **robust performance and developmental appraisal process** that informs a long ranging learning needs analysis.

We will continue to invest in **leadership and management development** for our existing and emerging leaders. In making this investment we will ensure that we develop people who are capable and have the capacity to deliver the best quality care possible and inspire their teams to innovate. Our development programmes will balance the need for maintaining our inward focus to ensure we are well led with paying particular attention to how we, as a thought leader, will influence and play a proactive role in the wider healthcare system. In doing this our ambition will be to create rounded system leaders who can develop our services internally but also connect them with our partner organisations across the STP and further afield.

### **Enriched career pathways**

For many years we have had higher than average turnover compared to other mental health trusts. Leavers often tend to be in mid-graded clinical roles and this presents us with a challenge as often this means that innovative and talented clinicians join our organisation and to progress they need to leave for roles in the wider healthcare system. In order to address this we will need to be clearer about our **career pathways** and move to a culture where we recruit for the future. This will not address all of our turnover, and so, we will also invest effort in helping those who decide to leave the organisation to continue to have a connection so that they benefit from their time here and can share learning across the wider system.

## Education and training

We play an important role in the health and social care space by providing specialist education programmes across a range of disciplines. The department of education and training has continued to grow and develop in recent years and we have formally recognised its importance by establishing it as an autonomous service line. To



ensure that we continue to be a viable organisation we will continue to develop a focused approach to education and training by building **career pathways** that ensures we educate future healthcare professionals and also attract those, with talent, to continue our legacy of life long education.

As an organisation we will continue to invest in education and develop a formal academic faculty that takes ownership and provides leadership across the diverse range of courses that we have to offer. In doing this we will continue to embed our fellowship programme to accredit our staff with academic recognition and then seek to develop a **Tavistock and Portman Academy** which continues to connect our alumni with the organisation once they complete their studies.

## Research and development

Our clinical staff play such an important role in the development of our services and to continue to enrich a career with the organisation we will seek to create time and space to pursue **research and development activities** that benefit both our staff, our service users and the organisation. To do this we will develop, collaboratively with clinical

colleagues, mechanisms to create space to pursue research grants and the necessary time to deliver on the required outputs.

### Commercial and international development

We have an innovative and entrepreneurial group of staff who have unique talents and abilities. We will encourage those staff to continue to develop new practice, be it clinical or academic, and support them with the necessary skills to package **our specialist services and take them to the commercial market** so that any contribution can be invested back in to our NHS activities and help to further raise our profile.

Our reputation is not limited just to the United Kingdom, we are recognised internationally but we have only capitalised on this in a limited way. There are many examples of best practice where NHS organisations have taken their specialist services to other countries to enhance their reputation and bring revenue which can be invested back in to healthcare. This is an approach we aspire to achieving to further enhance our reputation and to provide opportunities for our staff.

### Protecting physical and mental health and wellbeing

The Tavistock and Portman is a very small NHS organisation and our staff often feel the impact from the external environment. For many years we have seen higher than average levels of engagement but an acute and longstanding issue that we have yet to tackle is the level of staff who continue to work long hours.

From a procedural perspective we have adequate policies and ways of supporting staff but our focus needs to shift from technicalities to action that improves staff's health and wellbeing.

In our role as a thought leader in mental health we educate other healthcare professionals about the importance of health and wellbeing. In doing this we will need to reflect carefully about what we teach others and apply those models and theories to ourselves.

Our staff think and talk regularly about the importance of creating space to reflect on their experiences of working in mental health. We will commit as an organisation to preserving our reflective practice approach to ensure our staff can be resilient in a pressurised environment.

We will also commit to eliminating unnecessary burden and create an environment that creates more space for clinicians and faculty to focus on their practise and less on administrative aspects which add no value. We will also ensure that we take care in our approach to and the volume of meetings and also create a clear culture of effective communication, specifically around the use of email.

Throughout the lifetime of this strategy we will proactively develop our health and wellbeing services and look at what more we can do as an employer to support staff to look after both their physical and mental health. We will do this by establishing a **physical and mental health and wellbeing group** with representation from across the organisation and commit to an annual plan that is informed by our staff and prioritises action that will lead to reduced workplace stress. The group will be responsible to the joint staff consultative committee where it will report on its activities.

Working collaboratively with our occupational health service we will take proactive steps to **promote healthy lifestyles and services** available within the Trust and across our communities.

We will continue to embed our commitment to 'Time to Change' and ensure that we provide safe and confidential spaces for our staff to talk about their mental health and wellbeing. We will continue to build on this work to ensure that we continue to offer services like the staff consultation service and mental health first aiders.



## Respecting and valuing diversity

The Trust has a well-developed process for monitoring and championing equality of opportunity for all. Like many other NHS organisations in London we have known issues



that cut across all of the nine protected characteristics.

We know from workforce data, historic NHS staff survey results and also through the NHS workforce race equality standard (WRES) that we have a lack of diversity in the top tiers of the organisation. We also know through informal channels that there is a perceived culture of unconscious discrimination, a perception we commit to changing.

Our focus, from a workforce perspective, in the past has been to ensure we have robust and mechanistic procedures to reduce inequality. Going forward we need to now turn our attention to taking action that promotes how we support staff from across a broad spectrum of backgrounds and influence meaningful and sustainable **cultural change**.

In 2016 we asked staff using an appreciative inquiry approach to explain what a diverse and inclusive workplace would look like. They include a proportionate and representative senior management team, making a firm commitment to inclusion in the workplace and being able to have difficult conversations about what is less positive about working at the Trust.



To deliver this element of the strategy we will continue to harness the commitment from the equality, diversity and inclusion committee and seek out **diversity champions** who will help develop our priorities and strategic direction.

We will continue to develop our management and leadership development offerings and ensure that we encourage and support staff from underrepresented groups to access available opportunities and then **track career progression**. Throughout this we will also ensure that staff have access to **mentoring and coaching** to ensure that, as they develop their skills, they can call on our existing leaders to help shape their future career direction.

In addition to all of the above we will work collaboratively with other organisations to share practice and learn what more we might be able to do.

### Human resources as an enabler

The Trust has a clear mission and set of values. In order to be able to deliver those our human resources directorate will support managers to implement this strategy. Our purpose is to:

Deliver a comprehensive, collaborative, professional and proactive human resources and organisational development service. We will do this by aligning with our corporate objectives; respecting and valuing our current and future staff; and seeking to develop our organisation as a whole.

We will deliver this by ensuring that we continue to remain business focused and further develop our HR business partner model. The aim is to ensure that any manager or leader in the organisation has a chartered professional to support them in developing their staff, managing performance and to help implement change.

Our focus will be to continually develop HR policy and practice in the organisation, drawing on best practice, and use technology to improve processes and allow managers to make robust data informed decisions.

Delivering the strategy

This document provides the strategic direction of travel over the coming years. The operational delivery of these commitments will be done through annual organisational development and people planning processes that will set out who is responsible for action; accountable for delivery; required to be involved; and those who need to contribute. Each area will be clearly defined with timescales and reported at appropriate points through the Management Team and to the Trust Board.

The table below details, at a strategic level the interventions required to deliver each of our strategic priorities.

Strategic theme	Specific priorities	Action required	Outcome measure
Attract, recruit and select talent in to the organisation	Workforce planning	<ul style="list-style-type: none"> <li>• Improve and cleanse our existing workforce information</li> <li>• Invest in workforce planning skills</li> <li>• Develop an annual, directorate and trust level, workforce planning process which is led by managers supported by HR and finance</li> </ul>	Robust service led workforce plans that are predictive of our future staffing requirements taking in to account both demand and supply factors
	Career pathways	<ul style="list-style-type: none"> <li>• Informed by our workforce plans, review our clinical roles and map our desired career pathways</li> <li>• Recruit for the future and develop competency frameworks that allow easier progression</li> </ul>	To attract emerging and future talent in to the organisation
	Succession planning	<ul style="list-style-type: none"> <li>• Map the current natural successors for director, heads of service and senior faculty posts</li> <li>• Implement a succession plan and review it annually</li> <li>• Extend the succession planning process to lower tiers within the organisation</li> </ul>	Have a clear succession plan for staff in the organisation

Strategic theme	Specific priorities	Action required	Outcome measure
Develop, promote, reward, recognise and support our existing workforce		<ul style="list-style-type: none"> <li>Implement a robust and objective talent management process that identifies current and emerging leaders in the organisation.</li> </ul>	
	Marketing our offering as an employer	<ul style="list-style-type: none"> <li>Making best use of our website and social media, promote careers at the Trust</li> <li>Ensure that we capture talent from our students</li> </ul>	<p>To continue to be able to attract talent in to the organisation.</p> <p>Promote the important work that the Tavistock and Portman does.</p>
	Robust performance and appraisal system	<ul style="list-style-type: none"> <li>Review the appraisal process</li> <li>Map appraisal outcomes to the talent and succession plan</li> </ul>	<p>Improved views on the appraisal process – Staff Survey</p> <p>Meaningful education commissioning that meets our staff and the organisation's needs.</p>
	Leadership and management development	<ul style="list-style-type: none"> <li>Continue to deliver the internal leadership programme</li> <li>Commit to sponsoring staff to undertake national leadership programmes</li> <li>Use the annual appraisal process to commission relevant and timely</li> </ul>	<p>Develop our internal talent.</p> <p>Create a pipeline of future leaders.</p> <p>Equip our existing staff with the skills needed to work across systems</p>

Strategic theme	Specific priorities	Action required	Outcome measure
		education and training programmes for our staff	
	Career pathways	<ul style="list-style-type: none"> <li>• Informed by our workforce plans, look at our clinical roles and map our desired career pathways</li> <li>• Recruit for the future and develop competency frameworks that allow easier progression</li> </ul>	Better managed turnover.
	The Tavistock and Portman Academy	<ul style="list-style-type: none"> <li>• Scope the potential and create an academy model</li> <li>• Embed and evaluate the fellowship programme</li> <li>• Support, track and monitor our future academic leaders</li> </ul>	<p>Enriched career pathways that develop our future faculty.</p> <p>Status that rewards and recognises hard work.</p> <p>Create better opportunities to pursue research.</p>
	Research and Development	<ul style="list-style-type: none"> <li>• Working with the medical director and clinical directors, establish a research and development job offering</li> <li>• Encourage and promote research opportunities</li> </ul>	<p>Increase the organisation's capability to pursue research activity.</p> <p>Enrich our clinicians' job plans and create space for professional development.</p>

Strategic theme	Specific priorities	Action required	Outcome measure
Protect the physical and mental health and wellbeing of our staff		<ul style="list-style-type: none"> <li>• Establish an academic faculty</li> <li>• Develop a recognition process for clinical academic research</li> </ul>	
	Developing our commercial skills	<ul style="list-style-type: none"> <li>• Identify areas where the Trust has commercial potential</li> <li>• Scope the skills and capabilities needed to win new contracts and / or commercialise our services</li> <li>• Invest in commercial skills development</li> </ul>	<p>Enhance our leaders' skills to be able to proactively and rapidly respond to commercial opportunities.</p> <p>Develop services that the Trust can commercialise and generate income to invest back in to NHS care.</p>
	Establish a physical and mental health and wellbeing steering group	<ul style="list-style-type: none"> <li>• Constitute a group</li> <li>• Agree an annual plan</li> <li>• Implement reporting mechanisms</li> <li>• Embed actions in the quarterly HR reporting with an evaluation of activity</li> </ul>	<p>To improve the overall health and wellbeing of our workforce.</p> <p>Assess changes via the NHS staff survey</p>
	Promote healthy lifestyles	<ul style="list-style-type: none"> <li>• Work collaboratively with the Trust's occupational health service to promote healthy lifestyles</li> </ul>	To encourage our staff to live healthy lifestyles that allow them to be the best in their role.

Strategic theme	Specific priorities	Action required	Outcome measure
		<ul style="list-style-type: none"> <li>• Implement monthly healthy lifestyle campaigns using internal communications</li> <li>• Hold an annual health and wellbeing event</li> </ul>	
Value and respect our diverse workforce	Create cultural change	<ul style="list-style-type: none"> <li>• Develop a narrative about what is positive about the trust and where we need to focus for improvement.</li> <li>• Commit and provide senior oversight to the diversity and inclusion agenda</li> <li>• Report regularly on action being taken and positive stories</li> <li>• Embed diversity and inclusion as an integral part of all leadership development programmes</li> </ul>	<p>Demonstrate the organisation's commitment to tackling inequality in the workplace.</p> <p>Positive changes to our staff survey results</p>
	Attract and select diversity champions	<ul style="list-style-type: none"> <li>• Develop a role specification</li> <li>• Seek applications</li> <li>• Create a specialised development programme</li> <li>• Encourage the champions to develop workplace best practice</li> </ul>	Allow our staff to take ownership of their diversity agenda and receive senior management support to implement and influence change across the organisation.

Strategic theme	Specific priorities	Action required	Outcome measure
		and share through the equality, diversity and inclusion committee	
	Track career progression of leadership development participants	<ul style="list-style-type: none"> <li>Record all non-mandatory training data on ESR</li> <li>Report annually on training uptake</li> <li>Create a talent pool of leadership candidates to lead projects and be first to be offered secondments</li> </ul>	Increase diversity of staff in Bands 8a and above
	Create opportunities for coaching and mentoring	<ul style="list-style-type: none"> <li>Commission coaching and mentoring services for our staff</li> <li>Monitor and report on the number of staff receiving developmental support</li> <li>Track the career progress of those accessing support</li> </ul>	<p>Give confidence to our BAME staff to apply for promotions and developmental opportunities in the organisation.</p> <p>To increase diversity of staff in Bands 8a and above</p>



## Conclusions and next steps

The Tavistock and Portman is a specialised organisation with a group of staff that are highly committed. Their passion for the organisation is clearly demonstrated on several years of positive staff survey results and through the high engagement scores we receive. We have many good stories but also areas where we need to improve. This strategy sets the direction about how we will continue to be a leader in our field and develop our future leaders.

## References

NHS England (2016). *The Five Year Forward View for Mental Health [online]*. Leeds. Crown Stationery Office. Available from: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf> [Accessed on 01 December 2016].

NHS Improvement (2016). *Developing people – improving care [online]*. London. Crown Stationery Office. Available from: <https://improvement.nhs.uk/resources/developing-people-improving-care/> [Accessed on 06 December 2016].

NHS Leadership Academy (2013). *Healthcare Leadership Model: the nine dimensions of leadership behaviour [online]*. Leeds. Crown Stationery Office. Available from: [http://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm\\_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf](http://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf) [Accessed on 06 December 2016].



Specific priorities	Action required	Reporting Mechanism	2017/18				2018/19				2019/20			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Workforce planning	Improve and cleanse our existing workforce information	HR Senior Management Team												
	Invest in workforce planning skills	Management Team												
	Develop an annual, directorate and trust level, workforce planning process which is led by managers supported by HR and finance	Management Team												
Career pathways	Informed by our workforce plans, look at our clinical, non-clinical and leadership roles and map our desired career pathways	Professional Clinical Advisory Group												
	Recruit for the future and develop competency frameworks that allow easier progression	Management Team												
	Map the current natural successors for director, heads of service and senior faculty posts	Professional Clinical Advisory Group												
Succession planning	Implement a succession plan review it annually	Remuneration Committee												
	Extend the succession planning process to lower tiers within the organisation	Remuneration Committee												
	Implement a robust and objective talent management process that identifies current and emerging leaders in the organisation.	Management Team												
Marketing our offering as an employer	Making best use of our website and social media, promote careers at the Trust	Remuneration Committee												
	Ensure that we capture talent from our students	HR Senior Management Team												
	Review the appraisal process	Education and Training Programme Board												
Robust performance and appraisal system	Map appraisal outcomes to the talent and succession plan	Management Team												
	Continue to deliver the internal leadership programme	Staff Training Committee												
	Commit to sponsoring staff to undertake national leadership programmes	Management Team												
Leadership and management development	Use the annual appraisal process to commission relevant and timely education and training programmes for our staff	Staff Training Committee												
	Scope the potential and create an academy model	Education and Training Programme Board												
	Embed and evaluate the fellowship programme	Education and Training Programme Board												
The Tavistock and Portman Academy	Support, track and monitor our future academic leaders	Education and Training Programme Board												
	Working with the medical director and clinical directors, establish a research and development job offering	Training Programme Board												
	Encourage and promote research opportunities	R&D Committee												
Research and Development	Establish an academic faculty	R&D Committee												
	Develop a recognition process for joint work	R&D Committee												
	Identify areas where the Trust has commercial potential	R&D Committee												
Developing our commercial skills	Scope the skills and capabilities needed to win new contracts and commercialise our services	Management Team												
	Invest in commercial skills development	Management Team												
	Constitute an academic faculty	ISCC												
Establish a physical and mental health and wellbeing steering group	Agree an annual plan	ISCC												
	Implement reporting mechanisms	Management Team												
	Embed actions in the quarterly HR reporting with an evaluation of activity	Management Team												
Promote healthy lifestyles	Work collaboratively with the Trust's occupational health service to promote healthy lifestyles	HR Senior Management Team												
	Implement monthly healthy lifestyle campaigns using internal communications	HR Senior Management Team												
	Hold an annual health and wellbeing event	Management Team												
Create cultural change	Develop a narrative about what is positive about the trust and where we need to focus for improvement.	EDI Committee												
	Commit and provide senior oversight to the diversity and inclusion agenda	EDI Committee												
	Report regularly on action being taken and positive stories	WRES & PSED Reports												
Create cultural change	Embed diversity and inclusion as an integral part of all leadership development programmes	Staff Training Committee												
	Develop a role specification	EDI Committee												
	Seek applications	EDI Committee												

[illegible]

## Board of Directors : April 2017

**Item :** 10

**Title :** Mitigating the impact of the Apprenticeship Levy

### **Summary:**

The apprenticeship levy is a mandatory financial contribution that all employers with a wage bill that exceeds £3,000,000 are required to support and comes into effect from 6th April 2017. The Trust is expected to contribute £140,000 in 2017/18 towards the levy.

This paper provides as summary of the key elements of the Apprenticeship Levy and explores some of the potential ways that the Trust may be able to mitigate the impact of the new levy on Trust finances.

This report has been reviewed by the following Committees:

- Executive Management Team , March 21<sup>st</sup> 2017

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

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

- Equality
- Risk
- Finance

**For :** Noting and Discussion

**From :** Director of Nursing

## Mitigating the impact of the Apprenticeship Levy

### 1. Introduction and background

The apprenticeship levy is a mandatory financial contribution that all employers with a wage bill that exceeds £3,000,000 are required to support. The Government is committed to achieving three million apprenticeship starts by summer 2020 and the introduction of the levy will encourage employers to take on apprentices and upskill their existing workforce.

The levy will come into effect from 6th April 2017. For the first year, the Government will provide the employer with a £15,000 allowance per year which, in the case of organisations subject to the levy will reduce the total amount of levy contribution due by £15,000.

The Trust is expected to contribute c£140,000 in 2017/18 towards the levy. The Government will then distribute contributions across all business sectors to support employers to fund apprenticeship training. The exact amount that the Trust will receive back from the levy will be determined in May 2017.

This paper provides as summary of the key elements of the Apprenticeship Levy and explores some of the potential ways that the Trust may be able to mitigate its impact on Trust finances.

### 2. Apprenticeships

An apprenticeship is a genuine job with an accompanying skills development programme. Through their apprenticeship, apprentices gain the technical knowledge, practical experience and wider skills they need for their immediate job and future career. The main rules governing apprenticeships are:

- the apprentice must be employed in a real job; they may be an existing employee or a new hire
- the apprentice must work towards achieving an approved [apprenticeship standard](#) or [apprenticeship framework](#) with an approved training provider
- the apprenticeship training must last at least 12 months
- the apprentice must spend at least 20% of their time on off-the-job training - this training must be directly relevant to the apprenticeship framework or standard.

There are 2 different types of apprenticeship training you can choose from:

- Apprenticeship standards - each standard covers a specific job role and sets out the core skills, knowledge and behaviours an apprentice will need to be

fully competent in their job role and meet the needs of employers, standards are developed by employer groups known as 'trailblazers' which end with a synoptic assessment.

- Apprenticeship frameworks - a series of work-related vocational and professional qualifications, with workplace and classroom based training

Frameworks will be phase out between now and 2020 and will move over to the employer-led apprenticeship standards. All apprenticeship starts from April 2017 will be funded from one of 15 bands, each with an upper limit ranging from £1,500 to £27,000. Generally, the higher the level of role and training, the greater the cost of training. Apprenticeship training levels range from the equivalent to GCSE level to Masters Level (Level 7).

### 3. Accessing the levy

Funding from the apprenticeship levy can only be used to support apprenticeship training. Employers can use training providers registered with the Skills Funding Agency to deliver the apprenticeship training programme and assessment from an already agreed range of standards and frameworks. The Apprenticeship Levy can be used to develop existing staff, as long as the training meets an approved standard or framework and the individual meets the apprentice eligibility criteria.

The Digital Apprenticeship Service (DAS) is a new online portal to select apprenticeship programmes, training providers and process payments. Employers can only spend funds in their apprenticeship service account on training from a government-approved training provider. Through the online apprenticeship service all employers will be able to:

- select an apprenticeship framework or standard
- choose the training provider or providers you want to deliver the training
- choose the organisation that will assess your apprentices
- post apprenticeship vacancies

Employers who pay the levy can also use the apprenticeship service to:

- set the price agreed with the training provider
- pay for apprenticeship training and assessment
- request to stop or pause payments (for example, if an apprentice stops their training, or if the employer has not received the service agreed with the provider).

#### **4. Employing apprentices in the Trust**

We have already begun to scope the potential to employ apprentices by converting existing vacant posts into apprenticeships. Predominantly the posts identified to date have been Band 3 - 5 administrative posts. We are able to claim approximately £2,000 per post to pay for training (i.e. this cost does not come back into the Trust but is paid to the training provider).

Existing employees will also be offered the opportunity, with their manager's support, to access apprenticeship training programmes to support their personal and professional development. Taking this approach will address the gap we have around NVQ provision.

The important thing to remember that funding needs to be in place for the role and that each apprentice will need an allocated supervisor who will need time to support the workplace assessment process. Whilst apprentices tend to cost 60 - 80% of a full time employee at that Band, they are only available to work 80-90% of the time as they require regular release to attend for training or assessment. Using this approach only it is anticipated that the Trust could have around four apprentices per year (0.61% of the workforce). This would allow us to access 6% of our levy contributions. Any levy payments not accessed within a 24 month period will expire.

#### **5. Potential ways to increase our use of the levy for training and to be an income stream**

##### Pooling the levy

Groups of companies connected for the purposes of paying the levy will be able to collect their funds together into one account by registering to have PAYE schemes attached to a single account. Employers that are not connected will not be able to pool funds in an account. This might support an STP based approach or other such grouping of employers and increase the potential of the full levy being accessed.

##### Becoming a training provider

Employers can become a training provider, however, they need to register to become an approved provider and will be subject to Ofsted inspections and other obligations. As an existing training provider Tavistock and Portman may wish to become an apprenticeship provider and in doing so may wish to either access existing standards to engage in training or to work with partners (for example in the STP or the Mental Health Hub) to create trailblazer standards.

Becoming an apprenticeship provider would also provide the potential opportunity to convert existing postgraduate role training programmes within the DET portfolio into apprenticeships. This could include some of the clinical trainees currently employed by the Trust. These would be Level 7 apprenticeships and would be likely to attract higher fees. As both employer and training provider, this could be a route to bringing back some of the levy into the Trust's bottom line each year.



Pursuing this route would be a longer term solution and would not enable any mitigation of the impact of the levy in 2017/2018.

## **6. Conclusions and recommendations**

The apprenticeship levy provides both opportunities and challenges for the Trust. The main opportunity being that we will be able to offer our lower graded administrative and support staff the opportunity to access diploma level training through existing standards. The other that there may be scope for future income generation.

The challenges we do face, however, is around the uncertainty of how much we will receive back to provide apprenticeships and due to the specialist nature of our workforce applying the levy will be constrained in the first few years.

The Board of Directors are asked to note the contents of this paper.

Chris Caldwell  
**Director of Nursing**

Craig de Sousa  
**Director of Human Resources**



## Board of Directors : April 2017

**Item : 11**

**Title : Mental Health Workforce Development Collaborative**

**Purpose:**

This paper seeks the Board of Directors' formal agreement to the Trust's role in the establishment and development of the Mental Health Workforce Development Collaborative with 6 other partner Trusts. The Collaborative represents a major opportunity for the Trust and was crucial to the agreement of the revised National Training Contract with HEE. The Collaborative also provides a platform to develop other opportunities for joint working and business development, both in the UK and internationally. Early priorities have been identified in relation to primary care mental health and apprenticeships.

The proposal has been developed in partnership with the other Trusts who will be taking it to their own Boards for support during the next month.

**For : Discussion and agreement**

**From : Paul Jenkins Chief Executive**

## Mental Health Workforce Development Collaborative

### Introduction

1. Seven Mental Health Trusts have agreed to work together to establish a Mental Health Workforce Development Collaborative.
2. Representatives of the organisations have met on 21<sup>st</sup> December and 22<sup>nd</sup> February to scope the purpose and aims of such a collaborative and to develop proposals for initial priorities, business opportunities and governance.
3. This paper summarises the conclusions of those discussions and seeks the agreement of the Board of Directors for the Trust's proposed role in establishing and developing the Collaborative.

### Context

4. There are a number of factors which make collaboration in the area of mental health training and workforce transformation attractive at this time:
  - All providers face major challenges in sustaining and developing their workforce at a time of major financial pressure.
  - Implementation of the 5Y Forward View for Mental Health creates big requirements for the expansion and development of the mental health workforce.
  - There is a need to raise the profile and voice of mental health at a time when the agenda can be dominated by issues of acute providers.

- There is an ongoing need to facilitate the transfer of consistent best practice between providers.

## The Partners

5. The 7 proposed partners are:
  - Avon and Wiltshire Partnership Trust
  - Birmingham and Solihull Mental Health NHS Foundation Trust
  - Lancashire Care NHS Foundation Trust
  - Mersey Care NHS Foundation Trust
  - Nottinghamshire Healthcare NHS Foundation Trust
  - Oxford Health NHS Foundation Trust
  - Tavistock and Portman NHS Foundation Trust
6. Each of the partners brings a range of distinctive expertise in different areas of mental health practice and other areas of service delivery. The partners cover a broad range of national geography including a good mix of urban and rural settings. Each of the partners is well engaged with one or more STPs with a number of partners taking the lead, within their STP, on mental health or workforce work streams.
7. While not ruling out expanding, in time, the size of the Collaborative it has been agreed that the current number of partners was optimal in terms of balancing geographical reach and building trust and relationships between organisations.

## Purpose and aims

8. The Collaborative would exist to create a virtual centre of excellence around mental health education, training and workforce transformation which would:

- Provide a “go to” voice for HEE and other national bodies on issues relating to mental health workforce issues.
- Allow members to collaborate (collectively or bilaterally) to develop and share evidence based good practice.
- Support the pursuit of shared business development opportunities in the UK and internationally.

## Values

9. There was a discussion of the values which should underpin the work of the Collaborative. It was agreed that the partners should be committed to:
  - Development of consistent best practice across a National Health Service
  - A shared endeavour with equal commitment from all partners
  - Robust evaluation of the effectiveness and impact of its work
  - Openness and transparency between partners
  - Valuing the input of people with lived experience in the design and delivery of its activities

## Scope

10. The primary scope of the Collaborative will be the mental health workforce. However it was agreed we could consider a number of other subsidiary areas of scope:

- Learning disabilities.
- Public mental health and prevention.
- Core mental health skills and psychological informed practice for the physical health workforce
- Core physical health skills for the mental health workforce

## Priorities and Business Opportunities

11. An initial scoping has been undertaken of potential areas of work for the Collaborative. This is summarised at **Annex A**. This is grouped under 4 headings:

- Workforce Design including new roles
- Workforce Development including recovery focused practice
- Staff wellbeing
- Learning enhancement and measurement of impact

12. An initial business opportunity for the Hub exists in supporting the work of the Workforce Skills Development Unit commissioned by HEE from the Tavistock and Portman as part of its national contract. This will provide support on a number of national HEE training and education priorities. In 2017/8 priorities will include: perinatal mental health, primary care mental health, vulnerable children and staff resilience.

13. Beyond this discussions have identified two early wider priorities for the Collaborative:

- Primary care mental health and integrated working – focusing both on the developments stemming from STPs for the mental health workforce to facilitate integrated working in a primary care setting and actions to improve the skills of the primary care workforce.

- Apprenticeships – focusing on both identifying the range of roles in mental health which can be supported through the apprenticeship levy and helping to position the Collaborative in relation to apprenticeship training. Interpretation of apprenticeship standards for people working with service users with mental health problems
- Establish a forum to address key issues around workforce and to provide a channel of communication with HEE in relation to its workforce strategy.

## Quality

14. The Mental Health Workforce Development Collaborative) will be committed to deliver high quality standards of education, training and development will collaborate on the quality standards in the following areas:

- Training Programme/ Learning Intervention design – aligned to needs of service and the expectations of roles to deliver high quality service. Collaboration with service users; employees; subject matter experts and training design professionals will be a core expectation to be assured that programmes are designed fit for purpose.
- Training Programme/ Learning Intervention Delivery – to agree quality assurance standards for training delivery, trainer competence; resource development and the learning environment to ensure the maximum impact of all interventions.
- Evaluation of training – to agree the levels of evaluation which should be considered to be assured the training content is meeting the needs of service.



## Governance

15. A number of principles have been agreed as the basis of the initial Governance model for the Collaborative:

- The Collaborative was a shared endeavour with no single lead organisation although individual organisations would lead on specific agreed work streams.
- As a first step a Programme Board for the Collaborative would be established with representation from each of the partners.
- The Board would be chaired by a CEO from one of the partner organisations. This responsibility would rotate on annual basis between organisations.
- Administrative support for the Board and its initial work programme would be provided by the Tavistock and Portman funded from within its national agreement with HEE.
- A simple partnership agreement would be put together to support the work of the Collaborative. This would include core principles for collaborative programmes covering finance and accountability.
- The Collaborative will need some clear communications messages when its work becomes public.

## Organisational Commitments

16. Each of the Trusts committed to take a paper to their Boards to seek confirmation of support for their involvement in

the Collaborative. For 2017/8 the requirements for partner organisations are:

- Support for the aims, objectives and values of the Collaborative as set out in this paper.
- Commitment to field a consistent representative, with delegated authority, to be a member of the Partnership Board.
- Commit staff with relevant expertise to progress agreed priorities and work programmes.

17. At this stage no explicit financial commitment is required with development projects, initially funded through the Tavistock and Portman's national agreement with HEE. Any investment required to support any future development projects of the Collaborative would be subject to agreement by individual organisations based on an agreed business plan,

April 2017

## Annex A – Mental Health Workforce Development Collaborative – initial scoping of priorities

Work area	Priority Programmes
Workforce Design including new roles	<p>Development of new roles including physician associates, advance practitioners, associate/assistant practitioners.</p> <p>Interpretation of apprenticeship standards for people working with service users with mental health problems.</p> <p>Development of a Career Framework for mental health workforce to support alignment with training and education.</p> <p>Enhancement of workforce planning skills</p>
Workforce Development	<p>Skills development to support mental health liaison, IAPT, perinatal mental health and other key priorities in the 5YFV for Mental Health.</p> <p>CAMHS, in particular clinical leadership, culture and behaviour change.</p>

	<p>Identification of existing best of class learning and development interventions which could be disseminated more widely.</p> <p>Core mental health skills required across health and care workforce.</p> <p>Embedding recovery focused practice</p>
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Staff wellbeing	<p>Staff wellbeing and resilience</p> <p>Staff retention</p> <p>Staff engagement</p>
Learning enhancement and measurement of impact	<p>Development of technology enhanced learning</p> <p>Remote supervision</p> <p>Evaluation of impact of Leadership Development</p>



## Board of Directors : April 2017

**Item :** 12

**Title :** Annual Complaints Report 2016–17: Patient Services

**Purpose:**

The purpose of this report is to provide a summary of the formal complaints received by the Trust in 2016–17 and to identify any lessons learned from these complaints.

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

This report has been reviewed by the following:

- Corporate Governance and Risk Workstream Committee
- Patient Safety Workstream Lead
- Executive Management Team

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

- Patient / User Experience

**For :** Noting

**From :** CEO

## Annual Complaints Report

### 1. Introduction

The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. The number of formal complaints received by the Trust in 2016–17 has risen to 39. Although significantly higher than in previous years (in 2014–15 we received 14 and in 2015/16 we received 27), this is still relatively low compared to other NHS Trusts. The formal complaints received relate to aspects of clinical care and waiting times with a small number relating to facilities issues. This short report summarises the complaints received in the year, and the lessons learned from this important form of patient feedback.

This complaint report covers formal complaints received by clinical and corporate services. All complaints relating to Education and Training are logged and responded to by the Dean.

### 2. Formal complaints received

The chart below shows the numbers of formal complaints over the past 6 years.

Year	2012–13	2013–14	2014–15	2015–16	2015–16	2016–17
No of formal complaints	9	16	12	14	27	39

During 2016 –17 the Trust received 39 formal complaints. These were all acknowledged by the Chief Executive, investigated under the Trust’s complaints procedure and a detailed letter of response was sent by the Chief Executive to each complainant.



### 3. Time to respond to complaints

Of the 39 complaints received in 2016–17, 6 remain open at the end of the year. Formal responses have been sent to all completed complaints. Of these 21 were responded to within our 25 working days deadline, 12 were responded to after the 25 working days and 6 remain open. Patients are kept informed when investigations have not been completed in time resulting in a delay to the full complaint response. The majority of the late responses relate to the Gender Identity Development Service.

There have been a number of issues that have fed into the difficulty in getting GIDS complaints investigations completed within the time frame which include the huge pressure on resources owing to waiting times, the need to restructure the service in line with growth, the dedicated management resources and the complexity of the complaints. We are moving forward in restructuring the service to increase the senior and operational management of the service, with complaints investigation being a significant aspect to the operational management of the service. This is likely to improve response times going forward.

On 1<sup>st</sup> April 2017 we took over the Charing Cross Gender Identity Clinic. This service received approximately 40 complaints last year so this will significantly add to the number of complaints recorded. From discussion with staff in this service they have a good process for dealing with complaints and we will work with the staff in this service to ensure that complaints continue to be dealt with within the given deadlines.

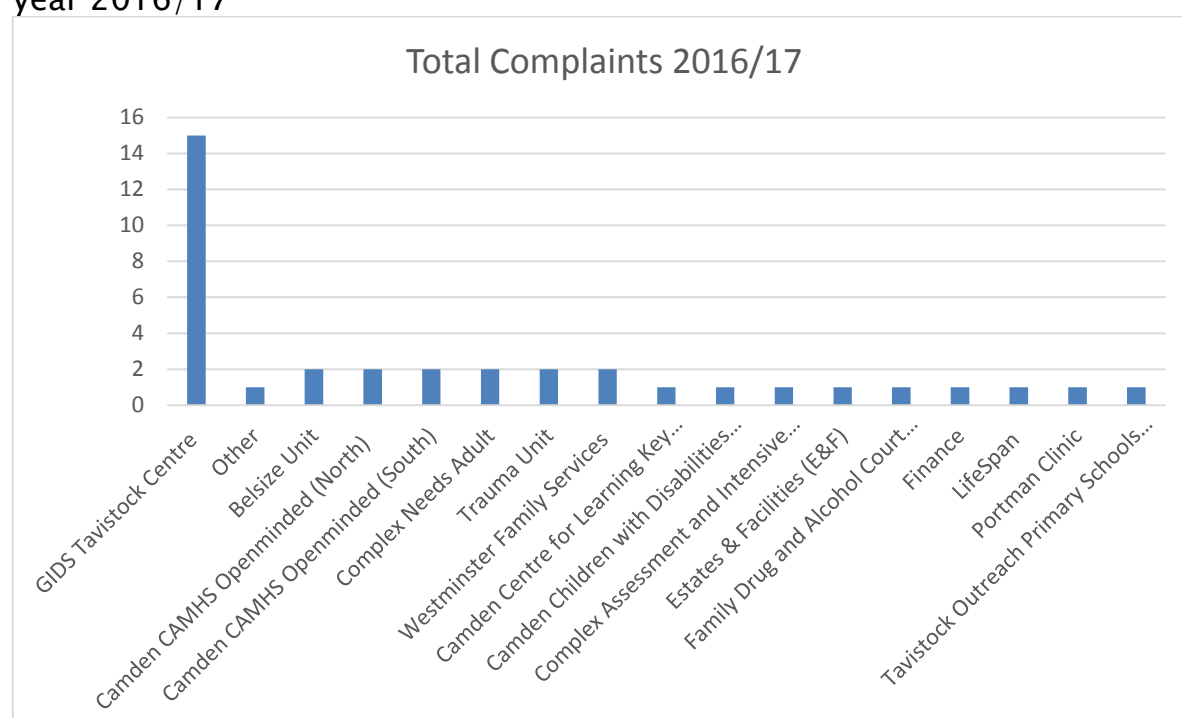
### 4. Complaints by Directorate and Service

The table below shows the number of complaints by directorate over the past 4 years.

Directorate	Number of Complaints			
	2013-14	2014-15	2015-16	2016-17
CYAF	5	5	19	28
A&F	7	9	6	8
Corporate	0	0	2	3
<b>Total</b>	<b>12</b>	<b>14</b>	<b>27</b>	<b>39</b>

Data source: Complaints database

The graph below shows the breakdown of complaints by service line for the year 2016/17



## 5. Topics of Complaints

In 2016-17 most complaints related to aspects of clinical care, however three complaints related to corporate issues.

The following table provides a summary of topic of complaints.

Topics of complaints received
Waiting times in GIDS
Unhappy about GIDS appointments no longer offered in Brighton
Transition to Adult services (from GIDS)
Patient alleged they were not given information on fertility when undergoing hormone treatment

Dissatisfaction with information given on transgender issues
Wrong name used for GID patient
Letters sent to wrong address
Promised treatment has not been delivered
Parent not included in discussion about child's treatment
Being treated with prejudice and discriminated against
Alleged Breach of confidentiality
Attitude of staff
Member of staff was rude and obstructive to patient making a complaint
Poor standard of care and child seen without parent's consent
Appropriate support not offered to patient leading to worsening of mental health
Unhappy with therapist
Inefficient administration
Poor communication
Disagreement about diagnosis
Dissatisfied with FDAC Service and delays to treatment
Inadequate communication around appointments and discharge
Alleged discrimination due to disability
Incorrect medical information on file
Patient not treated with respect
Clarification needed on provisions being made for children
Delay in starting treatment
Social Worker gave biased view in report

Data source: Complaints database

## 6. Complaints Upheld

There is a recognition that patients feel listened to when it is acknowledged that even small errors have occurred, even if the main basis of their complaint has not been upheld. 19 complaints were upheld fully or in part. Following these decisions action plans have been completed for each complaint so that improvements can be made to the services.

Was the complaint upheld?	2013-14	2014-15	2015-16	2016 - 17
Upheld in full	0	0	7	8
Upheld in part	2	3	7	11
Not upheld	9	9	9	14

Under investigation at time of report	0	2	4	6
<b>Total complaints</b>	12	14	27	39

Data source: Complaints database

## 7. Lessons learned

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

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

Complaints are discussed quarterly at the Executive Management Team so that the senior staff are made aware of any themes from the complaints and appropriate action taken. From 2016–17 one of the key issues was GIDS waiting times and transition to adult services. The service is working to ensure that young people in this service and moving to the adult service do not have to wait longer than is necessary.

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

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

Topic	What was upheld	Lessons learned
Therapist did not give clear answers.	Lack of clarity, errors in notes and lack of a clear care plan	Improvements will be made to our mechanism for

Topic	What was upheld	Lessons learned
Errors in notes, breach of confidentiality		reviewing cases ensuring that care planning is routinely present in team casework
Member of staff rude to patient and obstructive to patient making a complaint	Multi-agency response. Report provided to CNWL. Apology given to patient and matter referred to HR	Improvements made to information available for patients wishing to make a complaint
Breach of confidentiality, delay in access to notes, appropriate support not offered to patient.	Not communicating better with patient during treatment	No changes to service were recommended, but staff reminded of the importance of good communication with patients
Referral from GID to adult service	Confusion over transition arrangements	Staff reminded that all phone messages must be recorded on carenotes. Protocol on transition arrangements clarified.
Letter wrongly addressed, wrong name for transgender child used	Incorrect information used in correspondence	Staff reminded of the importance of checking information before it is sent to patients.

## 8. Parliamentary Health Service Ombudsman (PHSO) Investigations

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

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

During the year two patients referred their complaint to the Ombudsman. We have been contacted regarding one of these and

informed that no failings on the part of the Trust were found. In 2015–16 two patients referred their complaint to the Ombudsman, the report back on one of these found no failings on the part of the Trust but the recommendations stated that clinical trainees should make detailed clinical records for the patient files. The second complaint to the Ombudsman was not progressed.

## **9. Next steps**

For 2017–18 the Trust is committed to ensuring that all staff are fully aware of the different ways that patients can raise concerns. Further guidance has been issued to staff and new posters have been displayed in all patient areas on who to contact should a patient wish to make a complaint.

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

## **10. Whistleblowing**

There was one formal whistleblowing cases raised in 2016/17.

This case was raised on the 2<sup>nd</sup> March and concerned a perceived conflict of interest in Corporate Governance. It was investigated and resolved by the Chief Executive.

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

Gervase Campbell  
Trust Secretary, April 2017.

## 11. Report from the Freedom to Speak Up Guardian

The Trust takes the issue of staff being able to raise concerns, 'whistleblowing' very seriously and appointed Gill Rusbridger to the role of Freedom to Speak up Guardian in October 2015. This is in line with Francis Review recommendations. The Trust has in place a 'Raising Concerns and Whistleblowing procedure' and a lot of communications have gone to staff to make them aware of who our new Freedom to Speak up Guardian is, her role and contact details. Meetings have also been held with groups of staff to raise awareness.

There was one formal whistleblowing cases raised in 2016/17 and none in the previous two years, and the Trust has had no members of staff coming forward and raising formal complaints about patient care. However, since being appointed, staff have felt able to make contact to discuss other issues in confidence. These have related in particular to staff feeling not listened to by managers and feeling bullied. This is sometimes seen as having an indirect impact on the quality of care given to patients and families. We are committed to building a culture of openness and responsiveness to staff speaking out about anything that might place the care of our service users into question.

Contact has been made with the National Whistleblowing Helpline and our Guardian now receives regular newsletter updates. She has also joined the NHS Employers local Guardian hub and her details are on the Freedom to Speak Up Guardian map. Links have also been made with the London Freedom to Speak Up Guardians and a new group for those based in Mental Health Trusts. The National Guardian's Office is now establishing itself and is arranging regular conferences and training events. The National Guardian visited the Trust in February 2017.

Gill will continue to keep the profile of the Guardian in the Trust as high as possible. This is an important role that actively addresses and acknowledges the Trust's commitment to ensuring a culture of

openness where staff are encouraged to speak up about patient safety, knowing that their concerns will be welcomed, taken seriously and responded to quickly.

Gill Rusbridger  
Freedom to Speak Up Guardian

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

April 2017



## Board of Directors : April 2017

**Item : 13**

**Title : Smoke Free Policy**

### Summary:

This paper presents the Trust's Smoke Free policy. Smoking is the largest single preventable cause of morbidity, mortality and inequalities in health in Britain and accounts for about half of the difference in life expectancy between the lowest and the highest income groups. People with mental health problems smoke significantly more and are more dependent on nicotine than the population as a whole, with levels about three times those observed in the general population. The Trust is committed to supporting the health and well-being of patients, carers, staff, students and visitors to our sites. This policy sets out our approach to ensuring a smoke free environment and to providing active support to quit smoking or reduce tobacco intake. It also sets out our current policy on the use of e-cigarettes.

This report has been reviewed by the following Committees:  
Management Team, April 6<sup>th</sup> 2017

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

*(delete where not applicable)*

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

**For : Approval**

**From : Louise Lyon, Director of Quality and Patient Experience**

# Smoke Free Policy

Version:	2
Bodies consulted:	Medical Director, Director of Quality and Patient Experience, Director of CYAF and Director of AFS, Director of Human Resources
Approved by:	
Date Approved:	
Lead manager:	Associate Director for Quality and Governance
Responsible Director:	Medical Director
Date issued:	April 4 <sup>th</sup> 2017
Review date:	TBC



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# Smoke Free Policy

## 1 Introduction and Summary

Smoking is the largest single preventable cause of morbidity, mortality and inequalities in health in Britain and accounts for about half of the difference in life expectancy between the lowest and the highest income groups.

People with mental health problems smoke significantly more and are more dependent on nicotine than the population as a whole, with levels about three times those observed in the general population.

Urgent and effective action is required to close the gap in smoking rates between the general population and those with mental health problems.

Stopping smoking results in improved mental health with an impact on anxiety and depressive symptoms that at least matches the impact of antidepressants. Integrating physical and mental health care delivery in line with the public health agenda will help promote the recovery of the Trust's patients and the health and well-being of patients, carers and families.

Evidence suggests that smokers with mental health problems are as motivated to stop as smokers without. As only a minority of smokers with mental health problems receive any help, it is important that all health care staff employed by the Trust are trained in providing brief evidence-based smoking cessation interventions.

National Institute for Clinical Excellence (NICE) Guidelines for Smoking Cessation in Secondary Care; Acute, Maternity and Mental Health Services (NICE 2013) recommend that all NHS funded secondary care sites should become completely smokefree. Smokefree policies in inpatient units and mental health clinics must be complemented by community based smoking cessation programmes.

Nicotine vaporisers (e-cigarettes) have become the most popular quitting aid among smokers in England. Whilst not risk free, their use carries a fraction of the risk of smoking and there is no evidence of harm to bystanders from exposure to e-cigarette vapour.

This policy is informed by guidance from Public Health England (2016) which highlights key steps which will support mental health trusts in successfully implementing comprehensive smoke free policies

The Tavistock and Portman NHS Foundation Trust is committed to improving the health and wellbeing of patients, carers, staff, students and visitors. The historic image of mental health services is strongly associated with smoking. The Trust is dedicated to changing this to one that positively promotes health and wellbeing for all.

## 2 What is smoke free?

### 2.1 Definition of smoke free:

The guidance for local authorities defines smoking as ‘smoking tobacco or anything which contains tobacco, or smoking any other substance, and includes being in possession of lit tobacco or of anything lit which contains tobacco, or being in possession of any other lit substance in a form in which it could be smoked. This includes smoking cigarettes, cigars, herbal cigarettes and pipes (including water pipes, shisha and hookah)’.

In this guidance ‘smoke free’ is defined as the absence of smoking as described above.

This smoke free policy prohibits smoking in Trust premises i.e. buildings, grounds and Trust vehicles.

The NICE Guidelines ( NICE 2013) make it clear that it is not though simply enough to ban smoking both indoors and outdoors; rather that the

extension presents patients, staff, students, visitors and carers with an opportunity to reduce or stop their smoking.

We will provide treatment to smokers who wish to quit and support smokers who do not want to quit to temporarily abstain from smoking whilst in Trust buildings or grounds. We will provide a healthy environment to work in and create outside spaces that are conducive to nurturing wellbeing. The policy complies with Smoke free legislation (Health Act, 2006) and The NICE Guidelines (NICE, 2013).

## 2.2 E – cigarettes

For the purposes of this policy, the use of e-cigarettes ('vaping') is included and is treated in the same way as smoking as defined above. Whilst it is less harmful than smoking it carries a risk; it is important that patients, especially young people and families, do not observe use of e-cigarettes on Trust premises and thereby assume it is safe.

## 3 Background

Smoking is the main cause of preventable illness and premature death. Currently in the UK, approximately 19% of adults smoke. Approximately 60% of people accessing mental health services smoke and 88% of people who receive treatment for a substance use are currently smokers. People with a mental illness who smoke are more likely to be heavier smokers and more tobacco dependent than smokers in the general population (Public Health England 2016).

The high rate of smoking exacerbates the health inequality already experienced by those with a mental illness. The largest positive impact on the health of people with mental health problems will come from increasing the focus on their smoking behaviour and through the routine provision of smoking cessation support.

Smoking causes a wide range of diseases and medical conditions, including cancers, respiratory diseases, and coronary heart disease. It also has a negative impact on mental health. Smokers experience more severe mental health symptoms, require higher doses of psychotropic medication and spend more time in hospital compared to people with a mental illness who do not smoke.

Approximately a third of welfare benefits are spent on cigarettes and patients often prioritise buying tobacco over buying food, toiletries and spending on leisure activities (Public Health England 2016).

Smoking cessation amongst the population brings about the single most important health benefit to improve everyone's health. Smoking cessation has proved to be associated with improvements in mental health compared with continuing to smoke, in particular improving mood, self-confidence, and reducing levels of anxiety. (Public health England 2016)

Smoking behaviours are strongly influenced by our local social networks, our friends, families, carers, peers and the social norms. This policy is targeted toward those who work in the Trust as well as patients, carers and families and students.

## 4 Purpose

This policy aims to contribute to improving both mental and physical health of the community as well as patients, students, employees and visitors, by encouraging and supporting smoking cessation, providing a smoke free environment and promoting a tobacco free culture. This will be achieved by extending local restrictions on smoking and increasing support to those who want to stop or reduce smoking behaviour.

This policy sets out the requirements for all staff employed by the Trust to promote healthy behaviours. All clinical staff are specifically tasked with screening for smoking status and providing very brief advice – ASK, RECORD, ADVISE, ACT. Some clinicians are responsible for assessment and treatment of tobacco dependence. The extent and the nature of the

interventions delivered will be dependent on staff's role and the patient's choice. All clinicians are expected to be familiar with the care pathway for those who are tobacco dependent and ensure referrals are completed as required.

## 5 Scope

**5.1** This policy is applicable to all patients, carers, students, employees at all levels of the Trust's hierarchy, as well as sub-contractors who undertake activities on behalf of the organisation and any visitors on the Trust's premises.

**5.2** The aim of this policy is to improve health and well-being for all through providing:

- A guaranteed right to breathe air free from tobacco smoke
- Comprehensive screening allowing for identification of tobacco dependent patients
- Evidence-based interventions to reduce or quit tobacco use
- By eliminating the health risks associated with passive smoking, the health and wellbeing of patients, carers, students, staff and visitors is improved.
- By supporting patients to quit, patients are potentially able to reduce prescribed medications which may contribute to improved health status and reduced associated side-effects.
- As smoking cessation is the single most important way to reduce the risk of respiratory disease coronary heart disease, cancer and other serious illness, through raising awareness of the dangers associated with exposure to tobacco smoke
- Smoking cessation support will provide opportunities for improved health status, and for Trust staff in particular, good role modelling and potentially improved attendance at work.

**5.3** Promoting social inclusion by providing access to evidence based interventions that previously have not been easily accessible to people with mental health problems. It also supports patients in the ongoing management of their health care needs.



## 6 Duties and responsibilities

### 6.1 The Trust Board

- Ensures that the Trust has a smoke free policy and that there are procedures in place to monitor its implementation.
- Ensures resources are available for effective implementation.
- Complies fully with the policy and provide suitable role models for staff and patients.
- Monitors compliance with the policy via the Executive Management Team.
- Ensures systems are in place to ensure the following:
  - an appropriate level of representation at local borough Tobacco Control Networks via the Executive Management Team.
  - all jobs advertised will state that Tavistock and Portman NHS Foundation Trust is a smoke free Trust.
  - all Service Level Agreements with other organisations contain the following clause 'Tavistock and Portman NHS Foundation Trust is a smoke free Trust. Smoking is banned in all Trust buildings, grounds and any Trust vehicles'.

### 6.2 Health at Work Centre (HaWC)

- Provides expert occupational health advice and will, if requested, sign post staff to appropriate smoking cessation services.
- Supports the Trust to encourage staff to make healthy lifestyle choices.

### 6.3 Clinical staff

The Director of Children, Young Adults and Families and Director of Adult and Forensic Services are responsible for ensuring the adherence to this

policy through Service Line managers and clinical team managers. Their responsibilities are to ensure:

- Staff are competent at identifying and recording the smoking status of every patient in their electronic case notes.
- Where possible that staff use the electronic patient record system and complete the Physical Health form to record all assessments and interventions delivered to support temporary abstinence and smoking cessation activity, including referral to the Physical Health Specialist Practitioner.
- All staff have received training in providing very brief advice (VBA) to their patient group which can be accessed through an on-line module or face-to-face with the Physical Health Specialist Practitioner.
- All smokers are offered support to stop smoking when they first attend Trust services and at regular intervals throughout their treatment.
- The pathway to access Nicotine Replacement Therapy (NRT) is offered by all clinicians at the first appointment to all smokers accepting treatment to stop smoking. If this is not possible for clinical reasons this must be documented and the issue addressed as soon as is clinically acceptable.
- All smokers who want to stop or reduce smoking are referred to the Physical Health Specialist Practitioner or a tobacco-dependence service external to the Trust.
- Patient information regarding the relationship between smoking and illness (both physical and mental) is available in patient areas and is made accessible.
- Staff appraisals and personal development plans reflect an employee's training needs to deliver tobacco dependence treatment appropriate to their role. For the majority of staff this will only comprise mandatory VBA.
- There are sufficient staff trained in Tobacco Dependence Treatment Advanced Skills training (Level 2) to meet the needs of smokers in each clinical area.

- Staff are fully supported in reminding other people of the smoke free policy.
- Staff are encouraged not take smoking breaks during work hours.
- Staff who smoke and who show an interest in cutting down or quitting are supported to access an appropriate number of smoking cessation sessions either via the physical health specialist practitioner or external stop smoking services. If sessions take place during normal working hours, arrangements must be agreed with the Line Manager in accordance with the Trust policy on medical appointments.
- Ensure that initial patient information packs and promotional materials provided about the service describe the smoke free status.
- Ensure that all appointment letters and communications from the service communicate the smoke-free status in the service.

#### **6.4 Estates and Facilities staff**

Are responsible for ensuring the appropriate signage is posted at entrances to all buildings and on Trust premises and in gardens where services are delivered. Ensuring contractors / visitors are aware of the protocols and agree to comply whilst on Trust premises.

#### **6.5 Staff who smoke:**

- Must not smoke in Trust grounds or on Trust premises.
- Must not smoke in front of patients, their families or carers.
- Are encouraged not to take smoking breaks during their contracted hours. Staff will be encouraged to use NRT during working hours.
- Have access to support to cut down or quit smoking, via signposting through the Health at Work Centre or by the Tavistock and Portman Physical Health Specialist Practitioner smoking cessation service.
- Will meet with their line manager to discuss and agree arrangements to attend a smoking cessation clinic in line with the Trust policy on medical appointments in working hours.
- Staff must recognise that it is important to promote and improve the physical health of patients, students and staff by supporting

them to stop smoking. Staff are therefore responsible for ensuring they do not smell of smoke during working hours as this may have a negative impact on those who are receiving nicotine management support.

- Understand that Trust disciplinary procedures for continued non-compliance with this policy may apply.

## **7 Implementation**

### **7.1 Dissemination of smoking information**

This policy and its mandatory application will be communicated to all employees, sub-contractors, visitors and interested parties.

As part of the Trust's induction process, new starters will be made aware of this policy and where to locate it on the Trust's intranet system. All employees are responsible for informing sub-contractors and other visitors to their area of this policy.

### **7.2 Prohibition of smoking**

Smoking is strictly prohibited in any part of the Trust's premises, including at entrances or anywhere on its grounds. This includes areas that are outside but that form part of the Trust's premises. Smoking is also strongly discouraged directly outside Trust premises.

Staff will be discouraged from smoking during normal working hours.

### **7.3 Signage**

The Trust displays signs that make it clear that smoking (and use of e-cigarettes) is prohibited on its premises and in its grounds.

### **7.4 Vehicles**

Staff wishing to smoke in their own vehicles before work, during their lunch break or after working hours are not permitted to do so whilst on Trust premises.

## 7.5 E-cigarette use

The Trust does not support the use of disposable or any other form of e-cigarettes on Trust premises.

E-cigarette use does not currently support compliance with the Trust's smoke free policy; however they may help smokers manage their nicotine dependence. It is critically important that e-cigarettes do not simply replace cigarettes so that a culture of e-cigarettes replaces the smoking culture.

## 7.6. Guidance for staff who wish to use E-cigarettes

- Staff who smoke will be encouraged to make full use of smoking cessation services. Full and flexible support will be offered to staff in attempts to cut down and quit.
- Staff who smoke and are dependent on tobacco will be encouraged to use NRT whilst at work.
- Staff using e-cigarettes as part of their personal tobacco management plan should always do this discreetly and off site. Staff identifiable as Trust employees should not use e-cigarettes within view of the public or patients.

## 8 Managing breaches of the Smoke Free Policy

The Trust does not want anyone to feel they need to engage in difficult or overly challenging situations and should not approach individuals (whether staff or patients) to ask them to stop smoking unless they are confident to do so.

The Trust's expectation is to promote and develop a culture across all Trust buildings and sites that regards smoking as unacceptable and that everyone respects this. It is acknowledged that shifts in culture and behaviours can take time and will not be achieved simply by the release of guidance and policy documentation. With continued support of staff, the Trust envisages an environment where smoke free is a reality and where breaches are utilised as opportunities for learning and development.

## 8.1 Staff breaches

All Trust staff are expected to promote a smoke free environment and healthy living. Staff should avoid condoning or advocating tobacco smoking.

Trust line managers are responsible for ensuring that staff who report to them comply fully with this policy. They are responsible for fully supporting staff who bring this policy to the attention of any person in breach of it, by reinforcing the smoke free message and by intervening in situations that become difficult for a staff member to handle.

Disciplinary action should only be used by line managers as a last resort. It should however be contemplated when the staff member (s) involved persistently contravene the policy or smoke in an area that could put patients, staff, students or the public at risk.

## 8.2 Carers/Students/Visitors and Contractors breaches

All will be made aware of the Trust smoke free policy through signs, posters, leaflets as well as conversations with staff. The rationale for the policy will be explained and carers will be offered support to learn more about the harmful effects of tobacco dependence. If appropriate they will be directed towards their local Stop Smoking Service, the Trust Living Well Programme and Physical Health Specialist Practitioner.

It is recommended that where members of staff choose to approach a patient or visitor to inform them of the Trust policy, this approach is made only once. The information provided should be limited and along the lines of; 'Can I make you aware this is a smoke free Trust within the Trust buildings and grounds.' Breaches can be reported to mail to: [physicalhealthlead@tavi-port.nhs.uk](mailto:physicalhealthlead@tavi-port.nhs.uk) with a brief explanation of the circumstances and outcome.

If a member of staff observes a student smoking in Trust buildings or grounds, they should make them aware of the Trust's smoke free policy and ask them to stop smoking. If they do not comply, this should be reported to the Dean's Office and will be dealt with under the Student Misconduct Policy.

If a member of staff observes a contractor smoking on Trust premises, they should make the contractor aware of the Trust's smoke free policy and ask them to stop smoking. If the contractor does not comply, they should report the contractor to: Paul Waterman [PWaterman@tavi-port.nhs.uk](mailto:PWaterman@tavi-port.nhs.uk) Estates.

A zero tolerance approach will be applied to any individual who becomes abusive when reminded of the policy. Should the person become aggressive then the member of staff is to walk away from the situation and seek support from their line-manager.

### 8.3 Patient breaches

Should a patient be observed breaching the smoke free policy by smoking in Trust buildings or grounds and there is no immediate risk, staff should politely inform the patient of the restrictions and discuss the breach with his/her colleagues. Patients who are struggling to comply with the smoke free policy should be offered a Physical Health Assessment and Very Brief Advice on smoking, they can also be referred to the Trust Physical Health Specialist Practitioner or local Stop Smoking Service for suitable treatment and psychological support.

Patients in community settings are informed about the smoke free policy in the Trust. They will be offered access to Stop Smoking Services and referral to the Physical Health Specialist Practitioner. Those who are receiving treatment in their own home will be asked to ensure they do not smoke for one hour prior to or during their treatment session. If patients struggle to comply with this policy the staff will explore with the patient a variety of options such as using an NRT product during the treatment session or smoking in a different room than the one used for the treatment session.

Patients in community settings that persistently fail to comply with the policy will be reviewed by their care team with appropriate action agreed, taking into account their need for treatment and their risk assessment.

## 9 Policy monitoring

The policy will be monitored by a variety of different methods including an initial review after three months of approval and a more detailed review after the first 12 months. Reports will be provided to the Executive Management Team by the Physical Health Specialist Practitioner.

## 10 Reporting of smoking related incidents

The Trust has a robust incident reporting system in place. The aim of the system is to establish what is going wrong so that action can be taken to continuously improve the quality and the safety of the service provision. All members of staff should use the incident reporting system to promptly share information about any incident arising in respect of the implementation of smoke free policy. Analysis of all recorded incidents enables the Trust to be both proactive and reactive to reduce the impact and likelihood of future recurrence.

Staff should also record incidents when patients refuse treatment or self-discharge against medical advice because of the smoke free policy. Staff can use the [physicalhealthlead@tavi-port.nhs.uk](mailto:physicalhealthlead@tavi-port.nhs.uk) email address to provide a quick report about a breach of the smoke free policy in the grounds. This would be relevant if staff had observed smoking but did not feel confident to approach those concerned. The trust will ensure that appropriate measures are taken to enhance the smoke free policy at the location concerned.

## 11 References

National Institute for Health and Clinical Excellence (2013) Smoking Cessation in secondary care: acute, maternity and mental health services. *NICE guideline PH48*  
<https://www.nice.org.uk/Guidance/PH48>



Cahn Z, Siegel M.(2011) Electronic cigarettes as a harm reduction strategy for tobacco control: A step forward or a repeat of past mistakes? *Journal of Public Health Protocol* ;(32):16– 31.

The Her Majesty's Government (2006) Health Act 2006: Chapter 28  
[http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga\\_20060028\\_en.pdf](http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060028_en.pdf)

Public health England (2016) – Smoke free mental health services in England  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/509262/SF\\_MH\\_services\\_in\\_England\\_Guidance\\_for\\_Providers.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/509262/SF_MH_services_in_England_Guidance_for_Providers.pdf)

## 12 Associated Documents

Disciplinary Policy  
Health Safety and Wellbeing Policy

## Appendix A Equality Impact Assessment

Completed by	Marion Shipman
Position	Associate Director Quality and Governance
Date	13 February 2017

The following questions determine whether analysis is needed

	Yes	No
Is it likely to affect people with particular protected characteristics differently?		X
Is it a major policy, significantly affecting how Trust services are delivered?	X	
Will the policy have a significant effect on how partner organisations operate in terms of equality?		X
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X

Does the policy relate to an area with known inequalities?		X
Does the policy relate to any equality objectives that have been set by the Trust?		X
Other?		X

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

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?		X	Consultation with Directors and Managers responsible for implementing within the Trust.
If there is a greater effect on one group, is that consistent with the policy aims?		X	No greater effect on any one group
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		
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).



## Board of Directors : April 2017

**Item :** 14

**Title :** Draft Quality Report 2016/17

### **Summary:**

The Board is asked to review the Draft Quality Report which has been prepared in line with guidance from NHS Improvement.

An earlier draft has been provided to Camden CCG, Health watch Camden, Overview and Scrutiny Committee Camden and our Council of Governors for their review and formal responses.

This report has been reviewed by the Executive Management Team, April 18<sup>th</sup> 2017.

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

*(delete where not applicable)*

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

**For :** Discussion

**From :** Louise Lyon, Director of Quality and Patient Experience



# Quality Report

2016/17



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## Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) is a specialist mental health Trust which provides psychological, social and developmental approaches to understanding and treating emotional disturbance and mental ill health, and to promoting mental well-being. It has a national and international reputation based on excellence in service delivery, clinical innovation, and high-quality clinical training and workforce development.

The Trust provides specialist out-patient services, both on site and in many different community settings, offering assessment and treatment, and a full range of psychological therapies for patients of all ages. In addition, in Camden it provides an integrated mental health and social care service for children and families. The Trust does not provide in-patient treatment, but has a specific expertise in providing assessment and therapy for complex cases including forensic cases. It offers expert court reporting services for individual and family cases.

It has a national role in providing mental health education and training, where its training programmes are closely integrated with clinical work and taught by experienced clinicians. One of its strategic objectives is to further extend its national reach and widen participation in its programmes. A key objective is to develop its equalities agenda and to work to increase the diversity of staff and trainees to better reflect and respond to the multi-cultural representation of the communities where the Trust provides services. A key to the effectiveness and high quality of its training programmes are its educational and research links with its university partners, the University of Essex, the University of East London, and the University of Middlesex.

## Core Purpose

The Trust is committed to improving mental health and emotional well-being. We believe that high-quality mental health services should be available to all who need them. Our contribution is distinctive in the importance we attach to social experience at all stages of people's lives, and our focus on psychological and developmental approaches to the prevention and treatment of mental ill health.

We make this contribution through:

- Providing relevant and effective patient services for children and families, young people and adults, ensuring that those who need our services can access them easily.
- Providing education and training aimed at building an effective and sustainable NHS and Social Care workforce and improving public understanding of mental health.
- Undertaking research and consultancy aimed at improving knowledge and practice and supporting innovation.
- Working actively with stakeholders to advance the quality of mental health and mental health care, and to advance awareness of the personal, social and economic benefits associated with psychological therapies.

## Part 1: Statement on Quality from the Chief Executive

The annual quality report is an important way for the Trust to report on quality and show improvements in the services we deliver to local communities and stakeholders. The Board of Directors is ultimately responsible for ensuring that we continue to raise the bar on all our quality initiatives.

Our patients tell us that knowing that they will receive good treatment is the most important quality priority. This report sets out the ways in which we strive to provide that assurance to our patients, carers, commissioners and other stakeholders.

Embedded within the Trust is a genuine desire to improve each year the quality of our services across a number of broad headings, including:

- The experience that our patients and students have when they visit us;
- The effectiveness of the wide variety of treatments our patients receive from us;
- The way we collect, protect and store information about our patients, and report and use information about the outcome of patients' treatment;
- The value we place on all our staff and their wellbeing, fostering leadership, innovation and personal accountability to deliver the best possible services;
- The way we communicate with all those who use or are interested in our services, to keep them informed and to take their views into account.

In May 2016 we were pleased to receive an overall Good rating for our clinical services following a scheduled inspection by the Care Quality Commission (CQC) in January 2016. The CQC required improvement in one area, Safety, in our adult specialist psychological therapy services and we immediately drew up improvement plans. We were very pleased that the CQC recognised significant improvements when they reinspected in November 2016 and they have now rated all our services Good in all areas.

The Trust has actively taken up the CQC's challenge to bring together an integrated quality improvement strategy across our services. Our Clinical Quality Strategy approved by the Board in January 2017, sets out our approach to continuous quality improvement. The strategy draws on the commitment and creativity of our staff and the growing collaborative work with our patients, carers and their families and other stakeholders. As part of the strategy we have identified quality champions across the organisation and are investing in training in specific quality improvement skills and techniques.

In April 2016, the Trust welcomed the Quality Assurance Agency for Higher Education (QAA) to review our education and training services. We were highly satisfied that they reported that we met national standards in all areas reviewed. In addition they identified four areas of good practice and made recommendations for future development in a further four.

The Trust is proud of the work undertaken over the last year to develop integrated performance dashboards at Board and team level. The dashboards give a clear picture of our performance as a Trust allowing the Board to be sighted on changes in performance and to examine the relationship between each of the metrics.

We are committed to driving improvement and a culture of excellence throughout the organisation. We are pleased that 93% of patients continue to rate the help they receive at the Trust as 'good', that they are treated well and listened to. We work closely with our patients

including involving many on interview panels and listening to their stories at our Board of Directors' meetings.

We continue to have relatively small numbers of incidents and a good record on safeguarding with strong leadership from the Medical Director. Our staff consistently recommend the trust as a place to work or receive treatment but we know that we still have some work to do to address long hours of working.

Over the last year the work of our Freedom to Speak Up Guardian has become embedded in the Trust. The role is much appreciated and supports a culture of openness through providing an additional avenue for staff to raise concerns.

The Trust has also had to respond to challenges in relation to growing demand for a number of its services; increasing referrals to our very successful Gender Identity Service (GIDS) and City and Hackney Primary Care Psychotherapy Consultation Service have seen waiting times remain longer than we would wish. Progress has been made to address this issue but we will need to work to ensure it is maintained. Our recently introduced, team by team waiting times report keeps the Board and clinical teams alert to performance issues.

You will find more details in the next section and throughout the report about our progress towards our priority areas as well as information relating to our wider quality programme. Some of the information is, of necessity, in rather complex technical form, but I hope the glossary will make it more accessible. However, if there are any aspects on which you would like more information and explanation, please contact Marion Shipman (Associate Director Quality and Governance) at [mshipman@tavi-port.nhs.uk](mailto:mshipman@tavi-port.nhs.uk), who will be delighted to help you.

I confirm that I have read this Quality Report which has been prepared on my behalf. I have ensured that, whenever possible, the report contains data that has been verified and/or previously published in the form of reports to the Board of Directors and confirm that to the best of my knowledge the information contained in this report is accurate.



Paul Jenkins  
Chief Executive

## Achievements in Quality

We are proud to report that, in addition to our Quality Priorities, during the year 2016/17 we achieved the following:

- We are delighted to announce that the Care Quality Commission has given us an overall rating of Good following the inspection in January 2016 and follow up visit in November. This is a significant and positive achievement for us. Our patients, their families and carers and our commissioners can have every confidence in the clinical services we deliver.
- The Trust has been working for some time to develop a system of dashboards that provide a visual representation of our performance. These came to the Board for the first time in April 2016, and were judged to be a valuable tool that will allow a more systematic and consistent system of performance management, from Board to team level.
- We have developed a Trust-wide clinical quality strategy, approved by the Board in January 2017. This sets out a systematic, approach to continuous quality improvement, building on our high quality care and making best use of our rich resource of clinical knowledge and experience. We are bringing staff, patients and other stakeholders together to design improvements in the care we provide. We have set up a quality task force, identified quality champions and embarked on a programme of staff training in key quality improvement methodologies.
- In January 2017 the Board of Directors confirmed the previous decision to support relocation as the preferred option for the Trust's estate. The decision was approved by the Council of Governors at its meeting in February. The Trust wishes to relocate to a site within the borough of Camden, hopefully by 2019/20. The project is expected to be self-funding, meaning that the proceeds of sales of existing assets will cover the purchase and development of a new site.
- Our Gender Identity Development Service (GIDS) renegotiated their contract which has increased their budget to better reflect the demand for the service. Following an extensive recruitment drive, a large new group of staff joined the service in 2016/17. We are pleased that GIDS London now has newly configured dedicated accommodation within the Tavistock Centre with its own reception and waiting area.
- The Gloucester House School service has grown over the last year. Following the revision of the service model, which made the service more affordable for local councils, occupancy rates have increased to the point that they were able to open a third class. This is a great achievement, and is testament to the hard work of everyone working in Gloucester House, and the support they have had more widely from the Trust.
- Gloucester House School, GIDS and CAMHS work featured in the "Kids on the Edge" documentaries which were screened on Channel 4 during November/December 2016. The programmes, which attracted a total audience of 2.5 million, followed two years of careful work with the production company, Century Films, to produce high quality television which provided an appropriate platform for young people and their families

to share their stories and the significant issues they are dealing with in their lives. In doing so we aimed to help inform public debate about those issues and hopefully to make it easier for others with the same experience to talk about things openly and seek help.

- The Board signed off the Trust Safety Improvement Plans for the Sign Up To Safety campaign. The campaign has provided a good opportunity to review our work and look for areas that could be improved. It has provided a framework for bringing together work that was already in hand so that there would not be too much additional burden for clinicians. Quality of care and patient safety are central to the Trust and the plan sets out clear organisation aims for improving the health outcomes of patients and provide equitable services.
- Over the last year we have held a series of meetings with Black, Asian and Minority Ethnic (BAME) staff from across the Trust to help us better understand the issues facing them in the workplace. The meetings have been well attended by a broad range staff from different parts and levels of the organisation.

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## Camden CAMHS



### What is the service?

The Camden Transformation Team is an innovative multi agency team that was set up in 2012 in response to the national Troubled Families Programme. The team provides holistic help and support using a service model where a support workers engage with a family over a period of weeks or months. Rather than prescribing what the type of help is on offer, the team works to the priorities of the family which are often issues such as housing problems, debts, and getting into training or work. Once they have received help with these issues, they are usually ready to deal with other problems such as facing up to past trauma or getting help for adult and child mental health problems.

### Who is the service for?

The service is for families facing multiple disadvantage who have had long term contact with a range of services but without significant benefit. They have usually learned over many generations not to trust or engage with professionals.

Most of the appointments take place in the community, in family homes or at local community centres.

### Outcomes

Through developing trust and having (often for the first time) a positive experience of receiving professional help, many families have achieved a wide range of improved outcomes: such as overcoming alcohol or substance misuse, getting into employment, improved school attendance, improved academic attainment, improved family relationships.

### Quotes

At a recent away day support workers came up with the following hashtags that they felt described their experience in the team and the work they do with families: #creativityexpected #buildtrusteverywhere #righttobewrong #attachmentbasedrelationships #equal

## 1.2 Overview of Quality Indicators 2016/17

The following table includes a summary of some of the Trust's quality priority achievements with the RAG status, along with the page number where the quality indicator and achievement are explained in greater detail.

Target	RAG	Annual Achievement	Page No
<b>Child and Adolescent Mental Health Service Outcome Monitoring Programme</b>			
For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at Time 1 and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).		Not achieved	38
For 80% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).		Achieved	38
<b>Adult Outcome Monitoring Programme</b>			
For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 70% of patients.		Not achieved	39
<b>Patient and Public Involvement – 'Word of Mouth Project'</b>			
Develop a plan for raising awareness and levels of engagement for service users		Achieved	36
Raise awareness among staff both at the Tavistock Centre and external sites to promote active engagement with the project		Achieved	36
Launch a Visual Straw Poll on awareness of the Living Well Programme		Achieved	36
<b>Patient involvement with physical healthcare – 'Living Well Programme'</b>			
Consult with patients and carers on the scope and content of the Living Well Programme		Achieved	37
Raise awareness of the Living Well Programme with patients and carers for self or clinical referral		Achieved	37
Obtain feedback from programme participants and ensure that information is shared in PPI newsletters		Achieved	37
<b>Patient Safety Indicators</b>			
Patient Safety Incidents		114 Incidents	40
Child and Adult Safeguarding Alerts		Achieved	41

Target	RAG	Annual Achievement	Page No
Maintaining a High Quality, Effective Workforce			
Attendance at Trust Wide Induction Days		85%	42
Completion of Local Induction		97%	42
Attendance at Mandatory INSET Training		100%	43
Safeguarding of Children & Adult – Level 1 Training		95%	44
Safeguarding of Adult – Level 2 Training		88%	
Safeguarding of Children – Level 2 Training		88%	
Safeguarding of Children – Level 3 Training		94%	
Clinical Effectiveness Indicators			
Monitor number of staff with PDPs		100%	47
Patient Experience Indicators			
Complaints received		Achieved	48
Patient Satisfaction			
Percentage of patients that rated the overall help they had received as good:		Quarter 1: 93%	49
Quarter 1		Quarter 2: 91%	
Quarter 2		Quarter3: 92%	
Quarter 3		Quarter 4: 94%	
Quarter 4		2016/17: 93%	
Experience of Survey Questionnaire Results			
Number of Patients that would recommend the Tavistock and Portman to a Friend or Family if they required similar treatment.		Quarter 1: 90%	49
Quarter 1		Quarter 2: 92%	
Quarter 2		Quarter3: 90%	
Quarter 3		Quarter 4: 90%	
Quarter 4		2016/17: 90%	
Did Not Attend Rates			
Trust Wide – First Attendances		Achieved	52
Trust Wide – Subsequent Appointments		Achieved	52



## Part 2: Priorities for Improvement and Statements of Assurance from the Board

### 2.1 Our quality priorities for 2017/18

The priorities for 2017/18 which are set out in this report have been arranged under the three broad headings which, put together, provide the national definition of quality in NHS services: patient safety, clinical effectiveness and patient experience. Progress on achievement of these priorities will be monitored during the year and reported in next year's Quality Accounts.

#### Patient Safety

- Priority 1: Improve the physical health of patients receiving treatment
- Priority 2: Improve the management of patients where there is domestic abuse and violence
- Priority 3: Improve the identification and management of high risk patients

#### Clinical Effectiveness

- Priority 4: Review evidence-based clinical outcome measures
- Priority 5: Embed meaningful use of outcome measures in services
- Priority 6: Clinical Audit and quality improvement developments

#### Patient Experience

- Priority 7: Extend patient and carer involvement with clinical teams to improve clinical services
- Priority 8: Improve patient information
- Priority 9: Improve the use of equalities information to inform the delivery of clinical services

## How we choose our priorities

In looking forward and setting our quality priority goals for 2017/18 we have undertaken a wide consultation with a range of stakeholders, both internal and external over the last year. We have chosen those priorities which reflect the main messages from these consultations including focusing on reviewing the outcome measures that we use and reviewing how they are used in practice, continuing our focus on the physical health of our patients, looking further at how we identify and best manage domestic abuse and violence, and patients at high risk of harm.

Camden CCG (Clinical Commissioning Group, see Glossary) has played a key role in determining our priorities through review of the 2016/17 targets and detailed discussion to agree CQUIN targets for 2017/18.

Our Quality Stakeholders Group has been actively and effectively involved in providing consultation on clinical quality priorities and indicators. This group includes patient, Governor and non-executive director representatives along with members of the Patient and Public Involvement team, Associate Director Quality and Governance and is chaired by the Director of Quality and Patient Experience. The Governors Clinical Quality Group has played a key role in helping us to think about some of our quality priorities for next year.

## Patient Safety

### Priority 1: Improve the physical health of patients receiving treatment:

We have agreed with our commissioners, as part of our CQUIN targets for 2017/18, to further develop the 'Living Well' programme covering a number of public health issues including smoking, alcohol, drugs, healthy eating, and exercise and stress management. This is in addition to developing further the provision of individual support for staff and patients around smoking cessation and alcohol use which was a priority during 2016/17. This continues to be one of the Trust's Sign up to Safety goals.

#### 1. Improve the physical health of patients receiving treatment

##### Targets for 2017/18

This priority continues but with new elements from last year

1. Further develop and deliver the 'Living Well' programme
2. Provide staff information and training to increase knowledge of the 'Living Well' programme, its relevance and benefits and increase numbers trained to deliver Very Brief Advice on smoking and alcohol
3. Increase individual support for patients around physical health issues including smoking cessation and alcohol use

#### Measure Overview

We plan to use a number of different measures to evidence compliance with the targets including the development and dissemination of patient and staff information; development of a 'Living well' programme which is then evaluated by attendees; evidence on ongoing individual support for staff and patients; staff training to deliver Very Brief Advice for smoking and alcohol and ongoing monitoring to embed the use of physical health forms.

#### How we will collect the data for this target

Patients, carers and staff will be involved in further developing the 'Living Well' programme to be delivered during the year. Data will be collected on numbers recruited and feedback obtained from participants. Staff information will be provided to increase knowledge of the programme and provide training to deliver Very Brief Advice to patients on alcohol and smoking. This will be monitored from the physical health forms. Individual and self-referrals to the Physical Health Specialist Practitioner will continue, with use of the service monitored and evaluated at the end of the year.

#### Monitoring our Progress

We will monitor our progress towards achieving our targets on a quarterly basis, providing reports to the Patient Safety and Clinical Risk Workstream, the Clinical Quality Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Physical Healthcare Specialist Practitioner for the Trust will ensure that action plans are in place when expected levels of assurance are not achieved.

## Priority 2: Improve the management of patients where there is domestic violence and abuse

We have agreed with our commissioners, as part of our CQUIN targets for 2016/17, to embed the domestic violence and abuse programme established in 2015/16. This priority continues to be one of the Trust's Sign up to Safety goals.

### 2. Improve the management of patients where there is domestic violence and abuse

#### Targets for 2017/18

This priority continues from last year

1. 95% of Team Managers and/or local safeguarding leads will attend training using a child focused model of the Barnardo's Domestic Violence Risk Identification Matrix
2. 95% of eligible clinical staff to receive Level 3 domestic abuse and violence skills, knowledge and research as part of the mandatory children safeguarding training

### Measure Overview

All DASH trained Team Managers will be required to evidence how they have embedded learning from DASH tool to improve awareness and skills within their teams regarding Domestic Violence and Abuse by end of Quarter 2.

We also plan to provide training in the use of a child-focused domestic abuse and violence assessment model to Team Managers and/or local safeguarding leads and to ensure that 95% of eligible clinical staff receive Level 3 domestic violence and abuse training during the year.

### How we will collect the data for this target

Data will be collected for those attending training and a quarterly report drafted.

### Monitoring our Progress

We will monitor our progress towards achieving our domestic abuse and violence targets on a quarterly basis, providing reports to the Patient Safety and Clinical Risk Workstream, the Clinical Quality Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Lead for Domestic Abuse and Violence for the Trust will ensure that action plans are in place when expected levels of assurance are not achieved.

### Priority 3: Improve the Identification and Management of High Risk Patients

The highest priority of the Trust is the safety of patients seen in our services. For 2017/18 we plan to continue to roll out mandatory refresher training for all clinicians on risk assessment and risk management. Clinicians must attend refresher training once every three years.

Self-harm is particularly prevalent in some of the clinical populations that we assess and treat e.g. adolescents. We will be updating a number of relevant policies and procedures during 2017/18 to reflect the key elements of safer care in the context of being a provider of all age out-patient mental health services. An audit undertaken during 2016 showed there was further work to be done in respect of improving the recording of risk assessments and actions taken. This priority continues to be one of the Trust's Sign up to Safety goals.

#### 3. Improve the identification and management of high risk patients

##### Target for 2017/18

This priority continues from last year but with updated elements

1. To increase clinician's knowledge and awareness of the clinical risk assessment and management of self-harm and suicide with the aim of achieving 80% attendance at the end of a 3 year cycle.
2. Update and disseminate relevant policies and procedures
3. Regular re-audit ( twice yearly) of completion of risk assessment and risk management forms on Eletronic Patient Record.
4. Use of relevant sections of *Safer Services: A Toolkit for Specialist Mental Health and Primary Care . 10 Key Elements to Improve Safety.* (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, February 2017).

#### Measure Overview

Trust wide induction for all new staff already includes an update on suicide and self-harm as does the twice yearly staff mandatory training INSET days. For all clinicians the Trust will provide regular mandatory refresher training on clinical risk assessment and risk management. All clinicians should attend one of these sessions at least once every three years.

#### How we will collect the data for this target

A number of tools will be used to assess progress. By the end of a 3 year cycle we aim to have provided refresher training to 80% of clinicians. Clinician's knowledge of clinical risk assessment will be assessed via a specifically tailored survey tool sent 3 months after attendance at the training event. We will also monitor clinical practice by regular case notes audit of completion of the risk assessment form on the electronic patient record. Additionally we will use relevant quality/safety standards of the Safer Services Toolkit. A decision will be made on which 2 of the toolkit quality/safety standards will be used by the Trust. These will be audited in Q4.

#### Monitoring our Progress

We will monitor our progress on a quarterly basis, providing reports to the Patient Safety and Clinical Risk Workstream, the Clinical Quality Safety and Governance Committee, the Board of

Directors, Camden CCG and our clinical commissioners from other boroughs. The Lead for patient safety for the Trust will ensure that action plans are in place when expected levels of assurance are not achieved. There will be an audit during Q4 of quality/safety standards.

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## Clinical Effectiveness

### Priority 4: Review evidence-based clinical outcome measures

For 2017/18, we plan to review our use of clinical outcome measures, to establish which are most useful to staff, patients and carers and commissioners in monitoring and/or evaluating the effectiveness of our range of interventions. We have well established systems for collecting clinical outcome data. It is demanding in terms of staff time used in entering, analysing and reporting on data and it is therefore a priority to evaluate whether our current approach is best value. We now need to review which of the range of measures we currently use is best suited to our services and to indicating the outcomes which matter most in the lives of our patients and carers. In addition we will review whether there are alternative measures which are better suited to the needs of our services. This review is essential to our overall quality improvement programme.

#### 4. Review evidence-based outcome monitoring tools

##### Target for 2017/18

This is a new priority

1. Document full range of evidence based outcome monitoring measures across clinical Directorates
2. Collect data on frequency of use of each measure and compliance with relevant outcome measure collection protocol
3. Consult with clinical staff, patients, carers commissioners and other stakeholders on usefulness and relevance of the data derived from current suite of measures
4. Review literature and seek consultation with experts to identify potential alternatives, additions to or deletions from suite of measures

#### Measure Overview

Systematic review of outcome measures currently used in our clinical services

#### How we will collect the data for this target

Data will be collated by the Associate Medical Director and the Director of Quality and Patient Experience, supported by the Children Young Adults and Families and Adult and Forensic directorate clinical governance and quality leads and the trust wide Quality Team

#### Monitoring our Progress

We will monitor our progress towards achieving our review targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience Workstream, the Clinical Quality Safety and Governance Committee and the Board of Directors and the Clinical Quality Review Group

## Priority 5: Embed meaningful use of outcome measures in services

The aim is to ensure that the use of outcome measures becomes embedded in routine clinical practice and that the data is available in a timely way to clinicians and patients, and used to continually improve care at patient and service levels.

There are differences between the measures used by the Children, Young Adults and Families (CYAF) directorate and the Adult and Forensic Services (AFS) directorate, so these are addressed separately below. However, some common areas for improvement include how the measures are entered on to the patient information system and how they are used by clinicians, patients and teams to evaluate progress of treatment and review service delivery.

### 5. Embed meaningful use of outcome monitoring in services

#### Targets for 2017/18

This is a new priority

1. To liaise with the Patient and Public Involvement (PPI) team to gather information regarding patients' experiences of outcome measures. Findings will be utilised as part of an overall review of the appropriateness of currently used measures and how they are administered.
2. For outcome measures to be entered on to the patient information system within 1 week of completion or receipt
3. Improve access to patient and team level data, to include a dashboard to provide 'real-time' data which is reviewed by clinicians and teams to improve services.

## Measure Overview

**Measures currently used are outlined below.** Other outcome measures used will depend on the review of measures as per priority 4.

### Children, Young Adults and Families (CYAF)

For the Children, Young Adults and Families (CYAF) directorate, we continue to use the Goal-Based Measure (GBM) this year. The GBM enables us to know what the patient wants to achieve (their goal or aim) and to focus on what is important to them. As clinicians we wanted to follow this up to know if patients think they have been helped by particular interventions/treatments and to make adjustments to the way we work dependent on this feedback. For CYAF, Time 1 refers to the initial assessment, where the patient and clinician complete the GBM together when they are seen for the first time. Then, the patient reviews these goals again with their clinician after three months or, if earlier, at the end of therapy/treatment (Time 2), indicating whether or not they have shown improvement or achieved their goals. CYAF also use other measures to monitor progress, including the Strengths and Difficulties Questionnaire (SDQ), the Revised Children's Anxiety and Depression Scale (RCADS), and the Experience of Service Questionnaire (ESQ).



## Adult and Forensic Services

Adult and forensic services will continue to administer the CORE Outcome Measure (CORE-OM) and the Experience of Service Questionnaire (ESQ). The CORE-OM is a client self-report questionnaire that is administered before, during and after therapy. The client is asked to respond to 34 questions about how they have been feeling over the last week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'. The 34 items of the measure cover four dimensions:

- Subjective well-being
- Problems/symptoms
- Life functioning
- Risk/harm

Comparison of the scores offers a measure of 'outcome' (i.e. whether or not the client's level of distress has changed, and by how much).

The Experience of Service Questionnaire (ESQ, formerly CHI-ESQ) was developed by the then Commission for Health Improvement (now the Health Care Commission) as a means of measuring service satisfaction. It consists of 12 items and three free text sections looking at what the respondent liked about the service, what they felt needed improving, and any other comments.

At the Portman Clinic, an additional measure - the Shedler-Westen Assessment Procedure (SWAP), is administered at the beginning of treatment, at annual intervals thereafter, and after completion of treatment. The SWAP is a psychological instrument for personality assessment and clinical case formulation that is completed by the clinician. It is a well-validated instrument through empirical research. It has also been shown to be an effective method of demonstrating changes in personality functioning over time.

### How we will collect the data for this target

Once the information from questionnaires is collected, it is entered onto the Trust patient information system (Carenotes). This allows us to determine the proportion of patients who have completed outcome measures and how quickly these are available to clinicians.

### Monitoring our Progress

We will monitor our progress towards achieving our targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience Workstream. The Clinical Governance Leads for Children Young Adult and Families and Adult and Forensic services will ensure that action plans are in place when expected levels of assurance are not achieved.

## Priority 6: Clinical audit and quality improvement developments

For 2017/18, we plan to develop and embed new skills in quality improvement and to put these new skills into practice through clinician engagement in Quality Improvement projects. We will also make more introductory Quality Improvement trainings available across the Trust and skill up a few clinicians on more advanced methodologies. This programme of developing and embedding clinical quality improvement across the Trust is reflected in the Trust Clinical Quality Strategy 2017-2019.

Alongside the new developments the use of clinical audit as a quality improvement tool will be robustly maintained.

### 6. Clinical audit and quality improvement developments

#### Target for 2017 /18

Aspects of this priority are new and will be developed over a 2 year period.

1. Evidence that each directorate actively engages in all of the four clinical audit priority areas, evidencing changes in practice in at least one.
2. Evidence that each directorate has a number of staff trained in the use of common quality improvement tools
3. Evidence that each directorate has a quality improvement “champion” who has had additional training/skills development.
4. Evidence by the end of Q4 that each directorate has begun to build capacity to develop small scale improvement projects perhaps undertaken by trainees and supervised by the QI champion or a member of the Quality Taskforce.

### Measure Overview

Use of the Quality Impact Assessment (QIA) Screening tool will be rolled out across the organisation to ensure that when services are developed the impact that changes may have on the quality of services is fully considered. This priority also seeks to develop the use of clinical audit and quality improvement approaches across the organization.

### How we will collect the data for this target

The QIA Screening Tool will be monitored by the Management Team. Clinical audit projects and action plans will be monitored by the clinical audit lead. Implementation of the clinical quality strategy action plan will be monitored by the Director of Quality and Patient Experience and the Clinical Quality Task Force.

### Monitoring our Progress

Completed audits will be submitted to the clinical audit lead who will arrange dissemination of findings through Trust wide audit and effectiveness events. A report will also be provided quarterly to the Clinical Quality, Safety and Governance Committee

Progress on implementation of the clinical quality strategy action plan will be monitored at monthly Quality Task Force meetings and reported quarterly to the Clinical Quality, Safety and Governance Committee

## Patient Experience Involvement

### Priority 7: Extend patient and carer involvement with clinical teams to improve clinical services

For 2017/18, we plan to develop a Patient and Carer Involvement Charter. Patients and carers are involved in our services in many ways and over the last few years we have seen a very welcome development of the role of patients and carers in our services. We now plan to work with staff and patients and carers to set out the ways in which we can extend our work together to improve the quality and safety of our clinical services. This work is essential to our quality improvement programme as we need to work closely with patients and carers at every level to identify improvements required, develop interventions and measure impact.

#### 7. Extend patient and carer involvement with clinical teams to improve clinical services

##### Target for 2017/18

This is an ongoing priority

1. Develop a plan for raising awareness and levels of engagement for service users by co creating a Patient and Carer Involvement Charter
2. Launch the Charter and raise awareness among staff at the Tavistock Centre, Portman Clinic and external sites to promote active engagement with implementing the Charter

#### Measure Overview

Co-production of a clear set of expectations for involvement of patients and carers and staff in the development of our clinical services

#### How we will collect the data for this target

Reports on consultations with staff, patients and carers and other stakeholders

#### Monitoring our Progress

We will monitor our progress towards achieving our review targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience Workstream, the Clinical Quality Safety and Governance Committee and the Board of Directors and the Clinical Quality Review Group

## Priority 8: Improve patient information

For 2017/18 we plan to examine how best to ensure our patients have access to the information they need. Whilst service users are generally satisfied with the information we provide through our website, leaflets, newsletters and posters, some patients and carers feedback that they do not always have the information they want in time and in a format which suits them. We plan to work with patients, carers, clinical and administrative staff and other stakeholders to review how best to improve the provision of information. We will consult with our communications team for expert advice and support in developing proposals and implementing improvements.

### 8. Improve patient information

#### Target for 2017 /18

This is a new priority for 2017 /18

1. Consult with clinical teams , communications team , patients and carers and referrers on clinical team information in the form of leaflets, website and letters.
2. Review website content with patients and carers
3. Provide quarterly feedback on progress on the consultation.
4. Develop proposals for improvement, share with patients, carers and clinical teams and develop action plan to implement
5. Survey patients through ESQ or other method to evaluate whether patients have experienced an improvement in the provision of information

### Measure Overview

The PPI team will consult with patients and carers who are part of current and developing service user groups. The team will raise awareness of the review once feedback is obtained and share information through quarterly newsletters.

### How we will collect the data for this target

Feedback from group consultations. ESQ responses.

### Monitoring our Progress

We will monitor our progress towards achieving our targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience Workstream, the Clinical Quality Safety and Governance Committee, the Board of Directors and Clinical Quality Review Group

## Priority 9: Improve the use of equalities information to inform the delivery of clinical services

In 2017/18 we plan to embed the collection of more complete data on demographics and protected characteristics of our service users using revised equality monitoring forms. With more complete data, we can investigate whether all groups of patients are equally well served. Where patients appear to be less well served, we will investigate further in consultation with service users to identify ways in which our services can be more effectively tailored to patient and carers needs and wishes.

### 9. Improve the use of equalities information to inform the delivery of clinical services

#### Target for 2017/18

This is a new priority

1. Embed use of revised equalities monitoring data collection forms which cover all relevant protected characteristics
2. Provide quarterly reports to clinical directorates on service and team level data
3. Source and provide benchmarking data where possible to identify where there may be gaps in provision
4. Analyse and report on quality metrics according to demographic profile and protected characteristics

#### Measure Overview

Development of a systematic approach to analysing the quality of services.

#### How we will collect the data for this target

Data will be collected through the standard equality monitoring forms which every patient is invited to complete

#### Monitoring our Progress

We will monitor our progress towards achieving our targets on a quarterly basis, providing reports to the Clinical Quality and Patient Experience Workstream, the Clinical Quality Safety and Governance Committee and the Board of Directors and the Clinical Quality Review Group

## Complex Needs



### What is the service?

Our adult complex needs teams provide a range of psychotherapies for those who need a specialised service. Our approach is based on a psychoanalytic perspective which understands mental health as involving the whole person, their life and their relationships. This service is open to Adults aged 23 and over.

### Who is the service for?

Generally those who come to our service have been seen by counsellors or psychologists in the community (primary care), or in specialised mental health services. Most patients come with depression and anxiety. Many also have complications with their physical health. Relationships, isolation and work related problems are very common. Many wish to try to come to terms with early life and family relational experiences and difficulties.

### Outcomes

Of the Experience of Service Questionnaire forms we received in 2015-16, 90% of patients responded that it was 'true' that they felt the service they received was good. 91% of patients surveyed also noted that they would recommend the Adult Department services to a friend or family member.

### Quotes

"The therapist really helped me to open up and was honest."

"People were very nice and easy to talk to"

"Flexible with preferred time of appt. Being listened to."

"Feel of genuine care, not just obligation."



## 2.2 Statements of Assurance from the Board

This section contains the statutory statements concerning the quality of services provided by the Tavistock and Portman NHS Foundation Trust. These are common to all quality accounts and can be used to compare us with other organisations.

### A review of our services

During the reporting period 2016/17 the Tavistock and Portman NHS Foundation Trust provided and /or sub-contracted ten relevant health services.

The Tavistock and Portman NHS Foundation Trust has reviewed all the data available to them on the quality of care in ten of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 45% of the total income generated from the provision of relevant health services by The Tavistock and Portman NHS Foundation Trust for 2016/17.

### Participation in Clinical Audits and National Confidential Inquiries

During 2016/17 0 national clinical audits and 1 National Confidential Enquiry covered relevant health services that the Tavistock and Portman NHS Foundation Trust provides.

During that period Tavistock and Portman NHS Foundation Trust participated in 0% (0/0) national clinical audits 100% (1/1) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audit and National Confidential Enquiries that the Tavistock and Portman NHS Foundation Trust was eligible to participate in during 2016/17, are as follows:

- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness  
The national clinical audits and national confidential enquiries that the Tavistock and Portman NHS Foundation Trust participated in, and for which data collection was completed during 16-17 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.
- In 2016-17, three requests for information were made by Manchester University for patients believed to be under the Trust's care. However, after further investigation, it was discovered that none of these patients were with the Trust and therefore no additional information could be supplied.

The reports of 0 national clinical audits were reviewed by the provider in 16-17 and the Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided N/A – no description of actions

The reports of 9 local clinical audits were reviewed by the provider in 16-17 and the Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided [description of actions].

- **Identification and Management of Depression in Children & Young People:** Clinicians encouraged to document the severity of depression at assessment or treatment, and to complete

more frequent and regular follow up sessions after any medications started to monitor side effects.

- **Care Plans:** Clinicians reminded to discuss risks, benefits & alternatives with their patients and to document in the Care Plan. Also reminded to send a copy of the Care Plan to GPs.
- **Consent:** Improvement was shown in clinicians completing the consent area of the Assessment form, though the audit highlighted a change required in the 'Assessment Under 18 years' form.
- **Safe & Timely Discharge:** Highlighted that letters to GPs are being sent in a timely fashion, however, the content needs to be reviewed and updated for new standards.
- **Self-Harm & Suicidality:** Clinicians reminded to not only document these risks in the drop-down box area of the Assessment Form, but also to provide more detail in written notes area, set alerts as needed and include mention of these risks in letters to GPs.

**Timely Outcome Reporting:** Admin staff to send weekly reminders of un-outcome appointments to clinicians & team managers to remind clinicians and to inform CYAF Clinical Governance lead of any barriers to out-coming appointments after discussing with teams.

### Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by The Tavistock and Portman NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 33.

### The use of the CQUIN Framework

A proportion of The Tavistock and Portman NHS Foundation Trust income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between The Tavistock and Portman NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period is available electronically at <https://tavistockandportman.nhs.uk/about-us/cquin/>

The total financial value for the 2016/17 CQUIN was £471,587 and The Tavistock and Portman NHS Foundation Trust expects to receive £xxx. **\*Commissioners have not confirmed agreement to whether they agree if we have achieved CQUIN performance in Q2, 3 or 4 for 16/17. As a result data pending\***

### Registration with the Care Quality Commission (CQC) and Periodic/Special Reviews

The Tavistock and Portman NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is full registration without conditions, for a single regulated activity "treatment of disease, disorder or injury".

The Care Quality Commission has not taken enforcement action against The Tavistock and Portman NHS Foundation Trust during 2016/17.

The Tavistock and Portman NHS Foundation Trust have not participated in any special reviews or investigations by the CQC during 2016/17.

In January 2016 the Trust underwent a routine inspection by the Care Quality Commission (CQC) and a follow up inspection in November 2016. We continue to hold full registration with



the CQC without restriction. The full report is available on the CQC website, [www.cqc.org.uk](http://www.cqc.org.uk).  
The Trust assessment of domain compliance is below:

CQC Domain	Rating
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

### Information on the Quality of Data

The Tavistock and Portman NHS Foundation Trust did not submit records during 2016/17 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This is because The Tavistock and Portman NHS Foundation Trust is not a Consultant-led, nor an in-patient service.

The Tavistock and Portman NHS Foundation Trust Information Governance Assessment Report overall score for 2016/17 was 81% and graded Red.

The Tavistock and Portman NHS Foundation Trust were not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

### Information on the Quality of Data

The Tavistock and Portman NHS Foundation Trust will be taking the following actions to improve data quality:

- The Quality Team has continued to work with staff across the Trust to ensure effective processes and procedures are in place to meet our local and nationally agreed targets.
- The Quality Team developed Standard Operating Procedures for data collection, validation and reporting to support the quality of data.
- Weekly meetings with key Trust staff to address any data quality issues continue. Members of the Quality Team continue to meet with department managers on a monthly basis to review service/team performance in relation to CQUINs, KPIs and any locally-agreed targets and where data quality issues are identified they work with the service to deliver improvements.
- A monthly Clinical Data Validation Review Group was established during the year involving key Quality Team, Informatics, senior clinical and administration representation to support improvements in the quality of data.
- The Data Analysis and Reporting Committee (DARC), established in 2015/16 to look at clinical data in line with the Trust's overall strategic plans and to enable the Trust to benchmark services both internally and externally met twice in order to provide assurance to the Trust's Quality and Patient Experience Director and Trust Board met 2 times in 2016/17. This is a senior committee set up this committee meets twice yearly.

- With the trust settling in to the use of the electronic patient administration system, CareNotes, it has allowed the trust to easily capture the clinical and care data that is required. Mandatory CareNotes and Outcome Monitoring training has been a success but continues to ensure good quality data is being entered in to the system for robust data to be reported internally and externally.
- The Trust has a Data Quality Strategy was updated in June 2016 it includes additional sections around validation of data and checks on the completeness and accuracy of data. The Quality Team have also developed several Standard Operating Procedures to further ensure the veracity and timely capture of clinical and organisational data. An audit takes place for checking the accuracy of service user data as part of the Information Governance Toolkit and a Clinical Data Quality Review Group is established to analyse and critique data from the patient administration system, with clinical governance leads and administration lead, on a monthly basis.
- Monthly checks around missing data will continue to be run and disseminated by the Quality Team and Informatics department for services to resolve, in order to ensure a more complete and robust Mental Health Standard Data Set (MHSDS) return. These data items include missing demographic details such as ethnicity and employment status.

## 2.3 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital.

As specified by NHS improvement:

For each indicator the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods should be presented in a table. In addition, where the required data is made available by NHS Digital, the numbers, percentages, values, scores or rates of each of the NHS foundation trust's indicators should be compared with:

- The national average for the same and
- NHS trusts and NHS foundation trusts with the highest and lowest for the same.

However, the majority of the indicators included in this section ("Reporting against core indicators") are not relevant to the Trust. The Trust is exempt from the National Patient Experience Survey for community mental health services. In respect of safety incidents, the Trust does not report enough incidents to receive a report.

**Core Indicator No. 22** covers 'The Trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.'

Although, we have reported on patient satisfaction elsewhere in the Quality Report on page 49, the questions included in the Experience of Service Questionnaire (ESQ), which we use with patients we see in the Trust to obtain feedback on their experience of our services, cannot be directly compared with the questions derived from the National Patient Experience Survey for community mental health services.

However, we believe that with the positive feedback we have received from patients in 2016/17 (93% of patients in Quarter 1; 91% of patients in Quarter 2; 92% of patients in Quarter 3 and 94% of patients in Quarter 4 rated the help they had received from the Trust as 'good') means that we would score very positively for patient experience when compared to other mental health Trusts. Also 90% of patients would recommend us to a friend or family member if they needed similar treatment.

**Core Indicator No. 25** covers "The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death". Again, the data for this indicator can be found elsewhere in the Quality Report on page 40.

## FDAC



### What is the service?

The Family Drug and Alcohol Court helps families where children are put at risk by the substance misuse of their parents. The FDAC court provides an alternative to ordinary care proceedings. The focus is on solving the problems that lead Local Authorities to bring families to court. The parents have fortnightly reviews with a dedicated judge, and also has the support of a clinical team throughout the process. Parents are given a 'trial for change', offering them best chance of overcoming their problems within a timescale that is compatible with their children's needs.

At the heart of the FDAC team is the work of the social workers and substance misuse specialists. Where needed they can access specialist support from our Domestic Violence specialist, Adult Psychiatrist and Clinical Psychologist. Our Consultant Child and Adolescent Psychiatrist provides clinical leadership helping the team with formulation and decision making.

### Who is the service for?

FDAC is a service for families who are in pre-proceedings or in care proceedings where the parents have difficulties with substance misuse among other issues.

### Outcomes

FDAC has been evaluated on more than one occasion and the findings show that more families are reunified through FDAC, and not only this but a recent 5 year follow up study found that when comparing families reunified through FDAC and through ordinary care proceedings, FDAC families were less likely to breakdown in the future.

Of the 16 new cases taken on in 2016/17 in the London FDAC team, 8 have already concluded, in 4 cases the children remained with the family. In 1 case, the children were placed under a Special Guardianship Order with a family member. Three cases concluded with Care Orders for placement outside of the family.

### Quotes

When asked what was most helpful about being in FDAC, one parent said "Being able to talk to my keyworker about any troubles I'm facing. I feel confident enough to express how I feel and not be judged. I can get the advice and help I need."

## Part 3: Review of quality performance

### Review of progress made against last year's priorities

This section contains information on the quality of relevant services provided by The Tavistock and Portman NHS Foundation Trust during 2015/16 based on performance in 2016/17 against indicators selected by the Board in consultation with stakeholders.

#### 3.1 Quality of Care Overview: Performance against selected indicators

This includes an overview of the quality of care offered by the Trust based on our performance on a number of quality indicators within the three quality domains of patient safety, clinical effectiveness and patient experience. Where possible, we have included historical data demonstrating how we have performed at different times and also, where available, included benchmark data so we can show how we have performed in relation to other Trusts. These indicators include those reported in the 2013/14, 2014/15 and 2015/16 Quality Reports along with metrics that reflect our quality priorities for 2016/17. In this section, we have highlighted other indicators outside of our quality priorities that the Trust is keen to monitor and improve. Please note that data has been pulled at different times. Dates are included beneath individual tables.

The Trust Board, the Clinical Quality Safety and Governance Committee (CQSG), along with Camden CCG and our clinical commissioners from other boroughs have played a key role in monitoring our performance on these key quality indicators during 2015/16.



## Our quality priorities for 2016/17

Progress on achievement of our quality priorities for 2016/17 can be found in the following section.

### Patient Safety

Priority 1: Improving the physical health of patients receiving treatment, part of the 'Living Well' programme

Priority 2: Identifying and managing issues of domestic abuse and violence

Priority 3: Self-harm and suicide

### Clinical Effectiveness

Priority 4: Child and adolescent mental health service (CYAF) outcome monitoring programme

Priority 5: Young adult and adult outcome monitoring programme

Priority 6: Increase use of clinical audit and quality improvement methodologies across the Trust to support improvements in services

### Patient Experience

Priority 7: Improve awareness and levels of engagement for service users: 'Word of Mouth' project

Priority 8: Patient involvement with physical healthcare within the 'Living Well' programme

Priority 9: ESQ data developments – integrating the use of ESQ data to improve services

## 2016-17 Quality Priorities Summary

<b>1. Improving the physical health of patients receiving treatment</b>
1. Develop and deliver the 'Living Well' programme
2. Provide staff information and training to increase knowledge of the 'Living Well' programme, its relevance and benefits and increase numbers trained to deliver very brief advice on smoking and alcohol
3. Increase individual support for patients around physical health issues including smoking cessation and alcohol use
<b>Performance in 16-17</b>
1. In consultation with patients, carers and staff we designed and delivered a six-week Living Well Group Programme to improve patient and carer physical health and wellbeing. We also provided a clinical service across the Trust covering individual referrals and treatment related to physical health for patients, carers and staff. We established weekly staff lunchtime Mindfulness sessions
2. We undertook to increase staff knowledge of physical health matters in running a 'Mind-body Lecture Series' and making Very Brief Advice (VBA) training available for all staff. We have recruited eight service level physical health champions to help support this work. We have gathered physical health resources which will be available on the Trust internet and intranet.
3. We established use of physical health assessments for all clients aged 14 and over and a referral process from across the trust to the Physical Health Specialist Practitioner to provide a one to one physical health service to clients with problems relating to: smoking, alcohol, diet and exercise, stress, sleep disturbance and substance misuse. This service has also been available to staff and carers.
<b>2. Identifying and managing issues of domestic violence and abuse</b>
1. 95% of team managers trained to use the CAADA-DASH assessment tool (competency)
2. 95% of eligible clinical staff to receive Level 2 & 3 domestic abuse and violence training.
<b>Performance in 16-17</b>
1. (96%) 25/26 team managers or local safeguarding leads were trained by end of year. In addition, a further seven members of staff were trained (not included): FDAC Team and Patient Safety Lead
2. 94% by end of year trained to Level 3. All clinicians are required as from 1 January 2017 to complete Level 3 training.

### 3. Self-harm and suicide

1. To increase clinician's knowledge and awareness of the clinical risk assessment and management of self-harm and suicide with 80% attendance
2. To improve patient experience of clinical risk and safety in the Trust with 80% increase in attendee assessment score following training.

#### Performance in 16-17

1. Mandatory risk assessment and risk management training events are held on a termly basis and all clinicians and clinical trainees are expected to attend once in a 3 year cycle. These trainings have been running on a regular basis for 3 years but are mandatory since April 2016. The format of the workshop has been adapted to reflect feedback from participants, to incorporate learning from incidents and to consider the commitment of the Trust to the Crisis Care Concordat to ensure that people of all ages who experience mental health crisis receive appropriate, timely and urgent care and support.  
  
As the requirement is attendance once every three years and 2016/17 was year 1 of the current cycle it will not be possible to report on the percentage attendance until later in the cycle. However it is expected that more than 80% of clinicians will have complete this training by end of Year 3.
2. Feedback from participants at the risk assessment training is consistently high. One way of evaluating the impact of such training is to audit completion of risk assessment, risk management and crisis planning sections on the electronic patient record setting a baseline and re auditing biannually/annually depending on findings. This is a more robust way of determining change in practice than looking at an attendee assessment score following a training event. The patient safety lead has commissioned this audit which will be reported during Q2 2017/18.  
  
In February 2017 the CQC updated its overall rating to the Tavistock and Portman NHS Foundation Trust of good. Of particular note is the rating of good within the domain of safety for all Trust Services. At the last inspection in January 2016 the CQC rated specialist psychological therapy services as good in four of the five domains including caring, effective, responsive and well-led and rated safe as requires improvement. During the inspection of January 2017 the CQC found that the Trust had addressed the three issues leading to this rating and therefore changed the rating of safe to good. The issues from the November 2016 inspection were the use of crisis plans, risk assessments and management plans and having a separate waiting area for people under 18 at the Portman Clinic.  
  
During 2016/17 The Trust has also been part of the Sign up to Safety national initiative. The Trust focused on improving physical health of patients, improving clinician's knowledge of self-harm, suicide and domestic abuse and violence and improving awareness of the role of digital media on patient mental health.



#### 4. Child, Adolescent and Young Adult Mental Health Service Outcome Monitoring Programme

1. For 80% of patients (attending CYAF) to complete the Goal-Based Measure (GBM) at the Pre-assessment stage (known as Time 1) and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).
2. For 80% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).
3. Improve access to patient and team level data - developing a dashboard to provide 'real-time' data which is reviewed by teams to improve services.

##### Performance in 16-17

1. Not achieved, 48%. – please see table below for annual comparison
2. Achieved, 80%. – please see table below for annual comparison
3. A project team has been established, trialling software solution in preparation for data warehouse redesign

Source: CareNotes/Quality Team. Data depicts annual percentage. Data received and calculated: 5 April 2017

GBM – Results			
	2014/2015	2015/2016	2016/2017
Target 1 – GBM completion	73%	59%	48%
Target 2 – GBM Improvement	75%	83%	80%

\*Please see page 38 for commentary on GBM results.

#### 5. Adult Outcome Monitoring Programme

1. For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 70% of patients.

##### Performance in 16-17

1. Not achieved, 64%. – Please see below for annual comparison

Source: CareNotes/Quality Team. Data depicts annual percentage. Data received and calculated: 5 April 2017

CORE – Results		
2014/2015	2015/2016	2016/2017
53%	71%	64%

\*Please see page 39 for commentary on CORE results.

<b>6. Clinical audit and quality improvement developments</b>
1. Introduce the Quality Impact Assessment Screening tool across the organisation and evidence use in each service line where indicated.
2. Evidence that each directorate actively engages in all of the four clinical audit priority areas, evidencing changes in practice in at least one.
<b>Performance in 16-17</b>
1. The QIA tool was approved November 2015 by the Management Team. In 2016/17 the QIA tool was completed for the three services: CAMHS, Adult and Forensic services and Gender Identity Clinic.
2. Each directorate completed audits throughout the year to improve in the four Clinical Audit Priority areas. All audits have included action plans for improvement and change in at least one area within the given service.
<b>7. 'Word of Mouth' project</b>
1. Develop a plan for raising awareness and levels of engagement for service users
2. Raise awareness among staff both at the Tavistock Centre and external sites to promote active engagement with the project
3. Launch a Visual Straw Poll on awareness of the Living Well Programme
<b>Performance in 16-17</b>
1. Over 16-17 a word of mouth steering group began to run bi monthly. This group was identified primarily as a signposting forum to engage service users with other means of involvement. It was eventually disbanded as more value was seen in developing the engagement with service users attending the Adult reference Group, and the monthly Pizza and Chat. Within these groups more focused and detailed work was achieved for feedback to the trust and raising awareness within clinical teams to communicate directly with service users.
2. As well as continuation and strengthening of The Pizza and Chat group and the now self-renamed adult 'getting together' group, City and Hackney Primary Care Psychotherapy Consultation Service are establishing a service user lead group, and Camden Team Around the Practice have set up a monthly group supported by the PPI team.
3. The Visual Straw Poll ran and received over 100 responses.

8. Patient involvement with physical healthcare – ‘Living Well Programme’
1. Consult with patients and carers on the scope and content of the Living Well Programme
2. Raise awareness of the Living Well Programme with patients and carers for self or clinical referral
3. Obtain feedback from programme participants and ensure that information is shared in PPI newsletters
Performance in 16-17
1. Patient and Carer groups were consulted on the scope of the programme. General feedback was that it was detailed and thorough, although it did not appeal to the service users currently accessing involvement at the Tavistock Centre.
2. Posters and sign-up sheets were displayed around the trust throughout the year. Updates were provided in the PPI Quarterly newsletters
3. 80% Trust members were happy with the physical health topics covered by the programme, 20% made recommendation on how this can be improved (16.03.17)

9. ESQ data developments – integrating the use of ESQ data to improve services
1. Establish quarterly analysis of team level ESQ data
2. Disseminate the analysis to teams, discussing and agreeing actions as required
3. Establish regular feedback mechanisms for patients and staff
Performance in 16-17
1. The PPI team provide team level data to services at quarterly intervals.
2. The PPI team is meeting with teams to discuss the qualitative feedback from the ESQ; teams have responded positively and are currently negotiating the best way to feedback actions to patients.
3. Feedback mechanisms are varied by service and team and are held by the Clinical Quality Patient Experience Workstream.

## Clinical Outcome Monitoring

### Child and Adolescent Mental Health Service (CAMHS)

Child and Adolescent Mental Health Service Outcome Monitoring Programme			
Targets for 2015/16	2014/2015	2015/2016	2016/17
1. For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at Time 1 and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	73%	59%*	48%
2. For 80% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).	75%	83%	80%

Source: CareNotes/Quality Team. Data depicts annual percentage. Data received and calculated: 5 April 2017

#### Measure Overview

For our Child and Adolescent Mental Health Services (CAMHS), we have used the Goal-Based Measure again this year, building on the knowledge we have gained since 2012, with patients previously referred to CAMHS. The Goal-Based Measure enables us to know what the patient or service user wants to achieve (their goal or aim) and to focus on what is important to them.

As clinicians we wanted to follow this up to know if patients think they have been helped by particular interventions/treatments and to make adjustments to the way we work dependent on this feedback. As a result, we set the targets as stated in the table above. These were agreed with our commissioners and were measured as one of our CQUIN targets for 2015/16 (see Glossary).

For CAMHS, Time 1 refers to the Pre-assessment stage, where the patient is given the Goal-Based Measure to complete with their clinician when they are seen for the first time, where the patient decides what would like to achieve. Then, the patient is asked to complete this form again with their clinician after six months or, if earlier, at the end of therapy/treatment (known as Time 2), indicating whether or not they have achieved their goal.

#### Targets and Achievements

1. This year the Trust target of 80% was not met for the return rate of forms for the Goal-Based Measure completed by patients/service users, in conjunction with clinicians, at both Time 1 and Time 2. In year 2016/17 48% of patient with in the cohort met this target.

2. This year the target of 80% improvement in patients on the Goal Based Measure (GBM) from Time 1 to Time 2 was met, the trust achieved 80%; this is a pleasing result as this is important for demonstrating positive changes for patients. A Quality Improvement Project focusing the completeness and the quality of the GBMs completed will be undertaken in the early part of the financial year.

## Outcome Monitoring – Adult Service

Adult Outcome Monitoring Programme			
Targets for 2015/16	2014/2015	2015/2016	2016/2017
3. For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 70% of patients.	53%	71%*	64%

Source: CareNotes/Quality Team. All data is the annual percentage. Data received and calculated: 5 April 2017

### Measure Overview

The outcome measure used by the Adult Services the CORE (Clinical Outcomes for Routine Evaluation system, see Glossary) was designed to provide a routine outcome measuring system for psychological therapies. The 34 items of the measure cover four dimensions: subjective well-being, problems/symptoms, life functioning and risk/harm. It is used widely by mental health and psychological therapies services in the UK, and it is sensitive to change. That is, where it is useful for capturing improvements in problems/symptoms over a certain period of time. We think in the future this should enable us to use this data for benchmarking purposes, for providing information on how our improvement rates for adult patients compares with other organisations and services using the CORE.

For the Adult Service, we used the CORE form again for the current year, building on the knowledge we have gained since 2012, with patients previously referred to the Adult Service. We set the following targets, which also represent the CQUIN (see Glossary) target we had agreed with our commissioners for 2016/17.

### Targets and Achievements

For the Adult Service, for Target 1, Time 1 refers to the Pre-assessment stage, where the patient is given the CORE form to complete before they are seen for the first time. Then, the patient is asked to complete this form again at the End of Treatment stage (Time 2).

Unfortunately we regret to report that we missed the target of 70% of patients who completed the CORE forms at Time 1 and Time 2 showed an improvement in their Total CORE score from the Pre-assessment to the End of Treatment stage. At the end of the financial year 2016/17 we achieved 64%. We are pleased to report two thirds of our patients completing the measures showed improvement as a result of our psychological interventions. We plan to look at the results in more detail to understand better what contributes to improvement on the CORE measure.

*\*To be confirmed in conjunction with Q4 commissioner reports.*

## Patient Safety Indicators

Indicator	2014/2015	2015/2016	2016/17
Patient Safety Incidents	15	34	114

Source: Incident Database, Data received and calculated: 12 April 2017

### Measure Overview

The Trust records all reported incidents on a spreadsheet in order to support the management of, monitoring and learning from all types of untoward incident. In addition, patient safety incidents are uploaded to the National Reporting and Learning System (NRLS) for further monitoring and inter-Trust comparisons which promote understanding and learning. The NRLS definition of an incident that must be uploaded is as follows:

‘A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.’

The Trust has a low rate of ‘patient safety’ incidents due to the nature of its patient services, (we provide psychological therapies, we do not undertake any physical interventions, and are an out-patient service only). There is no comparative NRLS data as the incidents reported by the Trust, whilst appropriate, are too few in number for national reports to be generated.

Commencing in April 2016 the Trust took the opportunity with the NRLS Patient Safety Reporting Lead to review the types of incidents that would be classed as ‘patient safety incidents’ and therefore reported to the NRLS. It was confirmed that there are some incidents we should have been reporting but have not been. It was agreed that from 1 April 2016/17 we would report all of the following incidents – even if they do not happen on site. As is noted in the year on year numbers, by increasing the scope of the reportable incidents we are now reporting any and all incidents that ‘caused harm’ to patients including; Information Governance Incidents (relating to patient information), self-harm / attempted suicide (not previously reported as they were off site) and all Rapid Transfer incidents.

During 2016-17 the Trust had three Serious Incident investigations of completed suicides that were reported to STEIS

We have robust processes in place to capture incidents, and staff are reminded of the importance of incident reporting at induction and mandatory training events. However, there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on staff making the effort to report (often for this Trust very minor events). Whilst we continue to provide training to staff and there are various policies in place relating to incident reporting, there are ongoing efforts to remind staff to report all incidents.

## Being Open and Duty of Candour

Duty of candour fields have been added to the internal incident database. Where there is an incident with moderate to severe harm the duty of candour requirements are followed up with staff to ensure they are met. Requirements are covered in all Trust induction and training (INSET) days. Information on compliance is also included within the Trust Quarterly Quality News.

## Child and Adult Safeguarding Alerts

Indicator	2014/2015	2015/2016	2016/2017
Child Safeguarding Alerts	2	71	111
Adult Safeguarding Alerts	0	6	6

Source: Clinical Governance Report, Data received and calculated: 5 April 2017

## Measure Overview

Trust staff have made one safeguarding enquiry to the local authority in Q4. Staff consultations regarding safeguarding issues continue to be raised at the rate of about one per week. Staff are thoughtful and increasingly aware of the ten adult safeguarding categories and the range of ways in which these can present. In house level 2 and 3 adult safeguarding training is being developed and trialled. The new adult safeguarding policy has been launched. In 2016/17, 111 children identified and 6 adult safeguarding referrals were made.

The variance between the children's safeguarding alert reported numbers for 2015/2016 and 2014/2015 is due to the reporting system not being fully established until September 2014. Data systems were not established in 2013/14 to collect safeguarding alerts.



### Attendance at Trust-wide Induction Days

Indicator	2014/2015	2015/2016	2016/2017
Attendance at Trust Wide Induction Days	90%	85%	85%

Source: HR, Data received and calculated: 5 April 2017

### Measure Overview

This measure monitors staff attendance at mandatory Trust-wide induction, which all new staff are required to attend, when they first join the Trust. The Trust schedules this induction event on a rolling basis to new staff at least three times a year. As part of this Induction, staff are provided with an introduction to the work of the Trust and introduction to the Trust's approach to risk management and incident reporting; health and safety; infection control, confidentiality and information governance; Caldicott principles; safeguarding of children and counter fraud awareness, to ensure that all new staff are able to provide a safe and good quality service to service users.

### Targets and Achievements

12 members of staff joined the Trust after the last Trust-wide induction in February and are due to attend the next induction in May. The Trust will continue to monitor the attendance at mandatory training events, aiming to maintain a high level of attendance.

### Local Induction

Indicator	2014/2015	2015/2016	2016/2017
Completion of Local Induction	98%	96%	97%

Source: HR, Data received and calculated: 5 April 2017

### Measure Overview

The Trust provides all new staff with a local induction checklist in their first week of employment. This checklist needs to be completed within two weeks of commencing employment with line managers and a copy returned to Human Resources. This checklist is required by Human Resources to verify that the new staff member has completed their local induction.

This measure monitors the completion and return of the local induction checklist by new staff. The local induction process covers all local policies and procedures in place in individual service areas/directorates and ensures new staff are aware of all terms and conditions of employment, mandatory training requirements and arrangements in place locally that impact on working arrangements within the Trust.

### Targets and Achievements

We are very pleased to report that we received 97% returned forms to show that the local induction had been completed by almost all staff joining the Trust in 2016/17.



It is important that all new staff undertake a local induction with the appropriate manager, in order to ensure that staff are aware of policies and procedures that apply locally within their service area/directorate, and so that staff newly recruited to the Trust are able to provide a relevant, safe and good quality service to patients.

### Attendance at Mandatory INSET Training

Indicator	2014/2015	2015/2016	2016/2017
Attendance at Mandatory INSET Training*	98%	96%	100%

Source: HR, Data received and calculated: 5 April 2017

\*Staff are expected to attend training every two years. In order to achieve this 100% attendance is expected over a two year period. Therefore, the figure reported shows the % of staff up to date with mandatory training at 31 March 2017.

### Measure Overview

This measure monitors staff attendance at mandatory INSET training. The Trust provides the main mandatory training through an In-Service Education and Training (INSET) day, which all staff are required to attend once every two years. During this training day, staff receive training updates in risk management and assessment, health and safety, infection control, confidentiality, equality and diversity, information governance, PREVENT, safeguarding children and adults and fire safety.

### Targets and Achievements

It is important that staff remain up to date with developments in each of these areas, to ensure that they are able to provide a safe and good quality service for service users. We can report that 100% of our staff who were required to attend INSET training had done so within the previous two years and that the attendance rate has improved further since last year.

## Safeguarding of Children and Adults (Training)

Indicator	2014/2015	2015/2016	2016/2017
Safeguarding of Children & Adult – Level 1 Training*	97%	92%	95%
Safeguarding of Adults only – Level 2 Training	n/a	N=61	88%/ as of Q4 training was incorporated in level 3
Safeguarding of Children – Level 2 Training**	100%	96%	88%/ figures do not include Q4 as training for level 2 only was ceased
Safeguarding of Children – Level 3 Training**	94%	92%	94%

**Source: Clinical Governance, Data received and calculated: 5 April 2017**

\*All staff receive Level 1 training as part of mandatory INSET training.

Please note: Adult Level 1 and Level 2 Safeguarding training introduced in 2015/16

### Measure Overview

All staff receive Level 1 training as part of mandatory INSET training and must complete this training every 2 years.

All clinical staff, who are not in contact with children and young people and do not fulfil requirement for level 3, are required to attend Level 2 training. This training must be completed every 3 years. Further level 2 and 3 Adult safeguarding Training is being developed.

To ensure that as a Trust we are protecting children and young people who may be at risk from abuse or neglect, the Trust has made it mandatory for all clinical staff in Child and Adolescent services and other clinical services working predominantly with children, young people and parents to receive Level 3 Safeguarding of Children training once every three years.

### Targets and Achievements

The Trust places great importance on all staff receiving relevant safeguarding training and so we are very pleased that when compared with last year there has been an improvement in attendance for all three levels of Child Safeguarding training. By March 2017 95% of staff received Level 1 training and 88% of staff attended Level 2 training. In addition, 94% of staff requiring Level 3 training had attended this training.

## Infection Control

Due to the types of treatment offered (talking therapies) this Trust is at very low risk of cross infection. All public areas are cleaned to a high standard by internal cleaning staff. Toilets and washrooms are stocked with soap and paper towels and we have alcohol hand gel available for staff and public use in public areas of the Trust (e.g. at the entrance to the lifts in the Tavistock Centre). Anti-bac wipes have been made available in all administration offices and Reception as an additional cleaning resource. Since April 2016 we have initiated processes for support services staff to clean communal area toys on a regular basis (quarterly) in sites managed by T&P Estates

The Trust organised on site access to flu vaccination for staff at the Tavistock Centre by Occupational Health Royal Free Hospital (RHF) staff through the flu campaign from October to February, they can also attend the walk in clinics at the RHF. Outreach and community staff are encouraged to make arrangements for their own Flu vaccines and report to HR. Update on personal responsibility for reducing the risk of cross infection is raised at induction and mandatory INSET training.

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## Gender Identity Development Service

### Kids on the Edge: The Gender Clinic documentary



### What is the service?

The central aim of the service is to support the development of gender identity. We do this by exploring the nature and characteristics of the patient's gender identity. The aims of the service are to understand the nature of the obstacles or adverse factors in the development of gender identity, and to try minimise their negative influence.

### Who is the service for?

The Tavistock's gender service is the country's only NHS-run gender clinic for children and young people with gender dysphoria – a profound distress caused by feeling they've been born into the wrong body. With transgender issues and stories rarely out of the news, the gender specialists have seen a 100% rise in referrals, but still understand very little about why children feel this way.

### What was the documentary?

Following service user feedback the service took part in a Channel Four 3-part documentary series entitled "Kids on the Edge" about different services in the Tavistock. The one on the GIDS ("The Gender Clinic") involved two younger service users and their families. The documentary, which took two years to complete, aired in November 2016 and has received excellent feedback. This was an important opportunity to raise awareness in the context of a considered and balanced film.

### Media impact

The series aired Wednesday nights on Channel 4 at 10pm in Nov-Dec 2016, and total viewership for the series was nearly 2.5 million. The Gender Clinic specific episode had 871,400 TV views and 51,535 on-demand views. The Trust facilitated interviews with nearly all major UK newspapers including a cover article in the Times Sunday magazine and the Observer magazine. Further to this, print media coverage in this time had a "reach" of 945 million and 45 articles were rated as positive about the trust or wider issues involving mental health, 15 were considered negative, and 5 pieces rates as neutral. The documentary led to increase in Trust website and social media traffic.

## Clinical Effectiveness Indicators

### Monitor number of staff with Personal Development Plans (PDPs)

Indicator	2014/2015	2015/2016	2016/2017
Monitor number of staff with Personal Development Plans	98%	99%	100%

Source: HR, Data received and calculated: 5 April 2017

### Measure Overview

Through appraisal and the agreement of Personal Development Plans (PDP) we aim to support our staff to maintain and develop their skills. It also provides an opportunity for staff and their managers to identify ways for the staff member to develop new skills, so as to enable them to take on new roles within the organisation, as appropriate. A Personal Development Plan also provides evidence that an appraisal has taken place. In addition, the information gathered from this process helps to highlight staff requirements for training and is used to plan the Trust Staff Training Programme for the up-coming year.

The data collection period for Personal Development Plans has changed this year from January to March and now takes place from January to May each year. This has impacted our ability to report on the figures this quarter due to the transition process. We will be in a position to report on the appraisal statistics by the end of Q1 each year.

Regarding the statistics it is important to note that the staff group who have not completed a PDP include those staff who are on a career break or sick leave, new starters, or those who have not submitted their PDPs by the Trust deadline.

### Targets and Achievements

We are very pleased to report that 100% of staff had attended an appraisal meeting with their manager and agreed and completed a PDP for the upcoming year by the 31 March 2017 deadline. This is an improvement from last year's return rates.



## Patient Experience Indicators

### Complaints Received

Indicator	2014/2015	2015/2016	2016/2017
Complaints received	14	27	39

Source: Clinical Governance. Data received and calculated: 05-04-17

#### Targets and Achievements

The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. As in previous years the number of formal complaints received by the Trust in 2016/17 remains relatively low at 39 although this represents a rise in complaints from previous years, 14 in 2014/15 and 27 in 2015/16. This is due to patients feeling more able to raise issues with us and an increase in patient numbers, particularly in GIDS.

36 of the formal complaints received relate to aspects of clinical care, appointment times and delays in referral, three complaints relate to corporate services.

In order to maintain confidentiality of the complainants, given the small numbers of complaints, the Trust does not provide the details of these complaints however; a quarterly complaint summary is published on the Trust website. Each complaint was investigated under the Trust's complaints procedure and a letter of response was sent by the Chief Executive to each complainant. During the year there two complaints referred to the Health Service Complaints Ombudsman.

We endeavour to learn from each and every complaint, regardless of whether it is upheld or not. In particular, each complaint gives us some better understanding of the experience of our services for service users, a critical contribution to all of our service development. In addition, for 2016/17 the Trust has taken steps to ensure that all staff are fully aware of the different ways that patients can raise concerns and we have recently launched a short guidance note for staff to help them support their patients with raising concerns. We have also ensured that information on how to raise a complaint is in all patient waiting areas.

## Patient Satisfaction

### Trustwide

Indicator*	Q1	Q2	Q3	Q4
Patient rating of help received as good	93%	91%	92%	94%

\* Yearly averages: 2016/17 = 93% 2015/16 = 94%, 2014/15 = 92%, and 2013/14 = 94%  
Source: PPI, Data received and calculated: 4 April 2017

The Trust has formally been exempted from the NHS National Mental Health Patient Survey which is targeted at patients who have received inpatient care. For eleven years, up until 2011 we conducted our own annual patient survey which incorporated relevant questions from the national survey and questions developed by patients. However the return rate for questionnaires was very low and therefore in 2011 the Trust discontinued using its own survey and started to use feedback received from the Experience of Service Questionnaire (CHI-ESQ) to report on the quality of the patient experience on a quarterly basis. The ESQ was chosen because it was already being used as a core part of the Trust's outcome monitoring, and so we anticipated obtaining reasonable return rates to enable us to meaningfully interpret the feedback.

### Targets and Achievements

Results from the Experience of Service Questionnaire found that 93% of patients in Quarter 1 (April to June 2016), 91% of patients in Quarter 2 (July to September 2016) and 92% of patients in Quarter 3 (October to December 2016) and 94% of patients in Quarter 4 (January to March 2017) rated the help they had received from the Trust as 'good'. Our target for quarterly reporting is 92% achieved in 3 out of the 4 quarters in 2016/17.

The trust also takes part in the Friends and Family Test and reports as part of our Key Performance Indicator schedule on a quarterly basis. This allows us to see how many of our patients would recommend our service to a family or friend if the required similar treatment.

### Experience of Survey Questionnaire; Friends Family Test ONLY

Indicator*	Q1	Q2	Q3	Q4
Number of Patients that would recommend the Tavistock and Portman to a Friend or Family if they required similar treatment (Rated this question either 'Certainly True' or 'Partly True'.)	90%	92%	90%	90%

\*Please note that these figures are for London Contracts Only, data has been re-run for the year to capture all forms that may have been received by the trust after the quarter end.

\*Yearly average of 90% 2016/17

Source: PPI, Data received and calculated: 4 April 2017

### Targets and Achievements

It is pleasing to report that with an annual score of 90% we exceeded our quarterly target of 80% in every quarter throughout the financial year of 2016/17. This is a great way to measure

the way people are feeling about the treatment or service that has been delivered to them from the Tavistock and Portman. Thematic analysis of the qualitative data is also collected, and patients are contacted if they feel as though they have had a negative experience in one of the trusts services.

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## Physical Health: Living Well Programme



### What is the programme?

In the past year we have developed and delivered a programme of initiatives related to improving physical health and wellbeing across both user, carer and staff groups. These included the introduction of formal patient physical health screening, a structured physical health programme, front line clinical service, mindfulness groups and increasing staff knowledge. We established use of physical health assessments for all clients aged 14 and over and a referral process from across the trust to the Physical Health Specialist Nurse to provide both one to one and group physical health service to clients with problems relating to: smoking, alcohol, diet and exercise, stress, sleep disturbance and substance misuse.

### Why did we do this?

Good mental health is associated with good physical health and there is evidence that links the two. We believe that physical health should be included within the holistic management of patients at the Trust and that improving the physical health and wellbeing of our staff is also important. The Trust chose this programme as one of its Quality Priorities for 2016/17 and it was also one of the Trust's Sign up to Safety projects. Additionally, it was a priority for our health commissioners.

### Outcomes

A structure to support the delivery of physical health work across the organisation was set up during 2016/17. The Trust has two clinical physical health leads, one for the Children, Adult and Families service and one for the Adult and Forensic services. In addition the Trust appointed a Physical Health Specialist Nurse on 2 days per week to lead on developing and delivering the Living Well Programme. Service level physical health 'champions' have been supporting the work. We have developed an increased awareness of the importance of physical health across the Trust and will work with clinicians to further develop and embed a culture of integrated physical and mental health and wellbeing across the Trust.

By the end of quarter 3 over 60% of new patients aged 14 years and older had physical health assessments. One to one referrals to the PHSN have increased through the year, and weekly lunchtime staff mindfulness courses have been well attended.

### Patient feedback comments to the Living Well Programme

"The group really helped me to reduce my alcohol use and my blood pressure went down. Now I can do more at the gym and eat healthier".  
"By closing my kitchen/ bar earlier and developing new strategies for coping with stress, I reduced my alcohol use and my sleep pattern improved".

## Did Not Attend Data

Indicator	2014/15	2015/2016	2016/2017
<b>Trust-wide Total</b>			
First Attendance	7.8%	10.0%	10.0%
Subsequent Appointments	7.7%	7.2%	7.4%
<b>Adolescent and Young Adult</b>			
First Attendance	8.9%	15.2%	15.4%
Subsequent Appointments	14.8%	10.2%	8.5%
<b>Adult</b>			
First Attendance	8.5%	10.4%	11.6%
Subsequent Appointments	7.3%	6.1%	6.5%
<b>Camden Child and Adolescent Mental Health Service (Camden CAMHS)</b>			
First Attendance	8.8%	8.5%	8.3%
Subsequent Appointments	7.1%	7.3%	7.7%
<b>Other CAMHS (including Lifespan)</b>			
First Attendance	3.8%	4.1%	6.4%
Subsequent Appointments	4.1%	4.2%	6.1%
<b>City and Hackney</b>			
First Attendance	n/a	16.2%	12.9%
Subsequent Appointments	n/a	10.7%	10.2%
<b>Portman</b>			
First Attendance	2.7%	9.7%	5.7%
Subsequent Appointments	8.3%	6.7%	7.0%
<b>GIDS</b>			
First Attendance	n/a	8.8%	10.7%
Subsequent Appointments	n/a	7.6%	7.4%
<b>Westminster Service</b>			
First Attendance	n/a	4.3%	1.5%
Subsequent Appointments	n/a	4.9%	12.7%

Please note n/a data was not reported on.

Source: CareNotes, Data received and calculated: 5 April 2017

## Measure Overview

The Trust monitors the outcome of all patient appointments, specifically those appointments where the patient Did Not Attend (DNA) without informing us prior to their appointment. We consider this important, so that we can work to improve the engagement of patients, in addition to minimising where possible wasted NHS time.

## Targets and Achievements

DNA rates have remained the same for first attendances however, however slightly increased for subsequent/follow-up appointments compared with last year. First attendances remained at (10.0%) for 2016-17, and an increase in DNA rates for subsequent/follow-up appointments (7.4%) compared with 2015/16 (7.2%).

We believe that this has been as a consequence of the on-going and concerted efforts undertaken by all services to reduce the number of appointments patients fail to attend. For example, by offering a greater choice concerning times and location of appointments; emailing patients and

sending them text reminders for their appointments, or phoning patients ahead of appointments as required.

As DNA rates can be regarded as a proxy indicator of patient's satisfaction with their care, the lower than average DNA rate for the Trust can be considered positively. For example, for some patients not attending appointments can be a way of expressing their dissatisfaction with their treatment. However, it can also be the case, for those patients who have benefited from treatment that they feel there is less need to continue with their treatment, as is the case for some patients who stop taking their medication when they start to improve. However, this is only one of the indicators that we consider for patient satisfaction, which needs to be considered along with other feedback obtained from patients, described elsewhere in this report.

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## Waiting Time Breaches – Target dependent on service

Number (%) of patients attending a first appointment 6, 8, 11 or 18 weeks after referral received

Service	Target	Internal Breach	External Breach
Adolescent Service	<8 weeks (10%)	33 (14.0%)	14 (5.9%)
Camden CAMHS	<8 weeks (10%)	80 (5.4%)	26 (1.8%)
Other CAMHS	<8 weeks (10%)	69 (12.1%)	51 (8.9%)
Westminster (Family Assessment Service)	<6 weeks (10%)	15 (21.1%)	20 (28.2%)
Adult service	<11 weeks (5%)	30 (5.0%)	25 (4.2%)
Portman	<11 weeks (10%)	0 (0%)	4 (3.1%)
City and Hackney PCPCS	<18 weeks (10%)	82 (9.0%)	43 (4.7%)
Gender Identity Service	<18 weeks (10%)	2562 (100%>)	38 (1.5%)

Source: Carenotes, Data received and calculated: 5 April 2017

## Measure Overview

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait, especially those who are close to our target time of eleven weeks. The definition of this indicator is as follows:

The numerator is the number of patients who had attended a first appointment during the year more than either 6, 8, 11 or 18 weeks (dependant on service) after referral received.

The denominator is the sum of

- Number of first appointments that took place during the year
- Number of first appointments that were cancelled
- Number of first appointments where patients did not attend

Prior to their first appointment, patients will be contacted and offered two possible appointments, and invited to choose one of these appointments. If neither appointment is convenient for the patient, they will be offered an alternative appointment with the same therapist where possible. This system on the whole helps to facilitate patients engaging with the service. The majority of patients are seen within eleven weeks of the Trust receiving the referral.

## Targets and achievements

To help address the breaches, at the end of each quarter a list is drawn up for each service of those patients who had to wait longer than the given target of weeks for their first appointment, together with reasons for this. The services where the breach has occurred are

requested to develop an action plan to address the delay(s) and to help prevent further breaches.

Overall the Trust has seen an increased number of patients in 16/17. In many services patients are seen within our waiting time targets. However in some services the number of breaches has exceeded the target. In services such as the Adolescent and Young Adult Service, this is due to scarce availability of the specialised resources required for complex patients seen in this service. In our Gender Identity Service this is due to the continued increase in the referral rate. We anticipate seeing an improvement in waiting times as additional resources have been made available and thirty new staff have joined the London base over the final quarters of 2016/17.

With regards to Other CAMHS, Lifespan team breaches are a mixture of both internal and external reasons, the first external reason for breaches is the patient group Lifespan work with can at times be hard to engage. Moreover the unspecific demographics of the service prove hard to secure funding with in the 8 week target, as information from external services is needed to continue with referral. This in turn has an increase to our overall number of breaches.

Westminster Service (Family Assessment Service) has had unusually high number of referrals in the last three quarters which exceeds capacity and also exceeds targets for the year. This has means cases have had to wait for clinicians to become available to carry out the work. As the nature of the service is 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. The service is under 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.

City and Hackney PCPCS figures have improved greatly throughout the year due to improving the general intake criteria (better clarity and signposting for mental health services in City and Hackney area), intake processes (opt-in letter procedures and policies put in place) and staffing (fully staffed admin).



## 3.2 Performance against relevant Indicators and Thresholds

The majority of the mental health indicators set out in the Compliance Framework/Risk assessment framework are not applicable to The Tavistock and Portman NHS Foundation Trust, as they relate to inpatient and/or medical consultant lead services which the Trust does not provide. However, the 'mental health identifiers' (NHS number; date of birth; postcode; current gender; Registered General Medical Practice organisation code, and Commissioner Organisation code) apply to the Trust and in 2016/17 by achieving 97% data completeness for these mental health identifiers.

The Trust complies with requirements regarding access to healthcare for people with a learning disability.

## 3.3 Reported Raising of Concerns: Whistleblowing

The Trust takes the issue of staff being able to raise concerns, 'whistleblowing' very seriously and appointed Gill Rusbridger to the role of Freedom to Speak up Guardian in October 2015. This is in line with Francis Review recommendations. The Trust has in place a 'Raising Concerns and Whistleblowing procedure' and regular communications have gone to staff to make them aware of our Freedom to Speak up Guardian, her role and contact details. Meetings have also been held with groups of staff to raise awareness.

There were no formal whistleblowing cases raised in 2016/17 or the previous year 2015/16 and the Trust has had no members of staff coming forward and raising formal complaints about patient care. However, since being appointed, staff have felt able to make contact to discuss other issues in confidence. These have related in particular to staff feeling not listened to by managers and feeling bullied. This is sometimes seen as having an indirect impact on the quality of care given to patients and families. We are committed to building a culture of openness and responsiveness to staff speaking out about anything that might place the care of our service users into question.

Contact has been made with the National Whistleblowing Helpline and our Guardian now receives regular newsletter updates. She has also joined the NHS Employers local Guardian hub and her details are on the Freedom to Speak Up Guardian map. Links have also been made with the London Freedom to Speak Up Guardians and a new group for those based in Mental Health Trusts. The National Guardian's Office is now establishing itself and is arranging regular conferences and training events. The National Guardian visited the Trust in February 2017.

The Guardian will continue to keep the profile of the role in the Trust as high as possible. This is an important role that actively addresses and acknowledges the Trust's commitment to ensuring a culture of openness where staff are encouraged to speak up about patient safety, knowing that their concerns will be welcomed, taken seriously and responded to quickly.

### 3.4 Sign up to safety

The focus on quality of care and patient safety remains central to the Tavistock and Portman NHS Foundation Trust. The National Sign up to Safety Campaign's aim to deliver harm free care for every patient every time, halving avoidable harm in the NHS over the next three years is a commitment that the Trust fully supports. The Chief Executive signed up to the campaign on behalf of the Trust in October 2015. The actions the organisation would take in response to the five Sign up to Safety pledges within the National campaign can be found on our Trust website.

These commitments have led to the development of a Safety Improvement Plan which shows how we intend to reduce harm to patients over the next 3 years. This builds on and integrates with our Clinical Quality Strategy and Annual Quality Report. Our patient safety improvement plan focus on the following areas:

- Detection and management of e-safety risks in young people
- Improving the physical health of patients
- Improving domestic violence and abuse management
- Improving clinician knowledge of self-harm and suicide

The Trust has agreed a Clinical Quality Strategy to meet the local needs of our service users and believe that the core aims outlined in the Strategy will drive the Safety Improvement Plan.

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; and
- 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.

## 3.5 Staff Survey

### 1. The 2015 survey

The NHS Staff Survey took place between September and December 2016. For a second year running we offered all of our staff the opportunity to respond to the survey using the online questionnaire.

This year the survey was sent to 556 staff and 321 responded giving a final response rate of 58%, a 12% increase from the previous year. A copy of the national report can be found here: [http://www.nhsstaffsurveys.com/Caches/Files/NHS\\_staff\\_survey\\_2016\\_RNK\\_full.pdf](http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2016_RNK_full.pdf)

### 2. Key messages from the survey

Out of the 32 key finding areas 29 have not changed compared to previous years, 2 have got worse and 1 has got better.

The following areas are our top result areas:

- We have a higher than average engagement score (4th best compared to mental health trusts and 21st best when compared to all NHS provider organisations);
- Our staff would recommend the organisation as a place to work and be treated (best mental health trust and 18th best compared to all provider organisations);
- A higher proportion of staff are happy with the opportunities to work flexibly, this was a concern area last year;
- Communication between senior management and staff is better;
- Fewer staff experience bullying, harassment, violence or aggression from service users or their relatives;
- Whilst staff witness incidents the number is smaller than our peer group.

There are some less positive findings, some which are consistent with previous years and are also with feedback we have been receiving through less formal mechanisms:

The number of staff working additional hours continues to be a challenge;

The level of work place stress has increased;

That there is less resources and support;

Staff feel, less so, that their role makes a difference to service users and that they do not receive recognition from their managers;

That when staff feel they have been bullied or harassed by managers or colleagues they have not reported this;



That bullying and discrimination amongst our BME staff has increased since the previous survey; and

That a lower than average number of staff reported errors, near misses or incidents.

This year we have seen some changes in our best and less positive areas. We have also received results at both directorate and service line level which will help us to understand where we need to focus our attention and give support.

### 3. Responding to the workforce race equality standard (WRES)

During 2016/17 published our WRES data and action plan and have started an ongoing programme of work to improve on areas where we need to focus more attention. The data last year did indicate that there had been some small changes in our workforce composition at more senior levels in the organisation which is positive, however, it is still early days and we have committed as an organisation to developing and implementing a race equality strategy.

### 4. Setting actions and tracking progress

The bottom up action planning process that was followed last year proved to be successful and we will be repeating this process again. Our HR team will work collaboratively with service line managers and heads of service to discuss the results and agree how to best share the key messages and what support they will need to address the issues. This will then lead to local action plans being produced which inform a corporate plan.

## Portman Service



### What is the service?

We are a forensic psychotherapy out-patient clinic that offers psychoanalytic psychotherapy assessments and treatment to individuals presenting with problems of violence, criminality, antisocial behaviour and problematic sexual behaviours. We also provide risk assessments, teaching and consultations to forensic staff, teams and institutions within the NHS and Criminal Justice System and other services which work with forensic patients and offenders.

Because of the sensitive nature of the difficulties that our patients present with, we take issues of confidentiality very seriously whilst carefully assessing any risk posed towards self and others.

### Who is the service for?

We offer treatment to children, adolescents and adults presenting with problematic violent, sexual or antisocial behaviours. We have a national catchment area and accept referrals from anywhere within England and Wales. Our referrals come from GPs, secondary mental health services, probation and other services within the Criminal Justice System, social services and voluntary agencies. We also accept self-referrals. Our treatments include individual, group and couple therapy, and when working with children and young adults, we offer support to their parents and carers as well.

### Outcomes

Over 80% of our patients report a reduction in their problematic behaviours after six months of therapy.

Of the Experience of Patient Questionnaire (ESQ) forms returned in 2015-2016, 92% of patients reported that they had been treated well, 88% felt they had been listened to, and 95% felt they had worked well with their therapist.

### Quotes from patients

"Without therapy I'd be dead or in prison - possibly both."

"I feel deeply grateful. Thank you for all your help and concern."

"The therapist who assessed me was very professional and competent."

## Part 4: Annexes

TBC

DRAFT

## Appendix – Glossary of Key Data Items

**AFS-** Adult and Forensic Services.

**Black and Minority Ethnic (BME) Groups Engagement** - We plan to improve our engagement with local black and minority ethnic groups, by establishing contact with Voluntary Action Camden and other black and minority ethnic community groups based in Camden.

**CCG (Clinical Commissioning Group)** - CCGs are new organisations created under the Health and Social Care Act 2012. CCGs are independent statutory bodies, governed by members who are the GP practices in their area. A CCG has control of the local health care budget and 'buys' local healthcare services on behalf of the local population. Some of the functions a CCG carries out replace those of Primary Care Trusts that were officially abolished on 31 March 2013, such as the commissioning of community and secondary care. Responsibilities for commissioning primary care transferred to the newly established organisation, NHS England.

**Care Quality Commission** – This is the independent regulator of health and social care in England. It registers, and will license, providers of care services, requiring they meet essential standards of quality and safety, and monitors these providers to ensure they continue to meet these standards.

**CareNotes** - This is the patient administration system using, which is a 'live system' for storing information electronically from patient records.

**City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS)** - The City and Hackney Primary Care Psychotherapy Consultation Service offers talking therapies to adults aged 18 or over living in the City of London or London Borough of Hackney. Clinicians typically see patients who are experiencing problems such as depression, anxiety, stress, panic, and isolation, loss of sleep or persistent physical pain or disability. It is an inclusive service, seeing people from a diverse range of backgrounds. Depending on the individual needs clinicians will work with the individual, a couple, and a family or in a group of 8-12 others.

**Clinical Outcome Monitoring** - In "talking therapies" is used as a way of evaluating the effectiveness of the therapeutic intervention and to demonstrate clinical effectiveness.

**Clinical Outcomes for Routine Evaluation** - The 34 items of the measure covers four dimensions, subjective well-being, problems/symptoms, life functioning and risk/harm.

**Commission for Health Improvement Experience of Service Questionnaire** - This captures patient views related to their experience of service.

**CQUIN (Commissioning for Quality and Innovation payment framework)** - This enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

**Complaints Received** - This refers to formal complaints that are received by the Trust. These complaints are all managed in line with the Trust's complaints policy.

**CYAF** - Children, Young Adults and Families services.

**Did Not Attend (DNA) Rates** - The DNA rate is measured for the first appointment offered to a patient and then for all subsequent appointments. There is a 10% upper limit in place for the Trust, which is the quality standard outlined in our patient services contract.

The DNA Rate is based on the individual appointments attended. For example, if a family of three is due to attend an appointment but two, rather than three, family members attend, the appointment will still be marked as attended. However, for Group Therapy the attendance of each individual will be noted as they are counted as individual appointments.

DNA rates are important to the Trust as they can be regarded as a proxy indicator of patient's satisfaction with their care.

**Family Nurse Partnership National Unit (FNP NU)** - The Family Nurse Partnership is a voluntary home visiting programme for first time young mothers, aged 19 or under. A specially trained family nurse visits the young mother regularly, from early in pregnancy until the child is two. Fathers are also encouraged to be involved in the visits if mothers are happy for them to be. The programme aims to improve pregnancy outcomes, to improve child health and development and to improve the parents' economic self-sufficiency. It is underpinned by an internationally recognised evidence base, which shows it can improve health, social and educational outcomes in the short, medium and long term, while also providing cost benefits.

**Goal-Based Measure** - These are the goals identified by the child/young person/family/carers in conjunction with the clinician, where they enable the child/carer etc to compare how far they feel that they have moved towards achieving a goal from the beginning (Time 1) to the End of Treatment (either at Time 2 at 6 months, or at a later point in time).

**Infection Control** - This refers to the steps taken to maintain high standards of cleanliness in all parts of the building, and to reduce the risk of infections.

**Information Governance** - Is the way organisations 'process' or handle information. It covers personal information, for example relating to patients/service users and employees, and corporate information, for example financial and accounting records.

Information Governance provides a way for employees to deal consistently with the many different rules about how information is handled, for example those included in The Data Protection Act 1998, The Confidentiality NHS Code of Practice and The Freedom of Information Act 2000.

**Information Governance Assessment Report** - The Trust is required to carry out a self-assessment of their compliance against the Information Governance requirements.

The purpose of the assessment is to enable organisations to measure their compliance against the central guidance and to see whether information is handled correctly and protected from unauthorized access, loss, damage and destruction.



Where partial or non-compliance is revealed, organisations must take appropriate measures, (for example, assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. This in-turn increases public confidence that 'the NHS' and its partners can be trusted with personal data.

**Information Governance Toolkit** - Is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance included in the various Acts and presents them in one place as a set of information governance requirements.

**INSET (In-Service Education and Training/Mandatory Training)** - The Trust recognises that it has an obligation to ensure delivery of adequate and appropriate training to all staff groups, that will satisfy statutory requirements and requirements set out by the NHS bodies, in particular the NHS Litigation Authority and the Care Quality Commission Standards for Better Health. It is a requirement for staff to attend this training once every 2 years.

**LGBT** - Lesbian, Gay, Bisexual, and Transgender community.

**Local Induction** - It is the responsibility of the line manager to ensure that new members of staff (including those transferring to new employment within the Trust, and staff on fixed-term contracts and secondments) have an effective induction within their new department. The Trust has prepared a Guidance and checklist of topics that the line manager must cover with the new staff member.

**Monitoring of Adult Safeguards** - This refers to the safeguarding of vulnerable adults (over the age of 16), by identifying and reporting those adults who might be at risk of physical or psychological abuse or exploitation.

The abuse, unnecessary harm or distress can be physical, sexual, psychological, financial or as the result of neglect. It may be intentional or unintentional and can be a single act, temporary or occur over a period of time.

**National Clinical Audits** - Are designed to improve patient care and outcomes across a wide range of medical, surgical and mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care.

**National Confidential Enquiries** - Are designed to detect areas of deficiency in clinical practice and devise recommendations to resolve these. Enquiries can also propose areas for future research programmes. Most confidential enquiries to date are related to investigating deaths and to establish whether anything could have been done to prevent the deaths through better clinical care.

The confidential enquiry process goes beyond an audit, where the details of each death or incident are critically reviewed by a team of experts to establish whether clinical standards

were met (similar to the audit process), but also to ascertain whether the right clinical decisions were made in the circumstances.

Confidential enquiries are “confidential” in that details of the patients/cases remain anonymous, though reports of overall findings are published.

The process of conducting a national confidential enquiry process usually includes a National Advisory Body appointed by ministers, guiding, overseeing and coordinating the Enquiry, as well as receiving, reporting and disseminating the findings along with recommendations for action.

**NHS Litigation Authority (NHS LA)** - The NHS LA operate a risk pooling system into which Trust contribute on annual basis and it indemnifies NHS bodies in respect of both clinical negligence and non-clinical risks and manages claims and litigation under both headings. The Authority also has risk management programmes in place against which NHS Trusts are assessed.

The NHS LA has a statutory role “to manage and raise the standards of risk management throughout the NHS” which is mainly carried out through regular assessments, ranging from annually to every three years, against defined standards developed to reflect the risk profiles of the various types of healthcare organisations. Compliance with the standards can be achieved at three levels, which lead to a corresponding discount in contributions to the NHS LA schemes.

There are 50 standards to achieve covering the categories of governance, workforce, and safe environment, clinical and learning from experience. Level 1 assesses that the policies around each standard are in place, level 2 ensures that processes around each policy are in place and level 3 ensure compliance with both the policies and processes for each of the individual standards.

**Participation in Clinical Research** - The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited during the year to participate in research approved by a research ethics committee.

**Patient Feedback** - The Trust does not participate in the NHS Patients Survey but conducts its own survey annually, as it has been exempted by the Care Quality Commission from using the NHS Patient Survey, with the recognition that the nature of the services provided by the Trust differ to other mental health Trusts.

There are various other methods used to obtain feedback from patients, including small scale surveys and audits (such as the Children’s Survey, the Ground Floor Environment Survey, the Website Survey), the suggestions box, feedback to the PALS officer and informal feedback to clinicians and administrators.

**Patient Forums/Discussion Groups** – These meetings aim to increase the opportunities for patients, members and the public to obtain information, and to engage in discussions about topics, such as therapy - how it can help, and issues such as confidentiality. In turn, the feedback to the Trust generated by these meetings is used to improve the quality of our clinical services.

**Patient Safety Incidents** – This relates to incidents involving patient safety which are reportable to the National Patient Safety Agency database National Reporting and Learning System.

**Percentage Attendance** – The number of staff members who have attended the training or completed the inductions (Trust-wide and Local) as a percentage of those staff required to attend training or complete the inductions. Human Resources (Staff Training) record attendance at all mandatory training events and inductions using the Electronic Staff Record.

**Periodic/Special Reviews** - The **Care Quality Commission** conducts special reviews and surveys, which can take the form of unplanned visits to the Trust, to assess the safety and quality of mental health care that people receive and to identify where and how improvements can be made.

**Personal Development Plans** - Through appraisal and the agreement of a Personal Development Plan for each member of staff we aim to support our staff to maintain and develop their skills. A Personal Development Plan also provides evidence that an appraisal has taken place.

**Quality Stakeholder Meetings** - These include consultation meetings with stakeholders (Patient and Public Involvement representatives), Non-Executive Directors and a Governor, and the separate meeting with governors. The purpose of these meetings is to contribute to the process of setting quality priorities and to help improve other aspects of quality within the Trust.

**Return rate** - The number of questionnaires returned by patients and clinicians as a percentage of the total number of questionnaires distributed.

**Safeguarding of Children Level 3** - The Trust has made it mandatory for all clinical staff working in child and adolescent services and other clinical services working predominantly with children, young people and parents to be trained in Safeguarding of Children Level 3, where staff are required to attend Level 3 training every 3 years. (In addition, all other Trust staff regularly attend Safeguarding of Children Training, including Level 1 and 2 training.) The training ensures that Trust staff working with children and young people are competent and confident in carrying out their responsibilities for safeguarding and promoting children's and young people's welfare, such as the roles and functions of agencies; the responsibilities associated with protecting children/young people and good practice in working with parents. The Level 3 training is modelled on the core competencies as outlined in the 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' (Intercollegiate Document 2010); Working Together to Safeguard Children, 2010; the London Child Protection Procedures 4th Ed, 2010; NICE Clinical Guidance 2009: 'When to Suspect Child Maltreatment'.

**Specific Treatment Modalities Leaflets** - These leaflets provide patients with detailed information on the different treatment modalities offered by the Trust, to facilitate patients making informed choices and decisions about their treatment.

**Time 1** - Typically, patients are asked to complete a questionnaire during the initial stages of assessment and treatment, or prior to their first appointment.



**Time 2** - Patients are again asked to complete a questionnaire at the end of assessment and treatment. The therapist will also complete a questionnaire at Time 2 of the assessment and/or treatment stage.

Our goal is to improve our Time 2 return rates, which will enable us to begin to evaluate pre- and post- assessment/treatment changes, and provide the necessary information for us to determine our clinical effectiveness.

**Trust-wide Induction** – This is a Trust-wide induction event for new staff, which is held 3 times each year. All new staff (clinical and non-clinical) receive an invitation to the event with their offer of employment letter, which makes clear that they are required to attend this induction as part of their employment by the Trust.

**Trust Membership** - As a foundation Trust we are accountable to the people we serve. Our membership is made up of our patients and their families, our students, our staff and our local communities. Members have a say in how we do things, getting involved in a variety of ways and letting us know their views. Our members elect Governors to represent their views at independent Boards where decisions about what we do and how we do it are made. This way we can respond to the needs of the people we serve.

**Waiting Times** - The Trust has a policy that patients should not wait longer than 11 weeks for an appointment from the date the referral letter is received by the Trust to the date of the first appointment attended by the patient.

However, if the patient has been offered an appointment but then cancelled or did not attend, the date of this appointment is then used as the starting point until first attended appointment.

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait, especially beyond eleven weeks. A list of breached first appointments is issued at the end of each quarter for each service, together with reasons for the long wait and, if appropriate, the actions to be taken to prevent recurrence.



## Board of Directors: April 2017

**Item :** 15

**Title :** Q4 Dashboards

**Purpose:**

Key points to note are:

- We continue to perform well in almost all areas.
- 23% increase in patients seen compared to previous year.
- The further increase in over 18 week waits is 96% due to GIDS, but this is an indication that the waiting list is being cleared with a significant increase in 1<sup>st</sup> attendances rather than a worsening of performance. Further detail is available in the *Waiting Time Analysis By Team Board Report*
- HR – Improvements in both mandatory training and appraisals + new annual survey data included.
- Quality – Safety: Child safeguarding alerts remain elevated, due to new reporting methods, but indicates an improvement in practice.
- Effectiveness: Trust-wide DNA rate has risen to the 10% target limit
- Addition of DET CPD metrics – achieved or surpassed all predictions.
- Single Oversight Framework: Three data quality indicators now have a red rating. An action plan is in place to address this.

The Dashboards were reviewed at the Management Team on 18 April '17.

**For :** Discussion

**From :** Freddie Peel, Project Manager

## 1.0 The Development of the Dashboards

Following a pause in development owing to data quality issues with the test datasets the 'Team Dashboards' are now progressing and a number of prototype designs are being explored using a business intelligence tool.

## 2.0 Points to note

**Reach:** We are seeing 23% more patients than in the same period last year. (MOSAIC and EIS data is not yet available). 85% of this growth is the result of increased demand for our Gender Identity Development Service (GIDS) and the establishment of the Team Around the Practice (TAP) Service in Camden.

**Quality Well Led:** Most indicators suggest the Trust is performing extremely well in this domain and compares very favourably when benchmarked to other Trusts. One significant area for improvement since the Q2 report can be found in the proportion of staff reporting that they would recommend the Trust as a good place to work, rising 12% from 66% in Q3 (the bottom of our expected range of 66-69%) to 78% in Q4. The only two areas of performance that have declined since last year's annual survey are 'staff motivation at work' (down 2.4%) and 'support from immediate managers' (down 2%). Following the action plan to improve mandatory training compliance by using e-learning there has been a notable positive increase in overall compliance and last year staff appraisals reached 100%.

**Quality Safety:** The three SUIs from Q4 are internal SUIs as they did not meet the criteria for reporting externally on STEIS, but are included as it was felt there was organisational learning resulting from these incidents. The number of incidents at Gloucester House has increased a further 15% from an already elevated level last quarter. Child safeguarding alerts while dropping slightly remain at the same order of magnitude, confirming that last quarter was not a statistical error but rather a factor of the new Carenotes driven reporting system for alerts. As Sonia Appleby confirmed last quarter this is actually a positive step as we now have more accurate recording by staff and more systematic questioning about safeguarding issues. Under the sections covering the percentage of staff reporting bullying or witnessing errors, near misses or incidents despite these numbers rising compared to last year's survey we are now / match the best MH Trust score.

### Quality Responsive:

96% of those waiting over 18 weeks are in our Gender Identity Development Service. The significant increase in those waiting over 18 weeks in this instance is not a cause for concern, but rather the product of GIDS offering 19% more first appointments in Q4 compared to Q3; predominantly to those who have already been waiting over 18 weeks. Greater detail around the over 18 week waiters in other services can be found in the *Waiting Time Analysis By Team Board Report*. ESQ collection rates were the best ever at 78%.

**Quality Effective:** In Q4 the Trust-wide DNA rate reached 10%; our target ceiling. Patients' view of the help they received remained static. The project to review our outcome KPIs and presentation is ongoing.

Unfortunately our mechanism for reporting collection rates and improvement scores for our two key Outcome Measures; the GBM and the CORE, has malfunctioned and therefore no data was available for this current financial year. Further action will be taken in order to remedy this in time for the Q1 Dashboard.

### Education and Training:

This dashboard has been updated with the 2016-17 figures; indicating a slight drops in the numbers of students reporting satisfaction with the quality of their course (down 4%), and their perceived preparedness for their future career (down 2%), however both of these measures still remain above the benchmark. There was however a 9% increase in students stating that they have been able to apply their learning on the course to their job; DET's measure of effectiveness.

A new DET table has been included for the first time which captures the directorate's CPD work. As denoted by the colour coding, DET met or exceeded every one of their predictions in the last financial year.

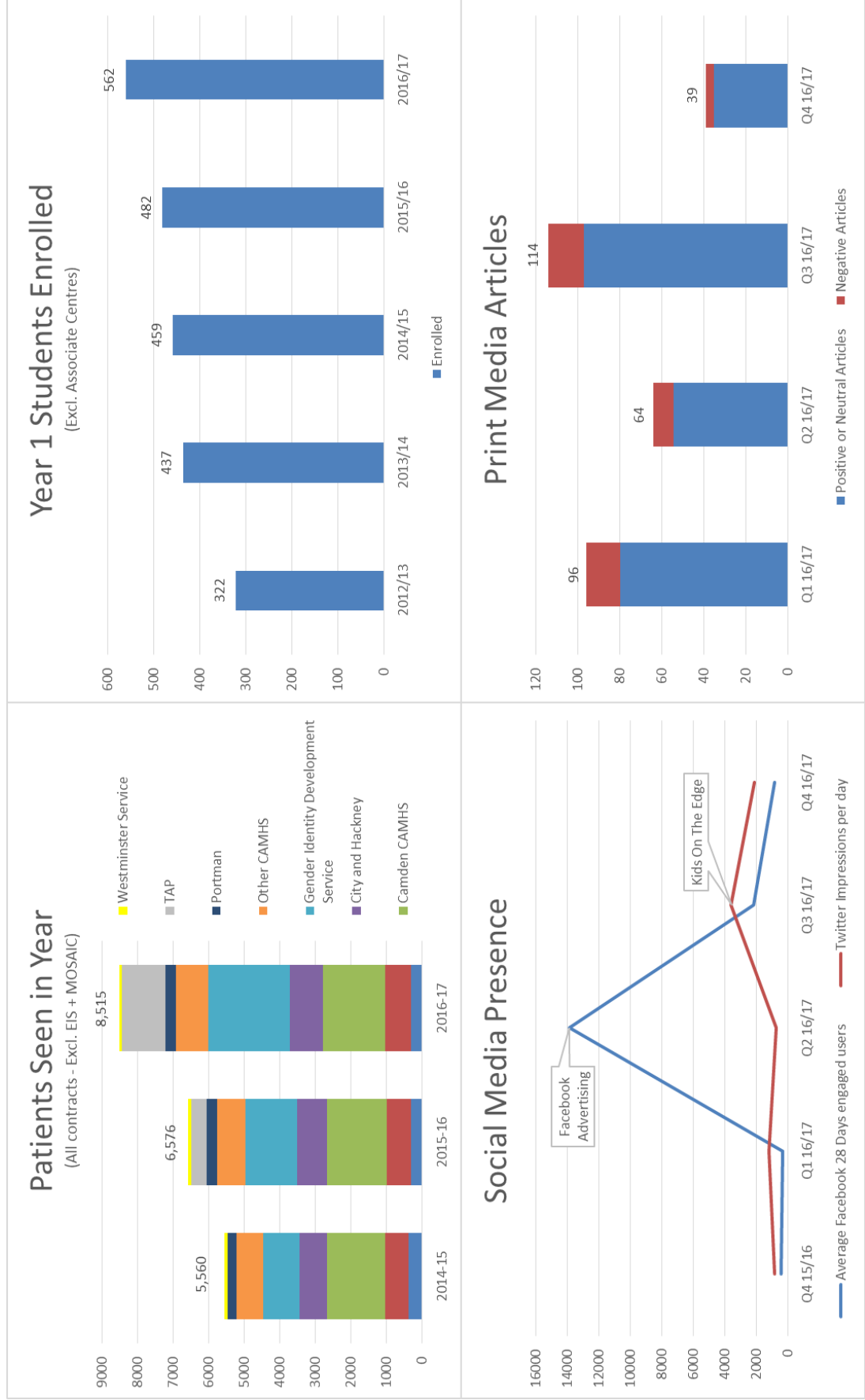
### Single Oversight Framework

Our current performance against the Single Oversight Framework appears here for the second quarter. Month 12 data was unavailable at the time this dashboard was compiled so here is presented Month 11 figures. The concern is our red rating against three data quality indicators. An action plan is in place to address this. We are clarifying what level of performance would trigger the Trust to be awarded a 2 for governance.



Q4 – 2016/17

# Trust Reach



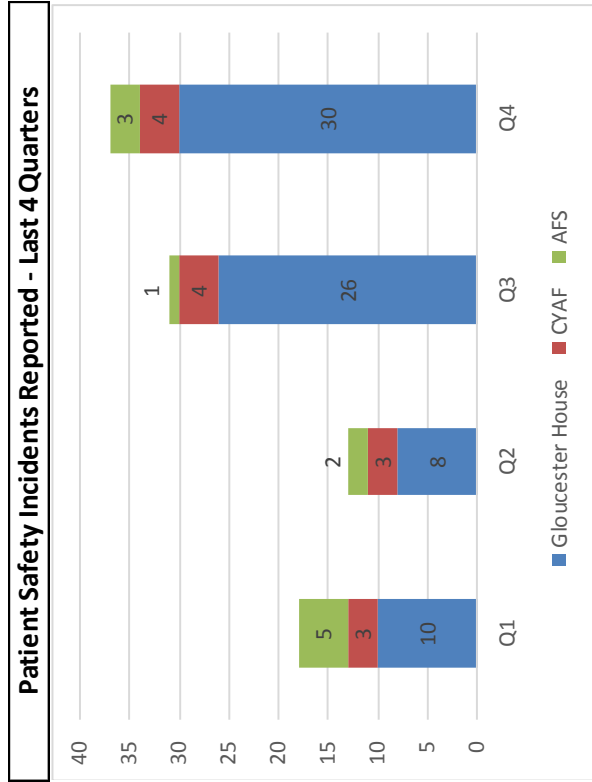
Q4 – 2016/17

## Quality – Well Led

MORALE	TRAINING	MANAGEMENT
<b>Staff sickness</b> <b>1.7%</b> Trust Benchmark (15/16) - all NHS Trusts <small>Source: TPNHSFT HR</small>	<b>Staff appraised</b> <b>99%</b> 2015/16 2016/17 <small>Source: TPNHSFT HR</small>	<b>Support from immediate managers</b> Trust 2014/15 Score <b>4.01</b> Trust 2015/16 Score <b>3.95</b> Trust 2016/17 Score <b>3.85</b> MH Trust 2016/17 Average <b>3.88</b> <small>Source: NHS Staff Survey</small>
<b>Staff motivation at work</b> Trust 2014/15 Score <b>3.91</b> Trust 2015/16 Score <b>3.99</b> Trust 2016/17 Score <b>3.87</b> MH Trust 2016/17 Average <b>3.91</b> <small>Source: NHS Staff Survey</small>	<b>Staff opinion on quality of appraisals</b> Trust 2015/16 Score <b>3.05</b> Trust 2016/17 Score <b>3.05</b> MH Trust 2016/17 Average <b>3.15</b> <small>Source: NHS Staff Survey</small>	<b>% staff reporting good comms between senior mgmt and staff</b> Trust 2014/15 Score <b>43%</b> Trust 2015/16 Score <b>46%</b> Trust 2016/17 Score <b>45%</b> MH Trust 2016/17 Average <b>35%</b> <small>Source: NHS Staff Survey</small>
<b>Staff recommend Trust as place to work</b> <b>66%</b> Q3 National Average Q4 <b>78%</b> 56% <small>Source: TPNHSFT HR</small>	<b>Mandatory training: % staff</b> <b>85%</b> Q3 Q4 <b>94%</b> <small>Source: TPNHSFT HR</small>	<b>Recognition and value of staff by managers and the organisation</b> Trust 2015/16 Score <b>3.92</b> Trust 2016/17 Score <b>3.61</b> MH Trust 2016/17 Average <b>3.56</b> <small>Source: NHS Staff Survey</small>
<b>Disclosure and Barring Service Compliance</b> <b>% of staff with a compliant DBS Check</b> <b>96%</b> <small>Source: TPNHSFT HR</small>	<b>Staff opinion of training</b> Trust 2015/16 Score <b>3.97</b> Trust 2016/17 Score <b>4.01</b> MH Trust 2016/17 Average <b>4.06</b> <small>Source: NHS Staff Survey</small>	



# Quality – Safety



Serious Incidents reported
Q3. YP (11) 3 days in a police custody suite awaiting secure bed
Q4. YP reported to have attempted to hang themselves
Q4. YP (14) took overdose whilst on home leave from Priory
Q4. YP on UCLH paediatric ward for 8 days under a section 2 of MHA waiting for a bed

Source: TPNHSFTHR H&S Manager

% DBS checks on relevant staff
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94% Q3 96% Q4

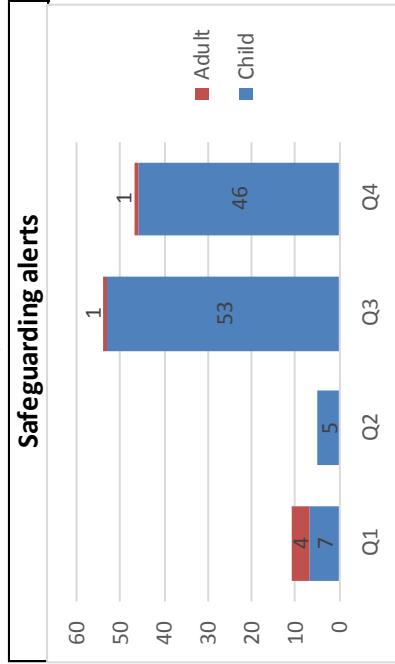
% staff experiencing harassment / bullying last 12m
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Trust 2016 Score 24%  
Trust 2015 Score 19%  
National MH Average 2016 33%  
Best MH Score 2016 24%

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

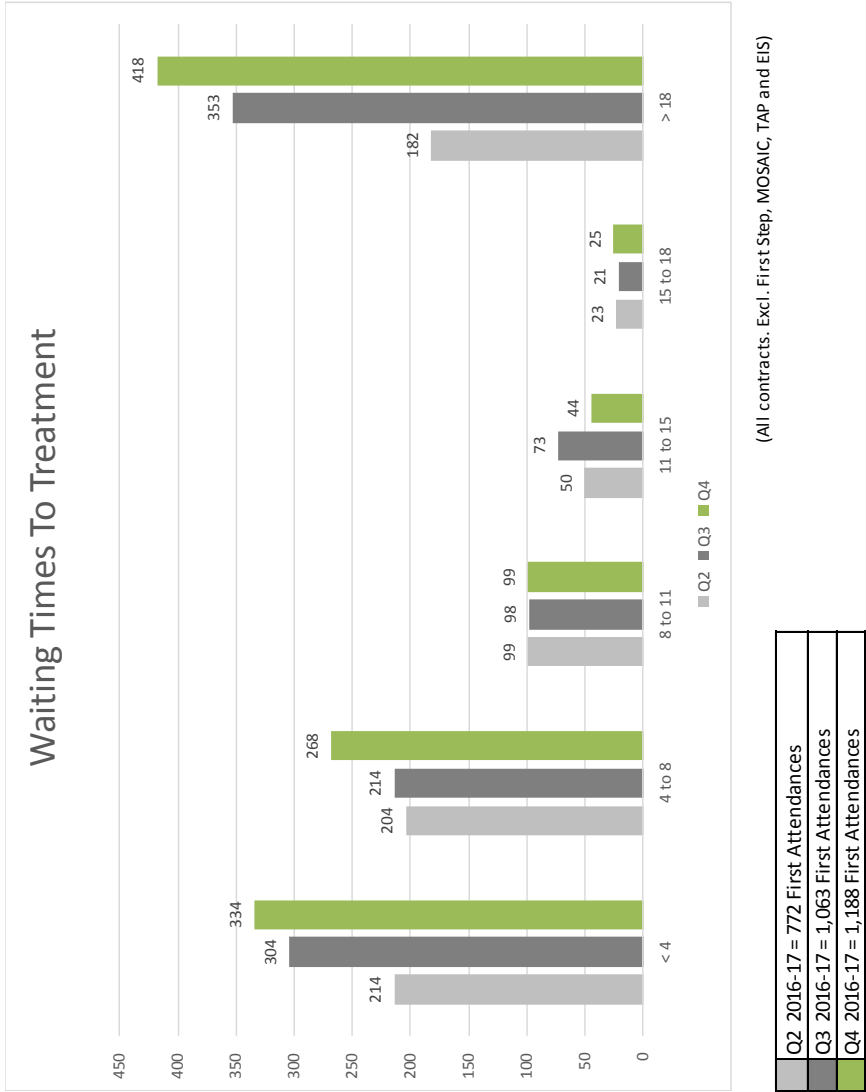
Trust 2016 Score 16%  
Trust 2015 Score 13%  
National MH Average 2016 27%  
Best MH Score 2016 16%

Source: 2016 National Staff Survey - TPNHSFT



Q4 – 2016/17

# Quality – Responsive



		2016-17				
		15-16	Q1	Q2	Q3	Q4
ESQ	Views and worries were taken seriously (Q4)	94%	93%	93%	94%	94%
	Involved in important decisions about my care (Q13)	87%	86%	87%	86%	86%
	ESQ Scores Collected	74%	63%	72%	73%	78%
Data Collection						

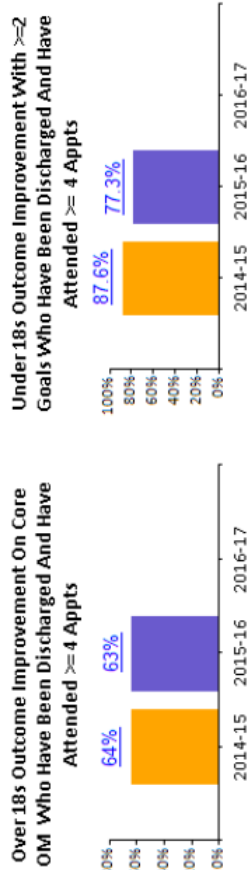
NB: ESQ report run on 12.04.17  
(All contracts. Excl. MOSAIC, TAP and EIS)

		2016-17				
		Q1	Q2	Q3	Q4	
No. of Complaints		12	6	13	11	

Q4 – 2016/17

# Quality – Effective

## Outcomes



Q4 98 Positive Outcomes Out of 154 Outcomes  
Q4 73 Positive Outcomes Out of 116 Outcomes  
Q4 0 Positive Outcomes Out of 81 Outcomes

All contracts. Excluding Portman, TAP, City and Hackney and CYAF (apart from adolescent team).

Q4 347 Positive Outcomes Out of 396 Outcomes  
Q4 289 Positive Outcomes Out of 374 Outcomes  
Q4 0 Positive Outcomes Out of 0 Outcomes

All contracts. Excluding AVA, FDAC, YPDAS, First Step, Westminster, Mosaic, EIS, GIDS and Portman.

		2016-17				15-16	
(All contracts. Excludes MOSAIC, TAP and EIS)							
KPI/Data	DNA Rate						
Patient	I received helpful info prior to 1st visit (Q6)	9.1%	10.0%	8.6%	10.0%	7.0%	Target Value
Patient	Help I received at Trust is good (Q15)	81%	81%	80%	80%	78%	
Satisfaction	Recommend Trust to others (Q11)	94%	93%	93%	93%	93%	
Data	ESQ Scores Collected (YTD)	91%	91%	91%	91%	89%	
		62.9%	72.1%	72.7%	78.2%	74.3%	

## Directorate of Education and Training (DET)

Student Experience and Outcomes									
Satisfaction: "Overall, I am satisfied with the quality of the course"			Personal Development /Prepared: "I feel better prepared for my future career"			Effectiveness "I have been able to apply my learning on the course to my job"			
Academic	Bench	Tavistock	Academic	Bench	Tavistock	Academic	Bench	Tavistock	
2012/13	88.3%	92.8%	2012/13	72.4%	82.3%	2012/13	80.3%	87.1%	
2013/14	87.0%	93.0%	2013/14	77.9%	86.2%	2013/14	77.0%	81.3%	
2014/15	83.0%	94.0%	2014/15	81.0%	91.0%	2014/15	78.0%	87.0%	
2015/16	86.0%	90.0%	2015/16	82.0%	89.0%	2015/16	87.0%	96.0%	
*excludes associate centres			*excludes associate centres			*excludes associate centres			

Benchmark UK data: [www.hefce.ac.uk/lt/nss/results](http://www.hefce.ac.uk/lt/nss/results) (Summary UK) [2016]

## Directorate of Education and Training (DET)

### CPD/CEDU (Updated)

Based on full costs including internal training costs and library (not reflected in the ledger for J55103 as accounted for elsewhere within DET)

As at 31/3/17

Year	13-14 FY	14-15 FY	15/16 FY	16/17 FY predicted	16/17FY Actual
CPD/E-learning	45	58	70	91	94
Bespoke work	14	18	10	36	38
Conferences	18	18	16	4	4
Student Numbers	2079	2738	2063	1719	1924
Income	501,917	556,261	493,090	596,758	608,526
Income growth on previous year	35%	16%	-11%	21%	23%
Contribution	160,769	158,104	123,616	141,301	184,900
Staff numbers	3	3	2	3.5	3.5

HCUK confs for 16-17. Previous years included confs delivered at Tavistock which have not been run this year.

Not incl. bespoke for 16-17

Excludes LCCPD

## Single Oversight Framework

Segmentation under the Single Oversight Framework: **1** (the best of the four possible ratings, no identified support needs)

There are five themes under the Single Oversight Framework that NHS Improvement considers when assigning organisations to Trusts. Of these Finance and Use of Resources is covered in the monthly board papers. Our current status for the other four themes is:

Quality of Care: **Green**

Strategic Change: **Green**

Leadership and Improvement Capability: **Green**

Operational Performance: **Amber**

	Target (%)	Month 11 (%)	Current / Future Target
Valid NHS number	95	99.6	Current
Valid Postcode	95	99.9	Current
Valid Date of Birth	95	100	Current
Valid Organisation code of Commissioner	95	98.7	Current
Valid Organisation code GP Practice	95	99.4	Current
Valid Gender	95	100	Current
Ethnicity	85	73.6	Current
Employment Status (for adults)	85	46.3	Current
Accommodation status (for adults)	85	46	Current
ICD10 coding	85	N/A	N/A

## Board of Directors: April 2017

**Item :** 16

**Title :** Quality Report Commentary Quarter 4 2016/17

### **Purpose:**

The purpose of this report is to provide commentary on key quarter 4 quality metrics where targets have not been met or the trajectory shows a worsening or improving position. Actions taken to address identified issues are included.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place. The detailed Q4 Quality Report is available on request.

This report has been reviewed by the following Committees:

- Executive Management Team,

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

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

**For :** Noting

**From :** Louise Lyon, Director of Clinical Quality and Patient Experience  
Kerri Johnson-Walker, Data Quality Manager

## Quality Report Q4 2016/17

### 1. Introduction

- 1.1 As requested by the Board of Directors the following paper provides a summary and narrative for quarter 4 quality metrics currently within the Quality Report. This report specifically covers those metrics where we are not meeting targets or where the trajectory suggests a worsening position. Service level updates and actions are provided by the Service Leads. Some significant improvements are also highlighted. Please note the data in this report is for London contracting only (As requested by commissioners)

- 1.2 The following metrics are summarised below:

- 1.2.1 Waiting times
- 1.2.2 Did not attend (DNAs)
- 1.2.3 Outcome monitoring
- 1.2.4 Physical Health KPI Targets and Living Well CQUIN programme
- 1.2.5 Safe and Timely Discharge CQUIN

### 2. Summary

- 2.1 Data is validated by services and is as accurate as possible. Standard operating procedures (SOPs) /checklists to improve validation at service level are under development. The Quality Team has a Data Quality SOP to streamline validation, and a Clinical Data Quality Validation Plan has been approved. A Data Quality Policy and a Clinical Data Quality Management Procedure were approved in quarter 4 2016/17.
- 2.2 Waiting time breaches within Adolescent and Young Adults (under 18) have increased from Q2 6.5%, Q3 18.2% to Q4 45% against a 10% threshold for 8 weeks. The trajectory for the GIDs services has continued to decrease from Q2 with 51.6% of patients in Q4 breaching the 18 week Waiting time target in comparison to 65.7% in Q3. Waiting times for Other CAMHS has decreased in Q4 to 5.5% compared with 18.3% in Q3. Adult Complex Needs service is just under 4% with a 5% target for 11 weeks. City and Hackney waiting times have decreased



from 11.5% in Q3 to 2.9% in Q4 against an 18 week target and 10% threshold.

- 2.3 DNA rates are a yearly average and expected to be no larger than 10%. The London Contract combined data decreased slightly from 9.7% to 7.6% in Q4. All services excluding City and Hackney (11.2%), met the target of 10%. Notably, the Adolescent and Young Adults service, Camden CAMHS, Portman and GIDS saw a slight decrease in DNAs when compared to Q3. Other CAMHS saw a slight increase of 0.2% when compared to Q3, similarly in Adult Complex Needs who observed a 0.1% increase in DNAs. The Family Assessment Service saw an increase from 13.3% in Q3 to 14% in Q4.
- 2.4 Outcome monitoring KPI CORE target is 70% of the eligible cohort showing improvement on the measure. In Q4 fifty patients were eligible with thirty two improving (64%). Goal Base Measure compliance requires improvement: forty two out of eighty eight (48%) had completed a Time 1 (initial) and Time 2 (Review) at the end of Q4) with a target of 80%. Out of the forty two that had completed a Time 1 and Time 2 thirty four (80.1%) showed an improvement on at least 2 goals. This indicates that we met the 80% target.
- 2.5 The physical health KPI targets for recording smoking status (80%) and offering intervention (50%) are challenging. Recording of smoking status decreased from 51% in Q1 to 27% in Q2 and 24% in Q3 However after actions targeted to improve performance, the target was exceeded The (84.4%). Interventions offered increased 12.9% in Q2 17% in Q3 but have decreased to 11% in Q4. The Living Well CQUIN includes completion of the physical health form and has increasing targets for the year which were met for Q1 and Q2 but not Q3, however we missed the Q4 target of 70%, scoring 66%. Actions are being taken to increase compliance.
- 2.6 The Safe and Timely Discharge CQUIN applies to all services excepting GIDs. Audit data showed we met the first target of sending 85% of the letters out within 2 weeks of discharge (85%). However the second target of including mandatory information was not met with only 45% of letters meeting the trust standard when the audit was taken in Q4 on

Q3 data. The Portman Clinic are audited separately in accordance with the CQUIN conditions, they also achieved the first target of sending 85% letters out in a timely way (100%), however 15% of letters included the mandatory information required for the second target (80%). Standards for discharge letter requirements were updated in April 2016 following an earlier audit, and a standardised discharge letter template was available from the end of Q1. However, it has been identified that owing to current internal discharge processes the template has not been widely used. Further work is being undertaken in Q1 2017/18 to expand the closing section on the review / closure form on CareNotes which clinicians complete and increase data which can be auto-populated so that the discharge template will be more fully populated. All Portman Clinic letters are now sent out via Andrew Williams to ensure all mandatory fields are included. This CQUIN will continue for the Portman Clinic in financial year 2017/18.

### 3. Data commentary

#### 3.1 Waiting Times

Waiting time targets, from receipt of referral, vary according to service contract agreements from 8 – 18 weeks. Targets are on the basis of internal breaches only and have a threshold of 10% for 8 and 18-week referrals, and 5% for 11-week referrals.

##### 3.1.1 Improvements

The management of Camden CAMHS waiting times is meeting the 8 week target with a further improvement from 3.8% in Q3 to 2.5% in Q4.

Other CAMHS waiting times are being met with an improvement from 18.3% in Q3 to 5.5% in Q4.

Adult Complex need Service has met their under 5% target for 11 week waiting times, from 5.8% in Q3 to 3.6% in Q4.

GIDS have continued to improve from Q2 (67%), Q3 (65.7%) to Q4 (51.6%), however are still a little way off the 10% threshold for their 18 week waiting times target, with the new recourses in place it has been

predicted that waiting times should be in line with this target by September 2017. Over 17 year olds present a particular challenge due to the long waiting list in adult services which also differ in their protocols. The transition between children to adult services is one of this years' CQUINs and taking on the GIC service from April will provide further opportunity to improve the flow between services. The Leeds base have piloted a group first appointment for over 17 year olds with excellent feedback.

City and Hackney have made a huge improvement in their waiting time target of 18weeks, with 2.9% of patients breaching in Q4 compared to 11.5% in Q3.

### 3.1.2 Decreasing trajectory

The Adolescent and Young Adult (under 18) services have an increased number of 8 week waiting times breaches from to 19.5% in Q3 to 45% in Q4. This is due to scarce availability of the specialised resources required for complex patients seen in this service.

## 3.2 DNAs

DNA rates are a yearly average and expected to be no larger than 10%.

### 3.2.1 Improvements

The Adolescent and Young Adult Service DNA rate went down from 9.7% in Q3 to 7.6% in Q4. The service is working hard to minimise failed patient appointments and sessions.

No changes have been made to the processes surrounding making and confirmation of appointments within Camden CAMHS, 7.1% DNA rate. The low DNA rate is a reflection of the lack of any major school breaks or National Holidays which we seem to struggle with in the other quarters.

Portman Service has a DNA rate of 7% in Q4 compared to 9.5% of Q3.

GIDS have also seen an improvement from 9.7% DNA rate in Q3 to 7.4% in Q4

### 3.2.2 Consistent trajectory

Other CAMHS DNA increased by 0.3% from Q3 giving them a DNA percentage of 6.5%, still with in the 10% target. The low DNA rate is a reflection of the lack of any major school breaks or National Holidays which we seem to struggle with in the other quarters.

Adult Complex Needs Service have a 0.1% increase on DNA rates from Q3–Q4, current DNA percentage is 7.5%.

### 3.2.3 Decreasing trajectory

Family Assessment service has seen an increase in their DNA rates in Q4 to 14%, compared with 13.3% in Q4. 245 appointments were scheduled between 8 staff and 27 of these were DNA's – unfortunately clients lose their schedules, forget to cancel or don't wish to engage. Text messages from CareNotes cannot be adopted as the clients are recorded under the youngest child. It has to be emphasised that a piece of work cannot be stopped until 3 DNA's in a row have been recorded then the Local Authority can be approached to approve discharging due to non-engagement. The service has had hard to engage clients who often do not wish to see more professionals but are ordered by the court to do so. Of the 8 clients who DNA'd only 3 later engaged and their work progressed, the other 5 were discharged as non-engagement.

## 3.3 Outcome monitoring KPI targets

Outcome monitoring KPI CORE target is 70% improvement. In Q4 fifty patients were eligible with thirty two improving (64%). Goal Base Measure compliance requires improvement forty two out of eighty eight (48%) had completed a Time 1 (initial) and Time 2 (Review) at the end of Q4 with a target of 80%. Out of the forty two that had completed a Time 1 and Time 2 thirty four (80.1%) showed an improvement on at least 2 goals. This indicates that we met the 80% target. The Quality team are

dedicated to a Quality improvement project around OM, focusing on GBM and will begin this in Q1 of the financial year 2017/18.

### 3.4 Physical Health KPI Targets and Living Well CQUIN programme

The physical health KPI targets of recording smoking status (80%) and offering intervention (50%) are challenging. Smoking status decreased from 51% in Q1 to 27% in Q2 and 24% in Q3. However, after actions targeted to improve performance, the target was exceeded (84.4%). Interventions offered increased 12.9% in Q2, 17% in Q3, but have decreased to 11% in Q4. The Living Well CQUIN includes completion of the physical health form and has increasing targets for the year which were met for Q1 and Q2 but not Q3; however, we missed the Q4 target of 70%, scoring 66%. Actions are being taken to increase compliance.

Following a review of the physical health data, it was noted that data generated included patients within the London contracts who were currently being seen, rather than the CQUIN requirement of new patients from 1 April 2016. The updated report definition is below along with updated figures: *‘Patients who have attended their FIRST appointment from the beginning of this financial year.’*

PHF COMPLETION		
	DATA SENT TO BOARD	NEWLY RUN DATA
Q1 (Target 35%)	33.90%	42.20%
Q2 (Target 45%)	35.70%	45.10%
Q3 (Target 60%)	n/a	60%
Q4 (Target 70%)	n/a	66%

Data run 5 Jan17

Monthly physical health data is now provided to Service Leads by the Quality Team and information is to be included in the developing Team Dashboards. From Q1 2017/18, service managers and admin leads will be required to provide a monthly update of Physical Health Form completion rates at Clinical Data Quality Review Group (CDQRG). A number of Team level physical health champions are supporting this work and the Physical Health Specialist Practitioner is working with the Trust Physical Health Clinical Leads, Drs Caroline McKenna and Rob Tandy.

### 3.5 Safe and Timely Discharge CQUIN

The Safe and Timely Discharge CQUIN applies to all services excepting GIDs. Audit data showed we met the first target of sending 85% of the letters out within 2 weeks of discharge (85%). However the second target of including mandatory information was not met with only 45% of letters meeting the trust standard when the audit was taken in Q4 on Q3 data. Portman are audited separately in accordance with the CQUIN conditions, they also achieved the first target of sending 85% letters out in a timely way (100%), however 15% of letters included the mandatory information required for the second target (80%). Standards for discharge letter requirements were updated in April 2016 following an earlier audit, and a standardised discharge letter template was available from the end of Q1. However, it has been identified that owing to current internal discharge processes the template has not been widely used. Further work is being undertaken in Q1 17/18 to expand the closing section on the review / closure form on CareNotes which clinicians complete and increase data which can be auto-populated so that the discharge template will be more fully populated. All Portman Clinic letters are now sent out via Andrew Williams to ensure all mandatory fields are included. This CQUIN will continue for the Portman Clinic in financial year 2017/18.

Kerri Johnson-Walker  
Data Quality Manager  
13<sup>th</sup> April 2017

## Board of Directors: April 2017

**Item : 17**

**Title : Waiting Time Analysis by Team**

**Purpose:**

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

A more detailed analysis of waiting times in the Gender Identity Service will be provided in their service line report, to be presented to the Board in May 2017

This report has been reviewed by the following Committees:

- Executive Management Team

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

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

**For : Discussion**

**From :** Louise Lyon, Director of Clinical Quality and Patient Experience  
Kerri Johnson-Walker, Data Quality Manager

## Waiting Times Analysis by Team

### 1. Introduction

- 1.1 As requested by the October Board of Directors the following paper provides an analysis and narrative for waiting times by Team on a quarterly basis in order to show whether the waiting time trajectory is improving or worsening. Actions being taken to address identified issues are included. Data is provided for the period 1 April 2016 to 31<sup>st</sup> March 2017.
- 1.2 The following services and the relevant waiting time targets have been included:
  - 1.2.1 Adults = 11 weeks
  - 1.2.2 City and Hackney = 18 weeks
  - 1.2.3 Portman Clinic = 11 weeks
  - 1.2.4 Camden CAMHS = 8 weeks
  - 1.2.5 Other CAMHS = 8 weeks
  - 1.2.6 Adolescent = 8 weeks, 11 weeks for over 18s
  - 1.2.7 GIDS = 18 weeks
  - 1.2.8 Westminster = 6 weeks
- 1.3 This report shows the number of seen waiters by team across services offered in the Trust. The data is for patients Trust wide including NHS England contracts for GIDS and Portman.
- 1.4 Waiting time information is taken from the date the referral was received to the first appointment. Service Leads and Team Administrators have provided commentary on where these are not well met and what action plans are in place to improve waiting times and meet the target.
- 1.5 Please note First Step and Gloucester House School have been excluded from the analysis.

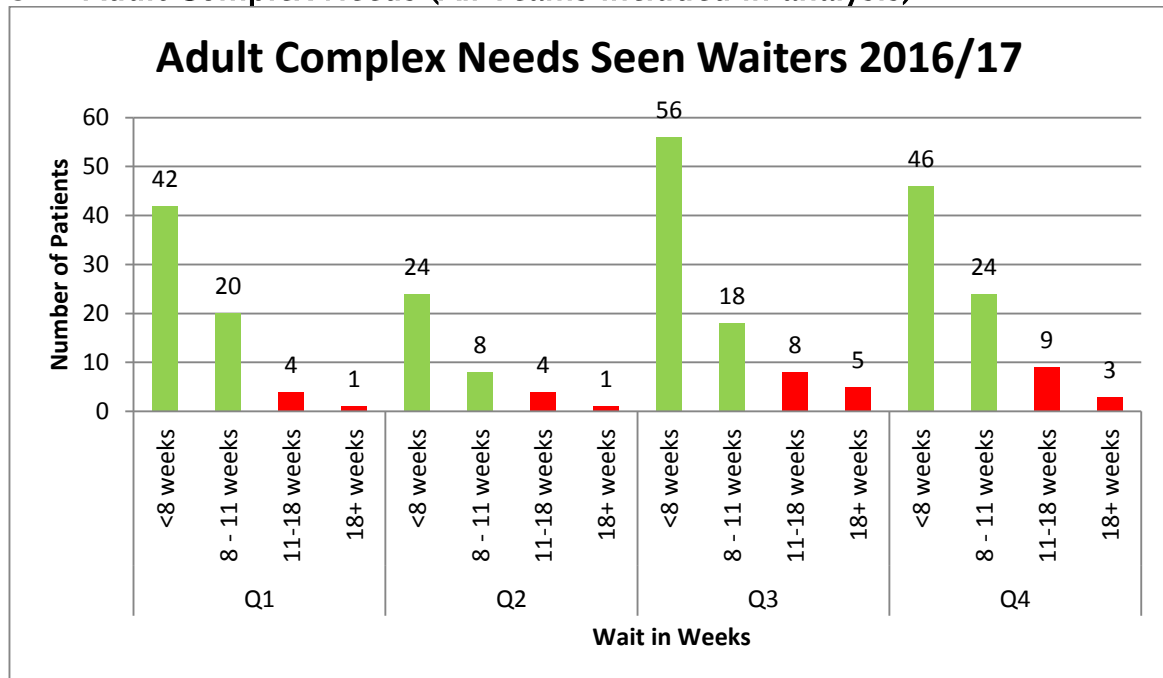


## 2. Summary

- 2.1 Table 1 shows the number of patients that have been seen in the quarter and how long they waited at a team level. The numbers in green indicate the number of people within their targeted waiting time and those in red have not met the target waiting time.
- 2.2 Adult teams: Overall Adults has maintained their waiting times. Although they have higher breaches than the Trust's 10% target.
- 2.3 City and Hackney have performed well the financial year keeping breaches to minimum consecutively over the quarters.
- 2.4 Increases in waiting times leading to breaches are noted in specific Other CAMHS overall, the GIDS service overall and Westminster FAS Family Assessment Team.
- 2.5 Camden CAMHS has performed particularly well throughout the year with such a high volume of patients.

### 3. Detailed analysis and commentary

#### 3.1 Adult Complex Needs (All Teams included in analysis)



Number of patients seen in Quarter 4 is double the amount seen in Quarter 2. However 13.5% of seen patients breached the target of 11 weeks in quarter 2 and this has only slightly risen to 14.6% in Quarter 4.

In the financial year of 2016/17 the Adult Complex Needs service saw 272 new patients from the waiting list 15.9% of these patients have breached the 11 week target.

**Total waiting at the end of the financial year: 62**

'The issue has been the loss of sessions from last year's savings in the Trauma Unit with a major reduction in Consultant time. The effect of this has accumulated through the year with the steady build-up of referrals. The Trauma Unit was flagged up as an issue of risk to the Board.

We have been able to make available one further clinical session for the service which will begin to take effect in the data from the next quarter. Further we have also found 2 sessions of investment money to create a new arm to the service of a treatment group for the survivors of sexual abuse. This will have a

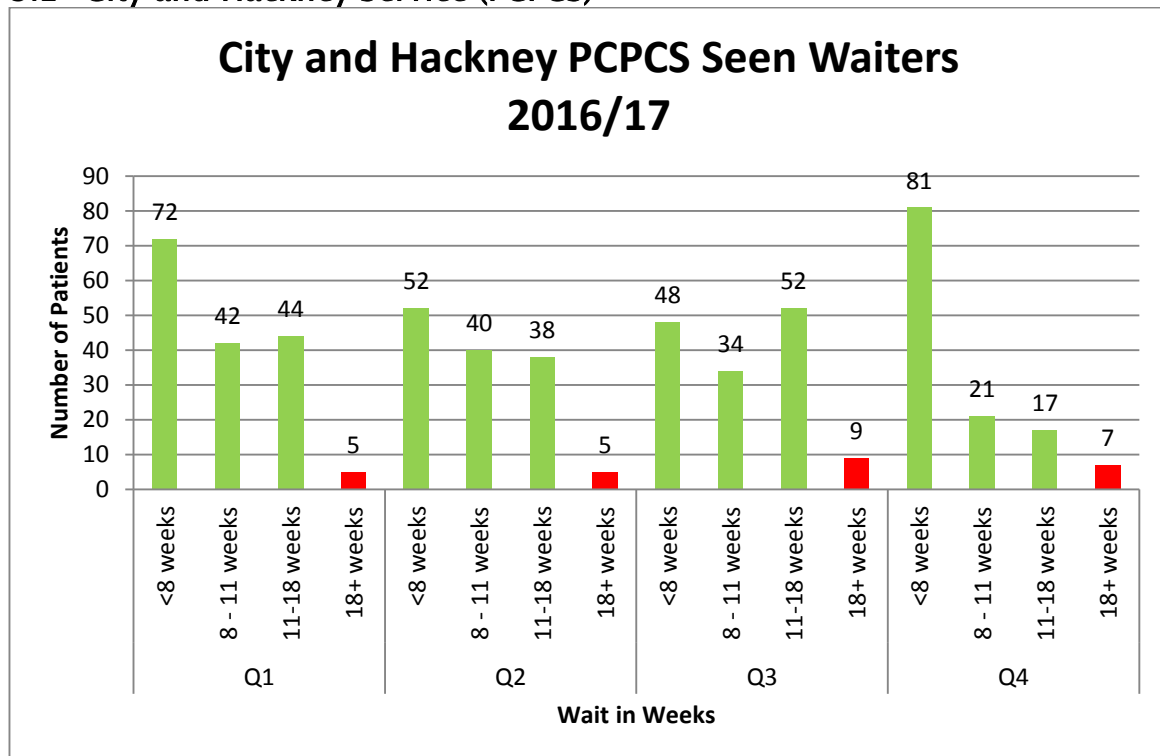
very beneficial knock on effect, by reducing the number of patients on the waiting list who need to be seen for review and freeing up more time for assessments.

A general issue is the turbulence in medical education which causes dramatic fluctuations in the availability of ST4/6s staff. Some handover will take place in the summer.

The Couples Unit also contributed to the breaches this year, and new staff sessions have been in post since January which should allow more students to see couple patients.'

*Michael Mercer, Head of Adult Complex Needs*

### 3.2 City and Hackney Service (PCPCS)



The waiting time target for City and Hackney is 18 weeks with 94.4% meeting this target in Q4, those seen within 8 weeks of received referral almost doubled from Quarter 3.

In the financial year of 2016/17 City and Hackney saw 567 patients from the waiting list, only 4.6% of the patients breached the 18 week target.

Number waiting at the end of the financial year: 95

“The PCPCS figures for the time between referrals and first assessment appointment have decreased. This is due to changes in three areas:

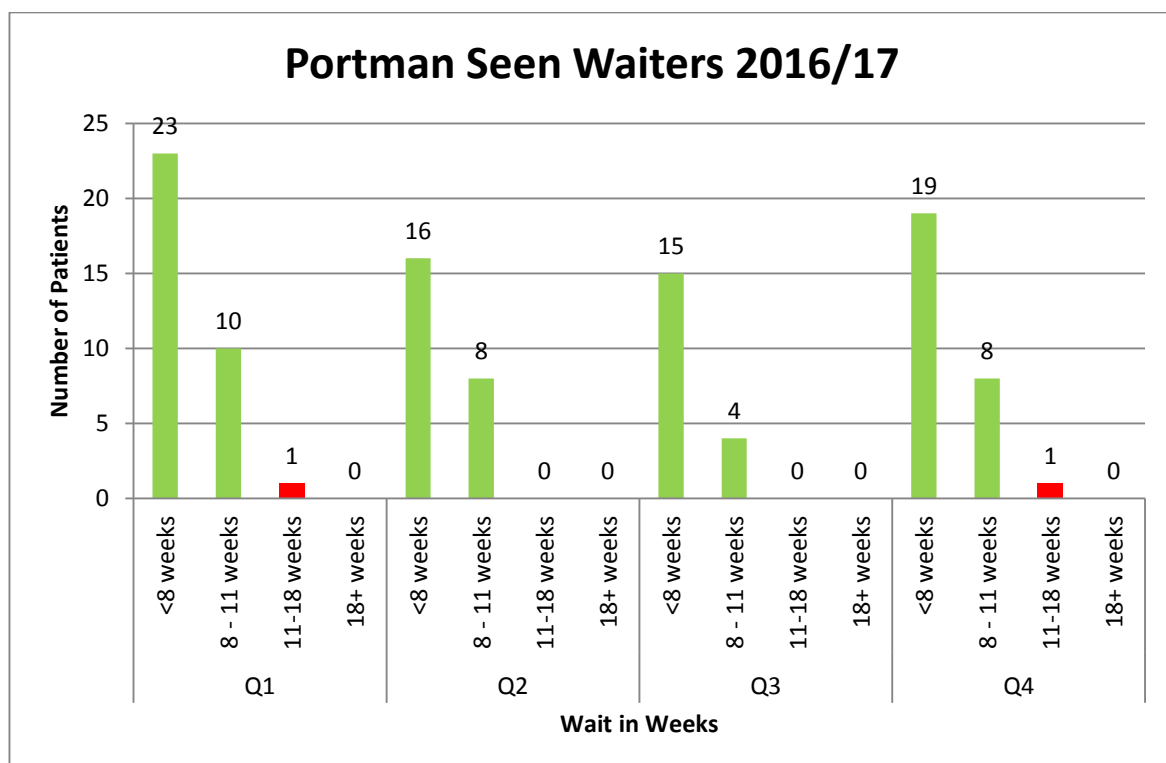
- 1) Intake Criteria: The commissioners have supported the Service to return to its initial intake criteria and focus on GP referrals only. As a result, more people are signposted to other Services and less people are accepted for an assessment.
- 2) Intake processes: The opt in letters for assessments are being sent the same or next day that intake takes place, which was not the case before.

As a result, the times between the acceptance of a referral and an appointment offered have decreased.

- 3) Staffing: We were fully staffed, both in terms of clinicians and admin staff. So we were quicker in processing referrals, sending letters out and offering appointments, but we also had more assessment appointments to offer in relationship to past quarters."

*Dimitra Lorentzatou, Clinical Operations Manager*

### 3.3 Portman Clinic



The waiting time target for Portman is 11 weeks with 96.4% meeting this target in Q4, which is a pleasing figure. Portman have only breached on 2 patients in this financial year.

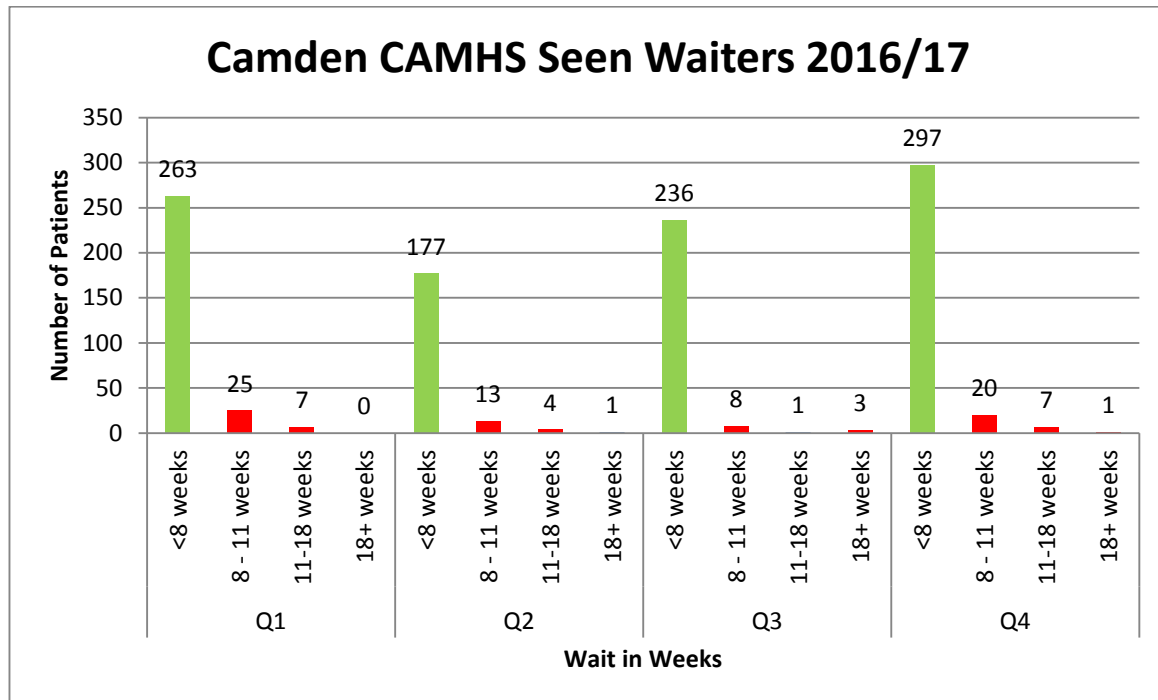
In the financial year of 2016/17 Portman saw 105 patients from the waiting list, only 1.9% of the patients breaching the 11 week target.

**Number waiting at the end of the financial year: 6**

‘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.’

*Jessica Yakeley, Director of the Portman Clinic*

### 3.4 CYAF (Camden CAMHS – All Teams Selected)



The waiting time target for Camden is 8 weeks with 91.4% meeting this target in Q4.

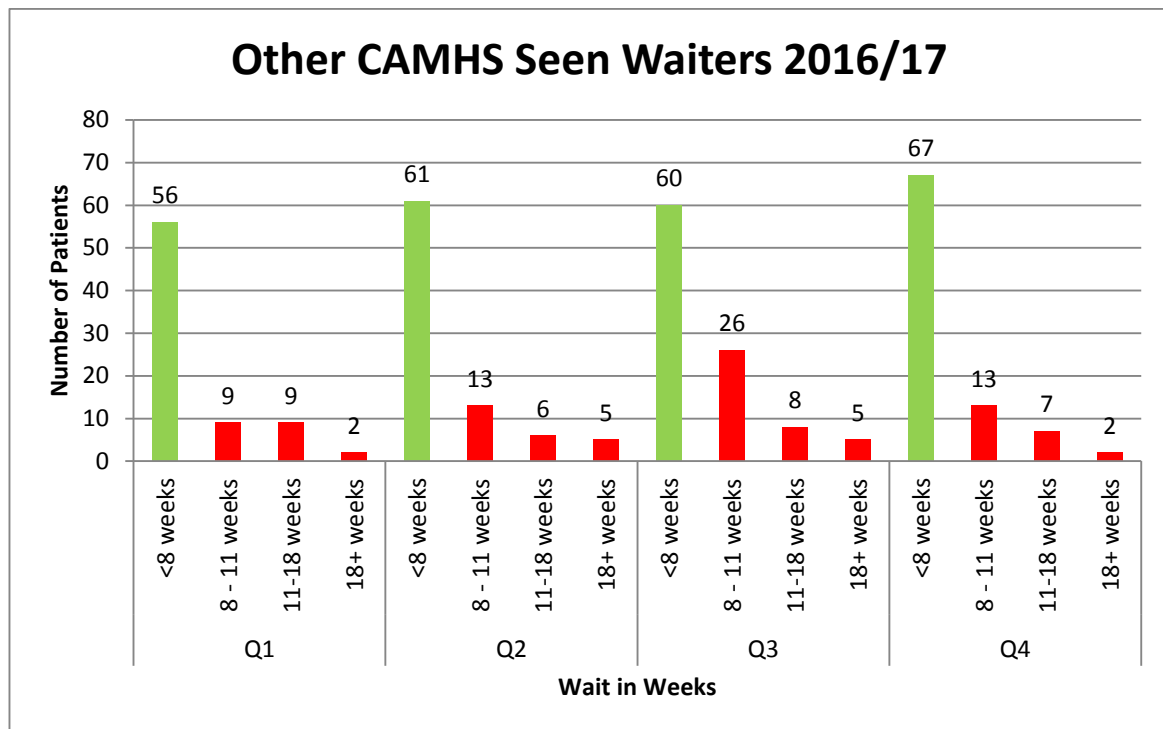
In the financial year of 2016/17 Camden CAMHS saw 1119 patients off of the waiting list only 8.1% of the patients breached the 8 week target.

Number waiting at the end of the financial year: 91

We are pleased that our waiting times in Camden are so low, however we are also mindful that our response rate on outcome monitoring has reduced and it may be that one is at the expense of the other. We will need to further explore the balance between clinical responsiveness and optimum documentation going forward.

*Sally Hodges, Director, Children, Young Adults and Families*

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



The waiting time target for Other CAMHS is 8 weeks with 75.3% meeting this target in Q4.

In the financial year of 2016/17 Other CAMHS saw 349 patients off of the waiting list only 30.1% of the patients breached the 8 week target. This is three times the trust target of <10% breaches.

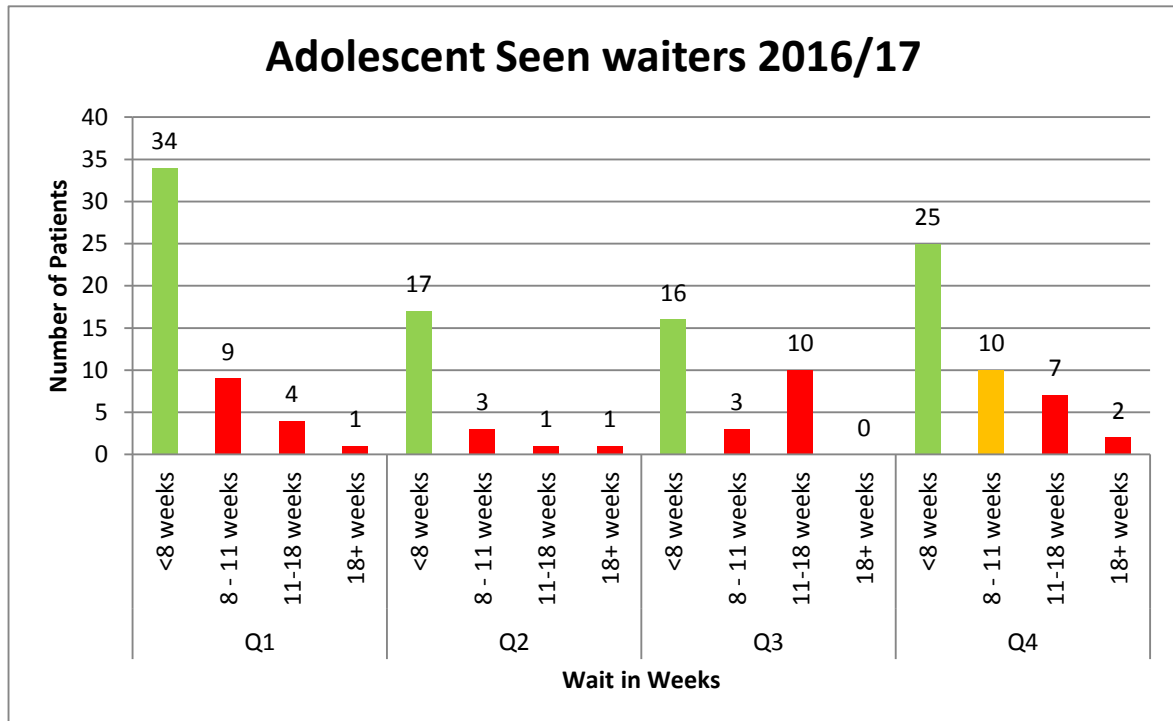
Number waiting at the end of the financial year: 41

‘With regards to Lifespan breaches there are a mixture of both internal and external reasons, the first external reason for breaches is the patient group Lifespan work with can at times be hard to engage. Moreover the unspecific demographics of the service prove hard to secure funding with in the 8 week target, as information from external services is needed to continue with referral. In quarter 3 the process of clinicians being able to book their own appointments changed, with the patients being allocated by Myooran Canagaratnam (Interim team manager), this is apparent in the number of breaches from Q3 (39) reducing in Q4 (22)’

*Joseph Anderson, admin team lead (on behalf of the Associate Clinical Director)*



### 3.6 Adolescent Service



The waiting time target for Adolescent is 8 weeks with 43% meeting this target in Q4. At closer inspection 9 out of the 10 patients in the 8–11 week wait in Q4 were over 18 and have a target of 11 weeks. If this is taken in to consideration 77.3% met their waiting time targets for Q4.

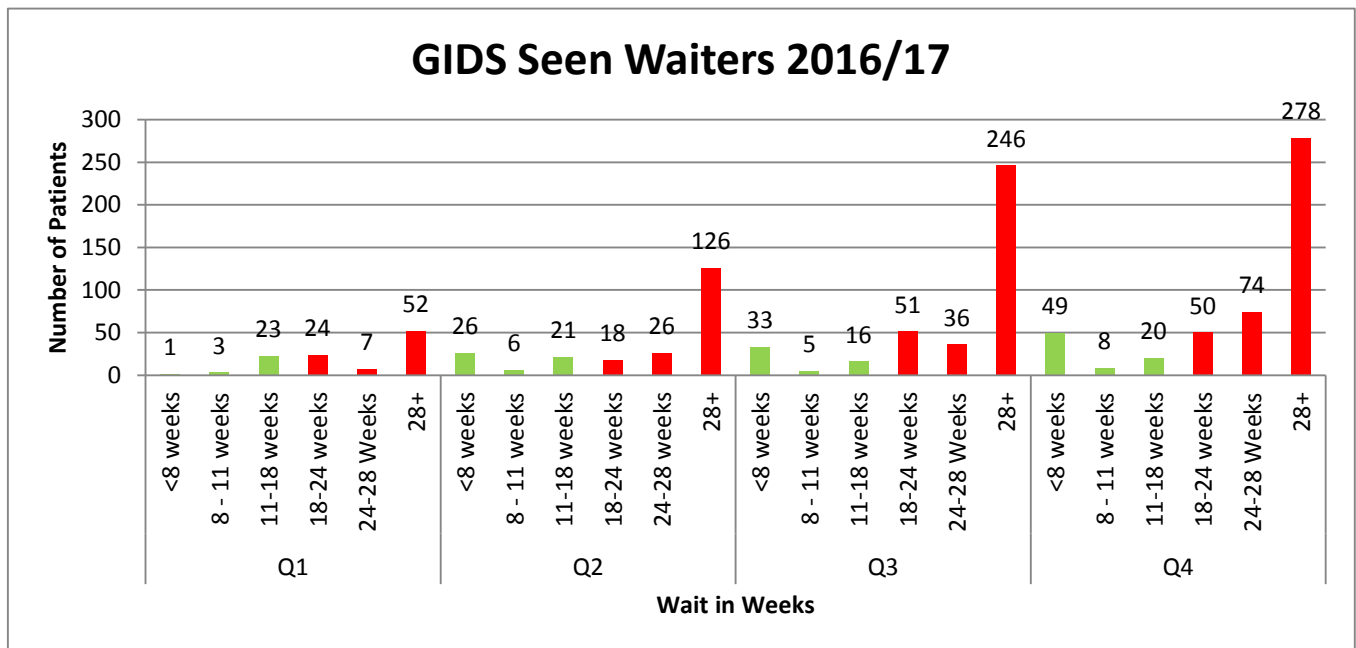
An annual report of adolescent is not available due to data not being analysed with data from under and over 18 from Q1–Q3.

**Number waiting at the end of the financial year: 8**

The specialised resources required for often complex patients seen in this service are scarce and there have been some staffing reductions, including some temporary changes in availability of staff in clinical training posts. Plans to increase capacity include the possibility of offering more therapy groups.

*Justine McCarthy Woods, Service Lead, Adolescent and Young Adult Service*

### 3.7 Gender Identity Development Service



GIDS have a significant number of breaches for their 18 week target, the amount of The

The number of patients seen in Q4 is 8 times that reported in Q1. There were 1002 patients waiting at the end of Q3, compared to the improved figure in Q4, 803. In Appendix 1 detailed waiting time numbers for those over 18 weeks have been included in a separate table for more information.

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

#### i) 17 year plus group pilot

##### Background

Increase in referrals last year has led to an increase in RTT times.

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

Adult services have different length waiting lists, waiting lists times change, follow different protocols, and accept referrals from the GIDS at different ages.

#### Aim and benefits of group first appointment

To offer timely appointments to over 17 year olds and facilitate appropriate, informed choices regarding transition to adult services. A number of group appointments have been undertaken. Feedback has overall been excellent.

### ii) **Assessment Clinics**

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

These challenges include:

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

### iii) **Case load**

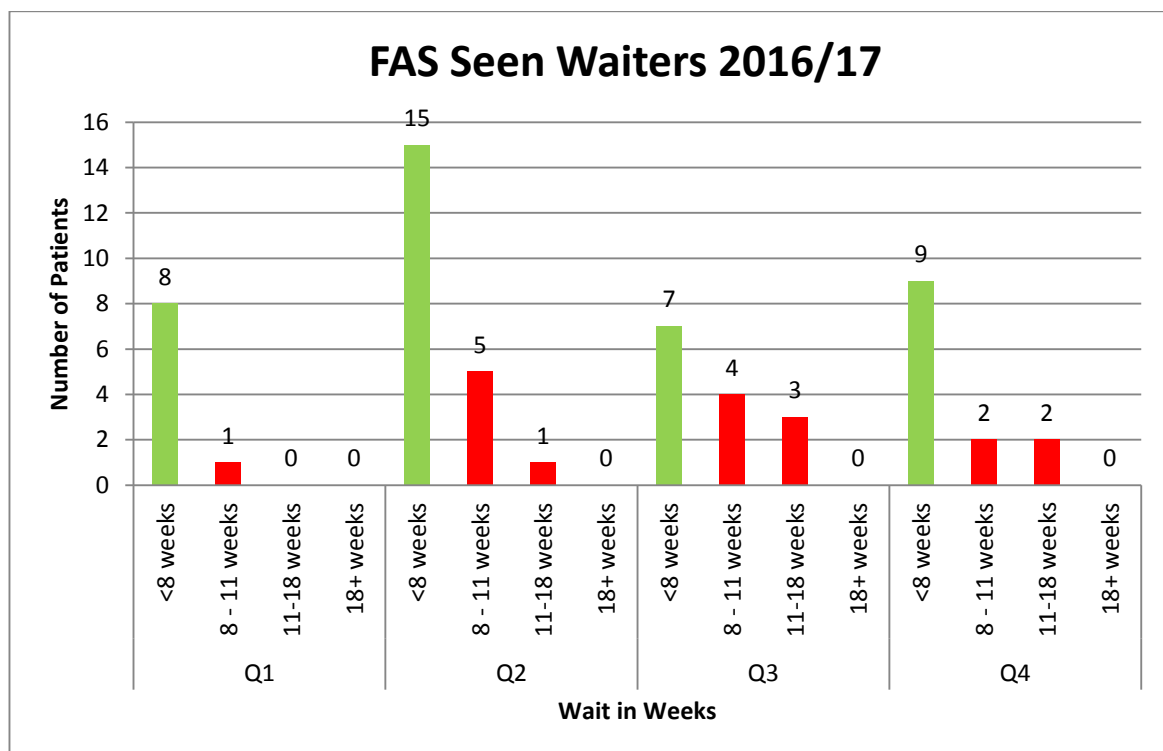
Clinicians carry large caseloads therefore new initiatives to offer appointments need to be carefully monitored in terms of the impact on caseload and the impact of appointments available for existing caseload.

iv) New specifications identify

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

*Keyur Joshi, Service Manager at GIDS*

### 3.8 Westminster Service



The waiting time target for FAS is 8 weeks with 66.6% meeting this target in Q4.

In the financial year of 2016/17 FAS saw 57 patients from the waiting list only 68.4% of the patients breached the 8 week target. Number waiting at the end of the financial year: 5

‘Waiting times at Westminster are a complex picture and the variables are not all within our control. Cases can wait if the statutory social worker in the local authority (Westminster or Hammersmith & Fulham) doesn’t supply all the

required information at the point of referral. We have this clearly listed in our referral processes but this is not always adhered to by the local authority. We have an unusually high number of referrals in the last three quarters which exceeds our capacity and also exceeds targets for the year. This has means cases have had to wait for clinicians to become available to carry out the work. Since we are a multi-disciplinary team, some of the referrals state the need for adult or child psychiatric input. This usually has to be explored further by the service prior to allocating this very limited resource in the team. For example the child psychiatrist works half a day per week and if they are named as specifically required in too many assessments at any one time, this will alter the time the case has to wait before being assessed. This is done in consultation with the referrer.

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

*Steve Bambrough, Associate Clinical Director*

**Kerri Johnson-Walker**, Data Quality Manager

11<sup>th</sup> April 2017

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## Appendix 1 Table1.

		Q1				Q2				Q3				Q4				Total n Waiting at the end of the financial year 16/17		
		<8 weeks	8 - 11 w	11-18 w	18+ weeks	<8 weeks	8 - 11 w	11-18 w	18+ weeks	<8 weeks	8 - 11 w	11-18 w	18+ weeks	<8 weeks	8 - 11 w	11-18 w	18+ weeks			
Adolescents	ADOLESCENT Camden Team	Number Pts Referral to First Appointment	6	5	1	1	5	1	1	1	4	2	6	0	4	3	2	0		
		%	46.2%	38.5%	7.7%	7.7%	62.5%	12.5%	12.5%	12.5%	33.3%	16.7%	50.0%	0.0%	44.4%	33.3%	22.2%	0.0%		
	ADOLESCENT Central and East Team	Number Pts Referral to First Appointment	2	1	1	0	1	1	0	0	2	0	2	0	2	2	2	1		
		%	50.0%	25.0%	25.0%	0.0%	50.0%	50.0%	0.0%	0.0%	50.0%	0.0%	50.0%	0.0%	28.6%	28.6%	28.6%	14.3%		
	ADOLESCENT Family Therapy	Number Pts Referral to First Appointment	0	0	0	0	0	0	0	0	2	0	0	0	1	0	0	0		
		%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%		
	ADOLESCENT North and West Team	Number Pts Referral to First Appointment	12	2	2	0	6	1	0	0	5	1	2	0	4	4	2	1		
		%	75.0%	12.5%	12.5%	0.0%	85.7%	14.3%	0.0%	0.0%	62.5%	12.5%	25.0%	0.0%	36.4%	36.4%	18.2%	9.1%		
	ADOLESCENT Parents Consultation Service	Number Pts Referral to First Appointment	3	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0		
		%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
ADOLESCENT Trauma Unit	Number Pts Referral to First Appointment	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
	%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
ADOLESCENT YPCS	Number Pts Referral to First Appointment	10	1	0	0	5	0	0	0	3	0	0	0	13	1	1	0			
	%	90.9%	9.1%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	86.7%	6.7%	6.7%	0.0%			
Total		34.0	9.0	4.0	1.0	17.0	3.0	1.0	1.0	16.0	3.0	10.0	0.0	25.0	10.0	7.0	2.0			
		70.8%	18.8%	8.3%	2.1%	77.3%	13.6%	4.5%	4.5%	55.2%	10.3%	34.5%	0.0%	56.8%	22.7%	15.9%	4.5%			
		n = 8																		

Adults	ADULTS Belsize	Number Pts Referral to First Appointment	5	5	1	0	6	3	1	0	15	5	4	0	11	8	0	0
			45.5%	45.5%	9.1%	0.0%	60.0%	30.0%	10.0%	0.0%	62.5%	20.8%	16.7%	0.0%	57.9%	42.1%	0.0%	0.0%
	ADULTS Couple Waiting Team	Number Pts Referral to First Appointment	3	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	ADULTS Couples Unit	Number Pts Referral to First Appointment	2	1	0	0	1	0	0	0	6	3	0	2	5	0	2	0
		%	66.7%	33.3%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	54.5%	27.3%	0.0%	18.2%	71.4%	0.0%	28.6%	0.0%
	ADULTS Fitzjohn	Number Pts Referral to First Appointment	1	2	0	0	0	0	0	0	1	0	0	1	2	2	0	0
		%	33.3%	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%	50.0%	50.0%	50.0%	0.0%	0.0%
	ADULTS Fitzjohn Waiting	Number Pts Referral to First Appointment	1	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0
		%	33.3%	66.7%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	ADULTS Group Waiting Team	Number Pts Referral to First Appointment	1	0	0	0	2	0	0	0	1	0	0	0	1	3	0	0
		%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	25.0%	75.0%	0.0%	0.0%
	ADULTS Hemel Team	Number Pts Referral to First Appointment	2	0	0	0	1	1	0	0	3	0	0	0	1	2	1	0
		%	100.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	25.0%	50.0%	25.0%	0.0%
	ADULTS Individual Intensive Waiting Team	Number Pts Referral to First Appointment	4	1	0	0	0	0	0	0	1	0	0	0	1	0	0	0
		%	80.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	ADULTS Individual Once Week Waiting Team	Number Pts Referral to First Appointment	5	2	0	0	4	0	1	1	4	3	2	0	2	3	2	0
		%	71.4%	28.6%	0.0%	0.0%	66.7%	0.0%	16.7%	16.7%	44.4%	33.3%	22.2%	0.0%	28.6%	42.9%	28.6%	0.0%
	ADULTS Lyndhurst	Number Pts Referral to First Appointment	4	4	3	0	3	2	1	0	15	6	1	2	15	6	0	1
		%	36.4%	36.4%	27.3%	0.0%	50.0%	33.3%	16.7%	0.0%	64.0%	24.0%	4.0%	8.0%	68.2%	27.3%	0.0%	4.5%
	ADULTS Maresfield	Number Pts Referral to First Appointment	7	3	0	0	1	0	0	0	1	0	0	0	3	0	0	0
		%	70.0%	30.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	ADULTS Trauma Unit	Number Pts Referral to First Appointment	6	0	0	1	5	2	1	0	6	1	1	0	2	0	4	2
		%	85.7%	0.0%	0.0%	14.3%	62.5%	25.0%	12.5%	0.0%	75.0%	12.5%	12.5%	0.0%	25.0%	0.0%	50.0%	25.0%
	ADULTS Watford	Number Pts Referral to First Appointment	1	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0
		%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
	Total		42.0	20.0	4.0	1.0	24.0	8.0	4.0	1.0	56.0	18.0	8.0	5.0	46.0	24.0	9.0	3.0
		%	62.7%	29.9%	6.0%	1.5%	64.9%	21.6%	10.8%	2.7%	64.4%	20.7%	9.2%	5.7%	56.1%	29.3%	11.0%	3.7%

n = 62

Camden Adolescent Intensive Support Service	Number Pts Referral to First Appointment	24	1	1	0	4	0	0	0	8	0	0	0	0	21	0	0	0
	%	92.3%	3.8%	3.8%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
CAMHS LAC	Number Pts Referral to First Appointment	8	1	0	0	5	1	0	0	6	2	0	0	0	13	0	0	0
	%	88.9%	11.1%	0.0%	0.0%	83.3%	16.7%	0.0%	0.0%	75.0%	25.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Complex Assessment	Number Pts Referral to First Appointment	2	0	0	0	0	0	0	0	3	0	0	0	0	2	0	0	0
	%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Complex Needs Outreach	Number Pts Referral to First Appointment	2	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0
	%	66.7%	0.0%	33.3%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
NORTH Primary Care	Number Pts Referral to First Appointment	5	1	0	0	2	0	0	0	5	0	0	0	0	6	0	0	0
	%	83.3%	16.7%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
NORTH Primary School Service	Number Pts Referral to First Appointment	24	1	0	0	3	0	0	0	14	0	0	0	0	18	1	0	0
	%	96.0%	4.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	94.7%	5.3%	0.0%	0.0%
NORTH Secondary School	Number Pts Referral to First Appointment	13	0	0	0	5	1	0	0	8	0	0	0	0	16	0	0	0
	%	100.0%	0.0%	0.0%	0.0%	83.3%	16.7%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
NORTH Service	Number Pts Referral to First Appointment	51	12	1	0	53	1	1	0	64	1	0	1	1	53	0	1	1
	%	79.7%	18.8%	1.6%	0.0%	96.4%	1.8%	1.8%	0.0%	97.0%	1.5%	0.0%	1.5%	0.0%	96.4%	0.0%	1.8%	1.8%
Refugee Service	Number Pts Referral to First Appointment	13	1	0	0	12	2	0	0	15	0	0	0	0	16	4	0	0
	%	92.9%	7.1%	0.0%	0.0%	85.7%	14.3%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	80.0%	20.0%	0.0%	0.0%
SOUTH Primary Care	Number Pts Referral to First Appointment	4	2	1	0	3	0	0	0	7	0	0	0	0	9	0	0	0
	%	57.1%	28.6%	14.3%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
SOUTH Primary School Service	Number Pts Referral to First Appointment	13	0	0	0	2	0	0	0	12	0	0	0	0	18	2	1	0
	%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	85.7%	9.5%	4.8%	0.0%
SOUTH Secondary School	Number Pts Referral to First Appointment	2	0	0	0	2	0	0	0	6	0	0	0	0	6	0	0	0
	%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
SOUTH Service	Number Pts Referral to First Appointment	62	5	3	0	46	5	3	1	41	1	1	1	0	50	6	0	0
	%	88.6%	7.1%	4.3%	0.0%	83.6%	9.1%	5.5%	1.8%	95.3%	2.3%	2.3%	0.0%	0.0%	89.3%	10.7%	0.0%	0.0%
TOPS	Number Pts Referral to First Appointment	1	0	0	0	7	0	0	0	12	1	0	0	0	9	0	0	0
	%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	92.3%	7.7%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%

Camden CAMHS



WFP Perinatal - Camden	Number Pts Referral to First Appointment	0	0	0	0	1	0	0	0	0	0	0	0	0	5	0	0	0
	%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
WF Perinatal - Euston	Number Pts Referral to First Appointment	4	0	0	0	3	1	0	0	5	1	0	0	0	15	0	0	0
	%	100.0%	0.0%	0.0%	0.0%	75.0%	25.0%	0.0%	0.0%	83.3%	16.7%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
WF Perinatal - Kentish Town East	Number Pts Referral to First Appointment	4	0	0	0	5	0	0	0	3	0	0	0	0	3	0	0	0
	%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
WF Perinatal - Kentish Town West	Number Pts Referral to First Appointment	2	0	0	0	0	1	0	0	0	0	0	0	0	6	2	2	0
	%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	60.0%	20.0%	20.0%	0.0%
WF Perinatal - Kilburn	Number Pts Referral to First Appointment	2	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0
	%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
WF Perinatal - Kings Cross and Holborn	Number Pts Referral to First Appointment	0	1	0	0	4	0	0	0	1	1	0	0	0	1	1	0	0
	%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%
WF Perinatal - YPS	Number Pts Referral to First Appointment	13	0	0	0	7	0	0	0	2	0	0	0	0	3	0	0	0
	%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Whole Family	Number Pts Referral to First Appointment	13	0	0	0	11	1	0	0	24	1	0	1	1	24	4	3	0
	%	100.0%	0.0%	0.0%	0.0%	91.7%	8.3%	0.0%	0.0%	92.3%	3.8%	0.0%	3.8%	3.8%	77.4%	12.9%	9.7%	0.0%
YPS	Number Pts Referral to First Appointment	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total		263.0	25.0	7.0	0.0	177.0	13.0	4.0	1.0	236.0	8.0	1.0	3.0	1.0	297.0	20.0	7.0	1.0
		89.2%	8.5%	2.4%	0.0%	90.8%	6.7%	2.1%	0.5%	95.2%	3.2%	0.4%	1.2%	0.3%	91.4%	6.2%	2.2%	0.3%

n = 91

		Q1					Q2					Q3					Q4					Total n Waiting at the end of the financial year 16/17
		<8 weeks	8 - 11 wks	11-18 wks	18+ weeks	<8 weeks	8 - 11 wks	11-18 wks	18+ weeks	<8 weeks	8 - 11 wks	11-18 wks	18+ weeks	<8 weeks	8 - 11 wks	11-18 wks	18+ weeks	<8 weeks	8 - 11 wks	11-18 wks	18+ weeks	
City and Hackney	CHPC Community Project Team	3	1	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number Pts Referral to First Appointment																					
	%	75.0%	25.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	CHPC Waiting Team	1	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number Pts Referral to First Appointment																					
City and Hackney	CHPC A	45	36	40	4	36	37	37	5	31.3%	32.2%	32.2%	4.3%	40	29	52	8	63.1%	17.2%	13.9%	7	5.7%
	Number Pts Referral to First Appointment																					
	%	36.0%	28.8%	32.0%	3.2%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	CHPC B	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number Pts Referral to First Appointment																					
City and Hackney	CHPC C	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	
	Number Pts Referral to First Appointment																					
	%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	
	TCPs Care Planning Team	22	2	0	0	12	3	1	0	75.0%	18.8%	6.3%	0.0%	8	5	0	0	100.0%	0.0%	0.0%	0	0.0%
	Number Pts Referral to First Appointment																					
Other CAMHS	Child Sex Abuse Hub	0	0	0	0	2	0	0	0	100.0%	0.0%	0.0%	0.0%	5	0	0	0	0.0%	0.0%	0	1	
	Number Pts Referral to First Appointment																					
	%	87.0%	8.7%	4.3%	0.0%	83.3%	13.3%	3.3%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	
	Family Service	20	2	1	0	25	4	1	0	25.0%	13.3%	3.3%	0.0%	17	10	0	0	29	6.1%	2	2	0
	Number Pts Referral to First Appointment																					
Other CAMHS	FDAC-Kent	6	0	0	0	2	2	0	0	50.0%	50.0%	0.0%	0.0%	7	0	0	1	60.0%	30.0%	10.0%	0	0.0%
	Number Pts Referral to First Appointment																					
	%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	12.5%	60.0%	30.0%	10.0%	0.0%	
	Fostering and Adoption	5	1	1	1	13	2	2	1	72.2%	11.1%	11.1%	5.6%	9	2	3	3	12	0	0	0	0
	Number Pts Referral to First Appointment																					
Other CAMHS	Lifespan	19	6	7	1	17	5	3	3	60.7%	17.9%	10.7%	10.7%	21	13	5	1	59.4%	25.0%	12.5%	4	3.1%
	Number Pts Referral to First Appointment																					
	%	57.6%	18.2%	21.2%	3.0%	66.7%	0.0%	0.0%	0.0%	66.7%	0.0%	0.0%	33.3%	52.5%	32.5%	12.5%	2.5%	59.4%	25.0%	12.5%	4	3.1%
	New Rush Hall School	3	0	0	0	2	0	0	0	66.7%	0.0%	0.0%	0.0%	0	0	0	0	100.0%	0.0%	0.0%	0	0.0%
	Number Pts Referral to First Appointment																					
Other CAMHS	VIPP	3	0	0	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	1	1	0	0	0	0	0	0	0
	Number Pts Referral to First Appointment																					
	%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Total	56.0	9.0	9.0	2.0	61.0	13.0	6.0	5.0	61.0	13.0	6.0	5.0	60.0	26.0	8.0	5.0	67.0	13.0	7.0	2.0	
	%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%

		Q1				Q2				Q3				Q4				Total n Waiting at the end of the financial year 16/17
		<8 weeks	8 - 11 w	11-18 w	18+ w	<8 weeks	8 - 11 w	11-18 w	18+ w	<8 weeks	8 - 11 w	11-18 w	18+ w	<8 weeks	8 - 11 w	11-18 w	18+ w	
Portman	Number Pts Referral to First Appointment	9	6	1	0	9	2	0	0	5	3	0	0	8	5	0	0	n = 6
	%	56.3%	37.5%	6.3%	0.0%	81.8%	18.2%	0.0%	0.0%	62.5%	37.5%	0.0%	0.0%	61.5%	38.5%	0.0%	0.0%	
	Number Pts Referral to First Appointment	14	4	0	0	7	6	0	0	10	1	0	0	11	3	1	0	
	%	77.8%	22.2%	0.0%	0.0%	53.8%	46.2%	0.0%	0.0%	90.9%	9.1%	0.0%	0.0%	73.3%	20.0%	6.7%	0.0%	
Westminster	Total	23.0	10.0	1.0	0.0	16.0	8.0	0.0	0.0	15.0	4.0	0.0	0.0	19.0	8.0	1.0	0.0	n = 5
	Number Pts Referral to First Appointment	67.6%	29.4%	2.9%	0.0%	66.7%	33.3%	0.0%	0.0%	78.9%	21.1%	0.0%	0.0%	67.9%	28.6%	3.6%	0.0%	
	%	6	1	0	0	13	5	1	0	7	4	1	0	7	2	2	0	
	Number Pts Referral to First Appointment	85.7%	14.3%	0.0%	0.0%	68.4%	26.3%	5.3%	0.0%	58.3%	33.3%	8.3%	0.0%	63.6%	18.2%	18.2%	0.0%	
FAS Intervention	Number Pts Referral to First Appointment	0	0	0	0	2	0	0	0	0	0	1	0	1	0	0	0	n = 5
	%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	
	Number Pts Referral to First Appointment	2	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	
	%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	
Total	Number Pts Referral to First Appointment	8.0	1.0	0.0	0.0	15.0	5.0	1.0	0.0	7.0	4.0	3.0	0.0	9.0	2.0	2.0	0.0	n = 5
	%	88.9%	11.1%	0.0%	0.0%	71.4%	23.8%	4.8%	0.0%	50.0%	28.6%	21.4%	0.0%	69.2%	15.4%	15.4%	0.0%	
	Number Pts Referral to First Appointment	0	3	18	2	17	22	22	22	7	2	11	49	32	15	4	15	
	%	0.0%	6.8%	40.9%	4.5%	18.5%	23.9%	23.9%	23.9%	6.0%	1.7%	9.5%	42.2%	27.6%	12.9%	5.3%	2.7%	
GIDS Leeds	Number Pts Referral to First Appointment	0	0	5	5	3	1	4	96	26	3	5	2	4	224	33	4	n = 5
	%	0.0%	0.0%	7.9%	7.9%	7.9%	7.9%	7.9%	7.9%	9.8%	1.1%	1.9%	0.8%	1.5%	84.8%	12.5%	1.3%	
	Number Pts Referral to First Appointment	1	0	0	0	0	0	0	8	0	0	0	0	0	7	2	0	
	%	33.3%	0.0%	0.0%	0.0%	66.7%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	11.1%	0.0%	0.0%	
GIDS London	Number Pts Referral to First Appointment	1	3	23	7	52	24	7	52	33	5	16	51	36	246	49	8	n = 5
	%	0.9%	2.7%	20.9%	21.8%	6.4%	47.3%	11.7%	2.7%	8.1%	11.7%	13.2%	9.3%	63.6%	10.2%	1.7%	4.2%	
	Number Pts Referral to First Appointment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
GIDS South West	Number Pts Referral to First Appointment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	n = 5
	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	Number Pts Referral to First Appointment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Total	Number Pts Referral to First Appointment	1	3	23	7	52	24	7	52	33	5	16	51	36	246	49	8	n = 5
	%	0.9%	2.7%	20.9%	21.8%	6.4%	47.3%	11.7%	2.7%	8.1%	11.7%	13.2%	9.3%	63.6%	10.2%	1.7%	4.2%	
	Number Pts Referral to First Appointment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	



## Board of Directors : April 2017

**Item :** 18

**Title :** IM&T Strategy and Programme Q4 Update

**Summary:**

In February 2016 the Board approved the IM&T Strategy and plan.

The Chairman requested that the Board be provided with regular update on the IM&T Strategy delivery.

The most recent IMT Programme Summary Report, covering to 13th March 2017 has been enclosed with this paper for information. In addition a brief update of project prioritisation for 2017/18 has been included as requested at the time of the Q3 update.

This report has been reviewed by the following Committees:

- Management Team, 18<sup>th</sup> April 2017

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

*(delete where not applicable)*

- IMT

**For :** Noting

**From :** Director of Technology & Transformation

## IM&T Strategy and Programme Q4 Update

Provided by David Wyndham Lewis, Director of IMT, covering to end of March 2017.

### Introduction

In February 2016 the Board approved the IM&T Strategy and plan.

The Chairman requested that the Board be provided with regular update on the IM&T Strategy delivery.

### Summary

The most recent IMT Programme Summary Report, covering to 13<sup>th</sup> March 2017 has been enclosed with this paper for information.

The programme remains as amber status for time and progress has slowed during the last period. While activities against the programme have progressed to a degree, since December 2016 the majority of available IMT resource has been diverted to the transfer of the Charing Cross Gender Identity Clinic ("GIC") to the Trust. The prioritisation of the GIC work was agreed with the Management Team before work commenced in the understanding that this would mean many IMT programme projects would not progress. Despite the earlier work to try to understand the work necessary to introduce the GIC, the project has required significantly more resource than expected. The network migration procurement has yet to commence. The email migration has however progressed to plan and is expected to complete on schedule.

As presented in the Q3 report the projects prioritised to progress remain as :

- Adult Gender Identity Clinic (IMT works expected to complete by 18<sup>th</sup> May 2017)
- Email Migration to Office365
- Network Replacement
- Electronic Referral
- Student Information Management System
- Patient SMS Appointment Reminder (limited trial only with main project progressing next year)
- Data Warehouse Replacement and Dashboards (limited deliverables only with main project progressing next year)
- Remote Patient Care (video contact with patients within GIDS – limited deliverables only with main project progressing next year)

### IM&T Programme Update

In summary of the attached highlight report presented to the IMT Steering Committee:

1. Email replacement (a.k.a. Office 365) is progressing well albeit delayed by resource constraints. The deadline set by NHS Digital for completion has been extended to September 2017, however all works are expected to complete before the original June deadline.
2. The replacement of endpoint devices (PCs, laptops, tablets & desk telephones) is now progressing with hardware delivered to site. Configuration and deployment of devices

will be delayed until post GIC however the plan is in place with the end of May as commencement date. An addition 90 tablet devices have been procured for CYAF to replace unsuitable devices previously deployed and to better support mobile staff and those on remote sites.

3. The deployment of the new data warehouse platform in preparation for a new dashboard system has been substantially delayed as all resource in this area required reallocation to GIC. The project will be reinitiated in late May 2017 to plan the completion of the data warehouse and the creation of the procurement specification for the dashboard system.

## Concerns

Cyber security remains a key concern. In addition the recent resignation of the Governance Manager has highlighted a lack of resilience in service provision in this area. A new job description has been developed that will amend the former Governance Manager role to one that focussed on both Information Governance and Information Security to include Cyber Security. The role requires the post holder to collaboratively support Trust staff in developing secure mechanisms for the delivery of Trust services. Further training and a trust wide communication programme are planned for the first quarter of the coming financial year.

As mentioned in the Q3 report connectivity problems being experienced in remote sites remain an issue. While the challenge and pain this creates for Trust staff working at remote staff is understood resource constraints have delayed any response. There is a risk that these staff will disengage from use of Trust IMT facilities and it may prove difficult to develop their Trust in the IMT services even once the underlying technical issues are addressed.

## Programme Plan for 2017/18

As requested at the time of presenting the Q3 report we have developed a prioritised schedule of the projects generated as a result of the IMT Strategy as well as those requested by the broader Trust. This schedule, enclosed with this paper for information, introduces a set of high level assessment criteria reflecting the benefits, both financial and non-financial, the likely cost and complexity of delivering the projects. This paper will be presented to Management Team to ratify the priority order and to develop an understanding of the organisations capacity to deliver the projects.

Until the above exercise is complete the priority order will remain as presented above, carried over from the 2016/17 year.

## Revision of the IMT Strategy

As also noted at the time of the Q3 report the environment surrounding the IMT Strategy is evolving. In particular, pressures related to the Sustainability and Transformation Partnerships must now be recognised within the Strategy. In addition the interdependencies between the IMT Strategy and those transformational changes required to prepare the Trust for Relocation are beginning to become apparent, for example in our approach to levelling of activity peaks and troughs through the working week, week to week and month to month.

A revision to the IMT Strategy is therefore suggested with a proposal that this be presented to the July Trust Board.





## Board of Directors : April 2017

**Item** : 19

**Title** : Finance And Performance Report  
Period ended March 2017

**Summary:**

Year To Date

Surplus

GREEN

Cash flow

AMBER

Supplier payments

AMBER

Agency spend

AMBER

SOF rating for Finance and Resources

GREEN

**For** : Noting

**From** : Carl Doherty, Deputy Director of Finance  
13 April 2017

# FINANCE AND PERFORMANCE REPORT

Period Ended March 2017

## 1. OVERVIEW

### Year To Date

1.1. Outturn surplus, at £0.801m is £1k above Budget, the agreed NHSI Control Total.

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

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

## 2. INCOME AND EXPENDITURE: 12 MONTHS ENDED MARCH 2017

### Summary

2.1. After twelve months, the Year To Date ("YTD") surplus is ahead of Budget by £1k.

£'000	YTD	YTD	YTD
	Bud	Act	Var
Income	49,073	49,307	233
Staff costs	(33,871)	(32,639)	1,232
Non-staff costs	(13,049)	(14,080)	(1,031)
Expenditure	(46,920)	(46,719)	201
EBITDA	2,153	2,588	435
Margin	4.39%	5.25%	
Interest receivable	7	10	3
Depreciation / Amortisation	(781)	(834)	(53)
Dividend	(580)	(627)	(47)
Surplus before restructuring costs	799	1,137	338
Restructuring costs	0	(337)	(337)
Net surplus	799	801	2
Margin	1.63%	1.62%	

EBITDA – Earnings before interest, tax depreciation and amortisation

Agency Costs	728	731
Percentage variance against Cap		0.4%
Staff numbers (WTE)	628	625

2.2. Income is 0.5% favourable to Budget, operating costs are 0.9% favourable to Budget and restructuring costs are adverse to Budget, resulting in a small overall net over performance.

2.3. The rating of the Finance and Resources element of the Single Oversight Framework ("SOF") for February will be submitted on 28 April with a Use of Resources metric of 1, which is the best possible rating.

### Income

2.4. The favourable performance against Budget of £233k is due, primarily, to CYAF and Gender Identity Clinical and "Other" income offsetting shortfalls in the Education Portfolio and Tavistock Consulting.

	£'000
"Other Income"	491
CYAF Clinical Income	242
Gender Identity	195
Health Education England	147
Education 'Portfolio'	(599)
Tavistock Consulting	(265)
Adult & Forensic Services	(134)
Misc.	157
	233

2.5. "Other Income" includes a refund from HMRC of £360k.

2.6. CYAF Clinical has over performed mainly due to additional income for Gloucester house and IAPT project income.

2.7. Gender Identity income has over performed due to additional non contracted named patient agreements.

2.8. Health Education England income is £147k above budget due to one-off project income (reflected in additional costs within Education and Training).

2.9. Education Portfolio income is down as student recruitment did not meet the, in retrospect, over ambitious target.

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

### Expenditure

2.11. YTD operational expenditure is £149k favourable to Budget due to variations to budget, as follows:

	£'000
GIDS	496
Education 'Portfolio'	465
Adult & Forensic Services	319
Camden CAMHS	111
Tavistock Consulting	175
	1,566
Estates-related overspend	(909)
Visiting Lecturers	(276)
Education and Training	(162)
Others	(70)
	149

Lower staffing costs in AFS, Tavistock Consulting and the Education Portfolio reflect the lower levels of income noted above. The lower spend in GIDS costs has been largely accounted for in the cost of office refurbishment (and associated) costs required to house the new GIDS team.

- 2.12. Of the Estates-related overspend of £909k, £554k relates to the Relocation Project (for which there was not a revenue budget). Of this £554k, £220k relates to staffing costs and £334k to non-staff. The balance of £355k relates to non-staff expenditure for items which were not budgeted for e.g. re-tarmac of car park.
- 2.13. At £731k, YTD agency staff costs are 0.4% adverse to the Trust's agency cap.
- 2.14. Restructuring costs are £337k in order to assist with achieving savings in 2017/18.

### 3. CASH FLOW AND CAPITAL EXPENDITURE

- 3.1. As at 31 March 2017, the Trust had cash balances of £2.1m. This is £2.5m adverse to Budget primarily due to outstanding debt from City and Hackney CCG of £1.2m which was settled on 3 April 2017. £315k remains outstanding from non NHS customers the majority of which are local Borough Councils. A payment run of £750k to our suppliers was also processed on the final day of the financial year.

#### Capital Expenditure

- 3.2. The 2016/17 Budget for capital expenditure was £2.5m, including £1.1m on the Relocation Project and £1.4m on other items.
- 3.3. As at the end of March, capital expenditure was £1.6m, including £0.6m of SITS-related expenditure. None of this expenditure relates to the Relocation Project.

### 4. BALANCE SHEET

- 4.1. A balance sheet is shown at Appendix C. The Land and Buildings value reduction of £2.1m between February and March is due to the revaluation performed by Gerald Eve.

#### Provisions / Accruals

- 4.2. As at 31 March 2017, the Trust held the following major provisions / accruals on its balance sheet:

	£'000
Bad debt provision	305
Holiday pay accrual	327

#### Creditors / Better Payment Practice Code

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

	YTD Actual	Target
Number of invoices	90%	95%
Value of invoices	92%	95%

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

Page 5 of 7

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST				APPENDIX B		
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2016-17						
All figures £000	Mar-17			CUMULATIVE		
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE
<b>INCOME</b>						
CENTRAL CLINICAL INCOME	623	658	35	7,536	7,533	(3)
SUSTAINABILITY AND TRANSFORMATION FUND	42	42	(0)	500	500	0
CYAF CLINICAL INCOME	450	499	48	5,452	5,694	242
AFS CLINICAL INCOME	523	582	59	7,444	7,309	(134)
GENDER IDENTITY	415	515	101	4,978	5,173	195
HEALTH EDUCATION ENGLAND TRAINING CONTRACT	605	737	132	7,254	7,401	147
CHILD PSYCHOTHERAPY TRAINEES	145	163	17	2,116	2,089	(27)
JUNIOR MEDICAL STAFF	70	96	27	838	942	104
POSTGRADUATE MED & DENT'L EDUC	7	12	5	88	96	9
PORTFOLIO FEE INCOME	546	434	(112)	5,892	5,292	(599)
DET TRAINING FEES & ACADEMIC INCOME	122	90	(32)	1,364	1,371	7
FAMILY NURSE PARTNERSHIP	257	274	16	3,086	3,116	29
TC INCOME	72	52	(20)	863	598	(265)
CONSULTANCY INCOME CYAF	2	3	1	20	35	15
CONSULTANCY INCOME AFS	16	(7)	(23)	193	182	(11)
R&D	159	193	34	454	489	35
OTHER INCOME	151	243	92	996	1,487	491
<b>TOTAL INCOME</b>	<b>4,205</b>	<b>4,586</b>	<b>381</b>	<b>49,073</b>	<b>49,307</b>	<b>233</b>
<b>EXPENDITURE</b>						
COMPLEX NEEDS	140	149	(9)	1,623	1,603	20
PRIMARY CARE	341	346	(5)	5,116	4,797	319
PORTMAN CLINIC	113	124	(11)	1,378	1,400	(22)
GENDER IDENTITY	394	353	42	4,027	3,532	496
NON CAMDEN CAMHS	422	447	(25)	5,105	5,178	(73)
CAMDEN CAMHS	418	443	(25)	4,968	4,858	111
CHILD & FAMILY GENERAL	61	72	(11)	730	707	22
FAMILY NURSE PARTNERSHIP	464	320	143	2,706	2,796	(90)
PSYCHOLOGICAL THERAPIES DEVT UNIT	2	30	(28)	356	391	(35)
JUNIOR MEDICAL STAFF	83	72	10	993	933	61
NHS LONDON FUNDED CP TRAINEES	144	138	6	2,095	2,108	(13)
TAVISTOCK SESSIONAL CP TRAINEES	2	1	0	18	15	3
FLEXIBLE TRAINEE DOCTORS & PGMDE	20	24	(4)	242	280	(38)
EDUCATION & TRAINING	384	445	(61)	4,004	4,166	(162)
VISITING LECTURER FEES	102	154	(53)	1,215	1,491	(276)
PORTFOLIOS	231	190	41	2,546	2,081	465
TC	57	25	32	687	512	175
R&D	166	161	5	494	489	5
ESTATES DEPT	159	368	(209)	1,904	2,813	(909)
FINANCE, ICT & INFORMATICS	300	237	64	2,946	2,868	78
TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	155	108	47	1,679	1,566	113
COMMERCIAL DIRECTORATE	59	57	2	521	502	19
HUMAN RESOURCES	75	103	(29)	699	741	(42)
CLINICAL GOVERNANCE	78	57	21	791	728	63
CEA CONTRIBUTION	10	57	(48)	117	165	(48)
DEPRECIATION & AMORTISATION	63	149	(86)	781	834	(53)
VACANCY FACTOR	0	0	0	0	0	0
PRODUCTIVITY SAVINGS	0	0	0	0	0	0
INVESTMENT RESERVE	0	0	0	0	0	0
CENTRAL RESERVES	(4)	0	(4)	(42)	0	(42)
<b>TOTAL EXPENDITURE</b>	<b>4,436</b>	<b>4,631</b>	<b>(195)</b>	<b>47,701</b>	<b>47,553</b>	<b>149</b>
<b>OPERATING SURPLUS/(DEFICIT)</b>	<b>(232)</b>	<b>(46)</b>	<b>186</b>	<b>1,372</b>	<b>1,754</b>	<b>382</b>
INTEREST RECEIVABLE	1	1	(0)	8	10	2
DIVIDEND ON PDC	(48)	(97)	(49)	(580)	(627)	(47)
<b>SURPLUS/(DEFICIT)</b>	<b>(279)</b>	<b>(143)</b>	<b>137</b>	<b>800</b>	<b>1,137</b>	<b>337</b>
RESTRUCTURING COSTS	0	196	(196)	0	337	(337)
<b>SURPLUS/(DEFICIT) AFTER RESTRUCTURING</b>	<b>(279)</b>	<b>(338)</b>	<b>(59)</b>	<b>800</b>	<b>801</b>	<b>1</b>







## Board of Directors : April 2017

**Item :** 20

**Title :** Directorate of Education and Training Board Report

**Purpose:**

To update on issues in the Education & Training Directorate.  
To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 3<sup>rd</sup> April 2017

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

- Quality
- Equality
- Risk
- Finance
- Productivity
- Communications

**For :** Noting

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

## Directorate of Education and Training Board Report

### 1. Introduction

- 1.1 To update on issues in the Education & Training Directorate. To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 3<sup>rd</sup> April 2017

### 2. National Contract/Mental Health Collaborative /National Workforce Skills Development Unit (NWSDU)

- 2.1 Lindsay Hobson, Contracts Manager, attended the programme board for this item.
- 2.2 She presented the report we are developing for Health Education England as part of the more robust, detailed reporting required for the national contract.
- 2.3 The report was well received and suggestions made as to how it could be further improved. Meetings will be arranged in the next week with the aim of sending the report by Easter.
- 2.4 Work continues to progress around the NWSDU with engagement events being set up with stakeholders across the country.
- 2.5 The interviews for the Associate Director for the NWSDU post will take place during April.

### 3. Student Recruitment, Marketing, and Alumni

- 3.1 Laure Thomas, Director of Marketing and Communications presented a paper on this item.
- 3.2 At this point in we have received 304 applications which is an increase of 16% on this point in 2016/17 (263 applications received).
- 3.3 Further to this 77 offers have been accepted which is an increase of 40% on last year (55 offers accepted).
- 3.4 Further details can be found in Appendix A.

- 3.5 The programme board discussed deferred places and agreed that while there are clear criteria and guidance for both staff and students with regards to deferrals this needs to be incorporated into our admissions policy, which is now being undertaken by our Academic Quality and Governance unit.
- 3.6 Over the coming months regular recruitment meetings will be held. These will allow issues and bottlenecks to be dealt with quickly.
- 3.7 There are concerns regarding possible low recruitment in the forensic portfolio. A meeting will be arranged with the relevant parties to see how this can be addressed.

#### **4. SITS (MyTap)**

- 4.1 David Wyndham-Lewis, Director of Technology and Transformation, attended for this item.
- 4.2 There have been issues regarding staffing as one member of the operational systems team has given their notice however we are moving to replace them as soon as possible. A permanent post for a senior SITS developer is also being created and will be advertised in May.
- 4.3 The main focus on the project timeline is the delivery of the assessment module which is planned for June. David advised that this was currently on schedule. The group discussed how the system had been received by staff. It was agreed that while largely positive there were some negativity and in many cases operational staff have had to contribute a significant amount to make the project a success which has taken its toll.
- 4.4 Brian Rock will send a communication to all DET staff including faculty emphasising the importance of engaging with the system.
- 4.5 The TEPMB has also requested an interim report for its next meeting on the benefits being derived from the system.

#### **5. Portfolio Managers Review**

- 5.1 Karen Tanner, Deputy Director of Education and Training and Associate Dean for Learning and Teaching, explained that this

meeting had been arranged to offer an opportunity to review the roles of portfolio managers now they are established in their posts.

- 5.2 The portfolio managers are keen to do more to establish better links between the clinical and training directorates, and this is encouraged.
- 5.3 Further it was agreed that Portfolio Managers, the Associate Deans and the Dean would meet more regularly to focus on strategy rather than operations, which will help foster alignment between the strategic direction and the operational course delivery.

## **6. Visiting Lecturers**

- 6.1 Fiona Hartnett, Dean's Office Manager, updated the programme board as to the progress of the Visiting Lecturers (VL) review.
- 6.2 It was agreed that at this time it was necessary to consolidate our strategy and the aims of the review before any decisions are taken as to progressing changes, particularly in relation to fees.
- 6.3 We are also working through a number of issues in relation to the implications for VLs and the changes to IR35 arrangements for our courses, including for the educational psychology programme.
- 6.4 A meeting has been arranged for the end of April with VLs and the Dean and Associate Deans to foster engagement and to outline the areas under consideration. The event has been welcome by VLs and ongoing engagement is necessary.

## **7. DET Business Plan**

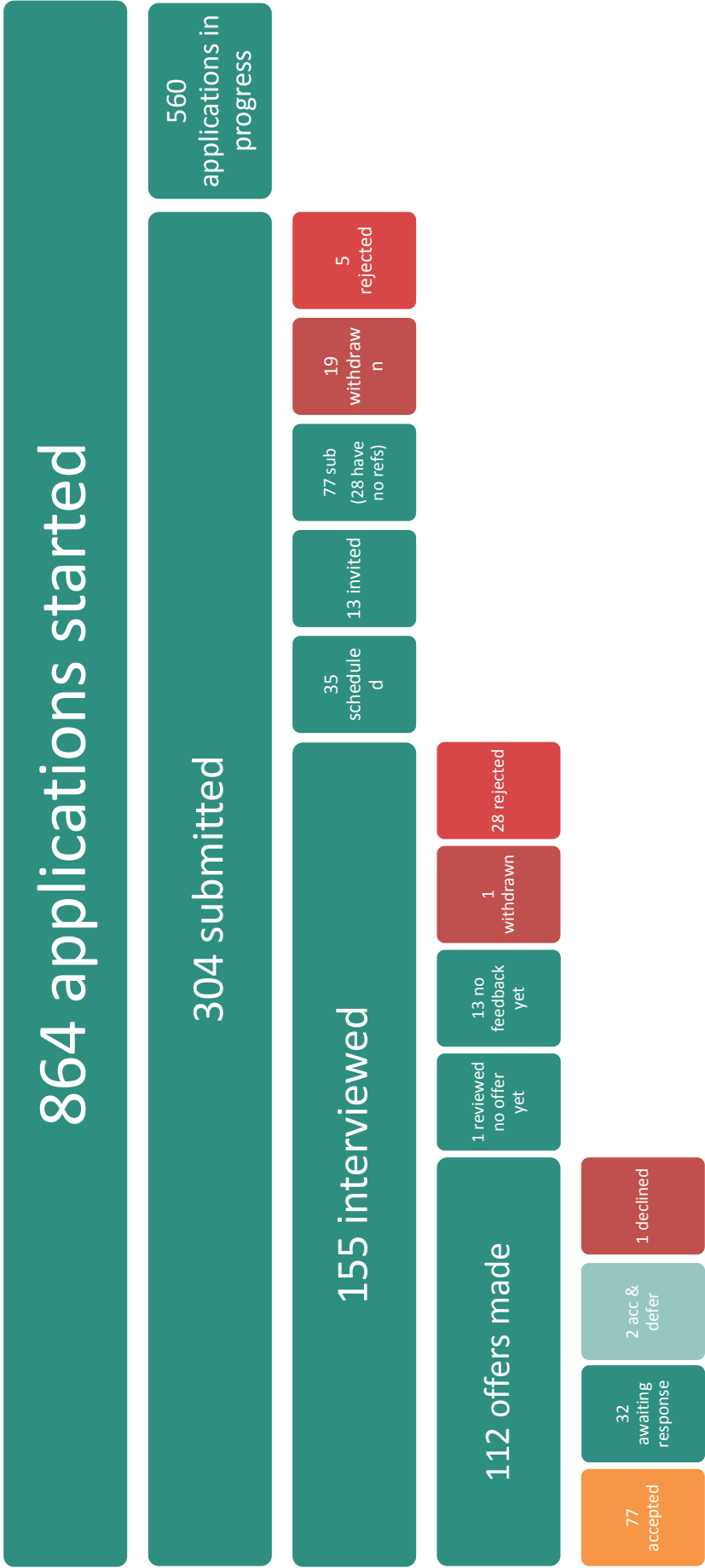
- 7.1 Karen Tanner presented the draft DET business plan for review.
- 7.2 It was suggested that the connections between research, clinical and education should be made clearer and that there should be a section on people.
- 7.3 The plan was approved subject to the above amendments.

**Brian Rock**

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

**10<sup>th</sup> April 2017**

April Recruitment Figures





BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 25<sup>th</sup> April 2017, 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	Enc.	p.7
4.	Matters arising Prof Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS				
5.	Patient Story Psychoanalytic Portfolio Student	To note	Verbal	-
6.	Service Line Report: Psychoanalytic Portfolio Ms Katie Argent, Portfolio Lead	To discuss	Enc.	p.8
7.	Trust Chair's and NED's Reports Prof Paul Burstow, Trust Chair	To note	Verbal	-
8.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.20
9.	People Strategy Mr Craig de Sousa, Director of HR	To approve	Enc.	p.23
10.	Apprenticeships Levy Update Dr Chris Caldwell, Nursing Director	To discuss	Enc.	p.57
11.	Mental Health Workforce Development Collaborative Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.62
12.	Clinical Complaints and whistleblowing report Ms Amanda Hawke, Complaints Manager & Ms Gill Rusbridger, Freedom to Speak Up Guardian	To discuss	Enc.	p.73
13.	Smoke Free Policy Ms Marion Shipman, Associate Director of Quality and Governance	To approve	Enc.	p.83
14.	Draft Quality Report Ms Louise Lyon, Director of Quality and Patient Experience	To discuss	Enc.	p.102

15.	<b>Dashboard Report Q4</b> Ms Julia Smith, Commercial Director	To discuss	Enc.	p.170
16.	<b>Quality Report Q4 narrative</b> Ms Marion Shipman, Associate Director of Quality and Governance	To discuss	Enc.	p.181
17.	<b>Waiting Times Quarterly Report</b> Ms Louise Lyon, Director of Quality and Patient Experience	To discuss	Enc.	p.189
18.	<b>IMT Q4 report</b> Mr David Wyndman Lewis, IT Director	To discuss	Enc.	p.210
19.	<b>Finance and Performance Report</b> Mr Terry Noy, Deputy CEO and Finance Director	To discuss	Enc.	p.213
20.	<b>T&amp;E Report</b> Mr Brian Rock, Director of E&T/ Dean	To note	Enc.	p.220
CLOSE				
21.	<b>Notice of Future Meetings:</b> <ul style="list-style-type: none"><li>23<sup>rd</sup> May Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre</li><li>27<sup>th</sup> June Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre</li><li>25<sup>th</sup> July Board of Directors' Meeting, 2.00-5.00pm, Board Room</li></ul>			