

Board of Directors Part One

Agenda and papers

of a meeting to be held in public

2.00pm–4.30pm

Tuesday 31st October 2017

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

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 31st October 2017, 2.00 – 4.30pm
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.9
4.	Matters arising Prof Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS				
5.	Service User Story Portman Clinic	To note	Video	-
6.	Service Line Report: Portman Dr Jessica Yakeley, Director of Portman	To discuss	Enc.	p.10
7.	Trust Chair's and NED's Reports Prof Paul Burstow, Trust Chair	To note	Verbal	-
8.	Organisational Objectives Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.17
9.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.25
10.	Finance & Performance Report Mr Terry Noys, Deputy CEO and Finance Director	To note	Enc.	p.29
11.	In Year Reforecasting Mr Terry Noys, Deputy CEO and Finance Director	To note	Enc.	p.35

12.	Organisation Development & People Strategy Report Mr Craig deSousa, Director of Human Resources	To discuss	Enc.	p.37
13.	Quality a. Quarterly Quality Dashboard & Commentary (including Performance Benchmark & KPIs) Report Ms Louise Lyon, Director of Quality & Patient Experience and Ms Marion Shipman, Associate Director Quality & Governance b. Waiting Times Quarterly Report Ms Louise Lyon, Director of Quality & Patient Experience c. IM&T Quarterly Report Mr David Wyndham-Lewis, Director of Transformation & Technology		Enc. Enc. Enc.	p.47 p.65 p.93
14.	Training and Education Report Mr Brian Rock, Director of E&T/ Dean	To note	To follow	
15.	Medical Education Strategy Dr Rob Senior, Medical Director	To discuss	Enc.	p.98
16.	Learning from Deaths Policy Dr Rob Senior, Medical Director	To discuss	Enc.	p.111
CLOSE				
17.	Notice of Future Meetings: <ul style="list-style-type: none"> 28th November, Board of Directors' Meeting, 2.00 – 5.00pm, Lecture Theatre 5th December, Leadership Group Conference, 2.00 – 5.00pm, Lecture Theatre 7th December, Council of Governors' Meeting, 2.00 – 5.00pm, Lecture Theatre 			

Board of Directors Meeting Minutes (Part One)
Tuesday 25th September 2017, 2.00 – 5.00pm

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	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:			
Terri Burns Trust Company Secretary	Debbie Colson	Tim Kent Adult Primary Care Lead (items 5 & 6)	Mr Ahmet Caglar Practitioner Psychotherapist PCPCS (item 5)
Ms N Service User (item 5)	Craig de Sousa, Director of HR (item 11)	Steve Bamborough Director of FDAC (part 2 item 6)	
Apologies:			
N/a			

Actions

AP	Item	Action to be taken	Resp	By
1	3a	Work plan to be presented to the Board in November for the quality data audit	LL	Nov 17
2	5	Service User video to be circulated to Board members	TB	Immed
3	9	Portman and CAMHS staff to be invited to Board lunch to celebrate achievements	TB	Nov 17
4	11	Report to Board addressing issues raised regarding governance changes	CdS	Nov 17
5	13	Seek solution to integrate GIC governance workstream	RS/SH	Nov 17
6	16	Research Strategy to October Board meeting	RS	Oct 17

1. Chair's Opening Remarks

- 1.1 Prof. Burstow welcomed the directors to the meeting. He welcomed Debbie Colson, who would be taking up post as a Non-executive Director in October, to the meeting. Prof. Burstow thanked Ms Murphy on behalf of the Board, for her thoughtful and valuable insights, as well as her constructive and supportive challenge. The whole Board wished Ms Murphy well in her new role.

2. Apologies for Absence and declarations of interest

2.1 Apologies as above.

2.2 No further declarations of interest were made.

3. Minutes of the Previous Meeting

3.1 The minutes of the previous meeting were agreed as a true and accurate record.

3a. Outstanding Actions

3.2 The action log was noted.

3.3 Actions two and three were completed. Revised due dates were noted for actions one and four.

3.4 Previous outstanding actions two, three and seven were noted as complete.

3.5 Outstanding action four - Dr Hodges reported that she had spoken with providers and the CRG chair was developing a training package to link with provider in house programmes.

3.6 Outstanding action five – Dr Hodges reported that children’s services were being reviewed in detail, with a meeting arranged for the following week to address impact factors. Meeting the 18 week wait target would not be possible as referrals continued to rise, however work was ongoing with NHSE to reduce the waiting list and ensure quality was not affected.

3.7 Outstanding action six – Ms Lyon reported that the first part of the work would be presented to the Audit Committee. The more detailed work would be delayed. The overall plan would be reported to the Board in November.

AP

4. Matters Arising

4.1 There were no matter arising.

5. Patient Story – AFS – Adult Primary Care

5.1 Mr Kent introduced Ms N and Mr Caglar to the Board. Ms N said that she had been feeling low after she had lost her husband. She had not wanted to leave the house. After seeing her GP she had joined the group at their suggestion. It suited her as she had a background in farming.

5.2 The group gave her hope and she was able to make friends there. It made her realise that there were others in the same position as her. She was able to learn practical skills and continued to apply the tools learned after leaving the group. She was on a waiting list for a further group.

AP

5.3 Mr Holt asked her if there was anything she would have liked to have been changed with the service. Ms N said that she wished it could continue for longer. Dr Hodges asked whether it had helped her children. Ms N said that her depression had been negatively affecting them and they had seen the positive change in her. She was able to explain their father’s death to them in a better way. Ms Farrow asked if the benefits had been continuing since she stopped attending the group. Ms N was upset when the group ended, but had been able to carry on using the experiences she had got from it.

The Board thanked Ms N and Mr Caglar.

6. Service Line Report – AFS – Adult Primary Care

- 6.1 Mr Kent reported that the changes in commissioning structures had altered the direction of primary care. The service was involved with the STP in central London and Camden, but less so in North East London. While the service was seeking growth opportunities, the restrictions on commissioners funding made this difficult. However, there was a clear need for services beyond IAPT. It was noted that the service was commissioned locally, rather than by NHSE as previously, meaning there was local accountability and good working relationships.
- 6.2 Mr Kent reported that the waiting list for the services had been reduced from 18 to 12 months. This was achieved by carefully restricting the access criteria. GPs and clinicians were initially reticent, but the process was working. The service was seeking to develop strategic partnerships as a way to develop business, as opposed to expensive competitive tendering. Dr Stern noted that this reflected what the Board had seen in the reputation audit.
- 6.3 Mr Kent stated that between them, the team were fluent in 10 languages and had sought to set up the group according to the needs of the local population. There were also personal links with St Mary's Garden and a grant, which had allowed the programme to take place.
- 6.4 Mr Holt expressed concern at the risks in the report, to the future of the service. Mr Kent stated that there was a clearly defined cash envelope. As the service lead, he also had to justify £80k Trust savings to commissioners. The concern was less about the continuity of the service and more about staff retention. Patient outcomes were very good, so the value of the service was proven.
- 6.5 Prof. Bhugra noted the reduction in number of patients accepted and questioned why this was. Mr Kent stated that this was due to the stricter referral criteria and being more selective as to when patients should be engaged with other services.
- 6.6 Mr Jenkins stated that he had visited the service and found the staff to be engaged and enthusiastic. The restructuring had been well managed and the service was working with, rather than in, primary care. Further research had also been commissioned into effectiveness to ensure people were not missed in the system.
- 6.7 Dr Hodges asked whether the service could be extended to children. Mr Kent stated that there could be potential for this, although it would require complex development and thought.

The Board noted the report and thanked Mr Kent.

6.8

7. Trust Chair's and NEDs' Reports

- 7.1 Prof. Burstow reported that he had had very interesting conversations with the early intervention service and speech and language in the GIC. There was also a positive follow up meeting with the thinking space team.
- 7.2 Ms Farrow reported that she had visited the Westminster services, where staff spoke about difficulties faced in getting questionnaires completed due to the nature of the service. She was

encouraged to see that the staff were being proactive in trying to generate ideas to address the potential of budgets being redirected elsewhere.

- 7.3 Prof. Bhugra noted that Mr Jenkins had been supportive of his attendance at a master class in Sweden in February. He would also be attending an academic conference in Bangalore. He also noted that the authorities in Hong Kong had agreed to pay for staff from the Trust to attend an event there.

8. Appointment of Deputy Trust Chair

- 8.1 Prof. Burstow reported that the position of Deputy Trust Chair would be vacant upon Ms Murphy stepping down from her role as a Non-Executive Director. He proposed that Prof. Bhugra be appointed as the new Deputy Trust Chair. The proposal had been considered by the Council of Governors, who had given their support.
- 8.2 The Board agreed that Prof. Bhugra be appointed as the Deputy Trust Chair.

9. Chief Executive's Report

- 9.1 Mr Jenkins reported that the Trust would be able to finalise student recruitment figures very soon. It was very positive as there were more students recruited than ever before. There were a number of courses that had done particularly well. Welcome Week had been well organised and delivered, with a great deal of enthusiasm from students. Mr Jenkins thanked staff in Education and Training for all of their hard work.
- 9.2 AP Mr Jenkins also reported that both the Portman and CAMHS services had been nominated for prestigious awards. The Board congratulated the services and suggested that they be invited to a Board lunch as a token of their appreciation.
- 9.3 Mr Jenkins reported that the Trust was positioning itself as an important organisation in workforce mental health. The HEE had published a workforce plan, which indicated the scale of the issue. Dramatic changes were needed around introducing new roles, as well as improving retention. The Trust was developing plans related to trauma and resilience. Ms Caldwell reported that the NWSDU had the potential to have a very wide impact. The senior programme manager would be a good critical friend in relation to IAPT.
- 9.4 Mr Jenkins had attended an event held by Universities UK, which highlighted the problems in student mental health. There was a growing worrying issue. The Trust was leading a piece of work developing best practice service plans to address this. Ms Murphy noted that Universities UK was a positive step in addressing the issue of supporting students. It often fell to staff who were not best placed to do so. Academic pastoral teams were struggling with the increased burden.
- 9.5 The Board noted the revised NICE guidance on depression. It was better than had been expected, however it was felt there was too much emphasis on CBT and not enough on other modalities. The Trust was preparing a response.

10. Finance & Performance Report

- 10.1

Mr Noys reported that there was a net margin of two percent, which was very tight. Income was down by £400k, which was mostly in Education and Training. There was a possibility of some invoicing issues, however lower staff costs had had an offsetting effect. All directorates were making a positive contribution to the Trust. Education and Training delivered 50% of the surplus, while CYAF delivered 40%. Gender identity services delivered 20% of the Trusts income, so was a significant contributor.

10.2

Mr Holt questioned how much of the lower staff numbers was intentional and how much was difficulty in recruiting. Mr Noys stated that a certain amount of vacancy level was built into the budget. Having a full complement of staff would reduce the surplus available. Dr Senior noted that vacancy control was being used in some teams as a short term budget control method. Mr Jenkins stated that the most important issue was identifying any areas where there was disproportionate under recruitment.

10.3

The Board noted the report.

11. Governance

a. Consolidation of NED & Chair Committees & Terms of Reference

11.1

Prof. Burstow reported that the consolidation and terms of reference had been agreed by the Council of Governors. The change brought together six committees into one in order to streamline the process of nominations, remuneration and appraisals.

11.2

Mr Holt noted that the quorum should be clarified to include at least either the Trust Chair or Senior Independent Director.

11.3

The Board noted the report.

b. Proposed changes to Board and other governance arrangements

11.4

Prof. Burstow reported that the proposals had been discussed by the Council of Governors and no concerns had been raised by them. The position of Associate Non-Executive Director was proposed in order to create greater chances for BAME candidates in future Non-Executive Director roles. The proposals also reduced the frequency of future Board meetings and instead created more frequent seminars.

11.5

Mr Holt questioned whether the Council of Governors had raised any queries about how the changes would affect their ability to hold Non-Executive Director to account. Prof. Burstow confirmed that this had been discussed in the context of creating more alternative methods of doing so, such as buddying Governors with a Non-Executive Director and Governors attending service visits. Mr Holt noted that consideration should be given to whether Governors could attend Board seminars.

11.6

Prof. Bhugra asked whether there would be any financial implication related to having Associate Non-Executive Directors. Prof. Burstow confirmed that there would be a future report on the terms of their engagement, including remuneration.

11.7

In response to queries from the Non-Executive Directors, Mr de Sousa stated that Associate Non-Executive Director positions were used by other organisations as a method of succession planning. Associate roles would also open up Non-Executive roles to those that did not have any previous Board level experience.

11.8 Prof. Burstow clarified that the changes would be reviewed once the final proposals had been worked through. The measures would be intended to free up Board member's time for getting things done rather than attending a lot of meetings. He also noted that the lack of BAME representation at Board level was an NHS wide issue. The need for accountability would remain a key consideration in any future implementation.

11.9 The Board agreed to the proposals, on the proviso that a future paper addressing the issues raised, with regards the creation of Associate NEDs, be brought to the Board, including seeking clarification from NHSI as to the independence of Associate Non-Executive Directors.

AP

12. Race Equality Strategy

12.1 Ms Lyon reported that the strategy had gone through a great deal of consultation and the points made previously by the Board had been taken into consideration. The strategy sought to tackle the idea of trustwide representation. The student survey responses would be used to inform further work. Mr de Sousa noted that the proposals were evidence based and senior level engagement had been very positive.

12.2 Dr Senior reported that there had been some positive feedback from the Council of Governors, which had been taken account of. They had been generally supportive and gave constructive feedback.

12.3 The Board noted that the strategy was an ongoing working document and would continue to be developed over time. The formal launch would be held on 2nd October, where Roger Klein had been invited to speak.

12.4 The Board approved the Race Equality Strategy.

13. Quality & Safety

a. CQSG Quarterly Report

13.1 Dr Senior reported that the way in which the Trust considered serious clinical incidents was important. Deciding when to publish information should take into account the patient and their family's privacy, as even anonymised information could be identifiable to them. The nature of the Trust meant that there were very few of these incidents. Dr Senior suggested that GIC have their own workstream for incidents temporarily, given the level of complaints that were being received. Dr Senior would be liaising with Dr Hodges to integrate the governance that was in place.

AP

13.2 Ms Farrow questioned why the CQC rating had been changed to amber. Dr Hodges clarified that the CQC had agreed that the GIC service rating would not affect the overall Trust rating initially, as the GIC rating was historical. The Trust rating would only be affected if the GIC rating did not improve. Prof. Burstow suggested that this should be included in the operational risk register.

13.3 Ms Farrow asked how the payments would be made over the two year period concerned. Ms Lyon noted that this had yet to be clarified. Prof. Burstow asked whether there was a policy in place. Dr Senior confirmed that this would be reported to the October Board meeting.

b. Serious Incidents Quarterly Report

13.4

Dr Senior reported that there had been helpful conversations at the CQSG meeting. Further discussion would take place in part two of the meeting, due to potential personal identifiable information in the report.

13.5

The Board approved the report.

13.6

c. Report on increased incidents at Gloucester House

Dr Senior reported that the number of incidents at Gloucester House Day Unit exceeded the rest of the Trust. This was in part due to the nature of the service and the service user needs. The school was required to meet Ofsted reporting standards, which it was doing. How to reduce the number and seriousness of incidents was a constant consideration. It was apparent that there was a peak in the number of staff injuries at the beginning of the academic year. The data was taken seriously and a full investigation undertaken. A number of recommendations were made, as detailed in the report.

13.7

Dr Senior stated that the staff did a fantastic job of getting children back into mainstream school, when other services had given up on them. There was a need to be able to bring in additional staff when required, however this was difficult given the specialised nature of the training needed. The school had also become a victim of its own success, as numbers of referrals rose.

13.8

Ms Farrow asked whether there was clarity on the relocation requirements of the school. Dr Hodges confirmed that this had been developed and any move would need to be outside of the school year and allow room for the service to grow further.

13.9

Dr Hodges stated that the report would also be discussed with staff at the Gloucester House steering group. The Board noted that the investigation and recommendations were evidence of staff welfare being of paramount importance.

13.10

The Board approved the recommendations in the report.

13.11

d. Infection Prevention & Control Annual Report

Dr Senior reported that the outbreak of flu in Australia this year was the highest it had been for 15 years. It would be likely to have a similar effect in the UK. A programme of immunisation was in place at the Royal Free Hospital. Staff were also reminded to stay away from work if they were unwell, as this was an even more effective method of prevention than the flu jab.

13.12

The Board noted the report.

14. Guardian of Safe Working Hours Report

14.1

Dr Senior reported that the report was a result of the new junior doctor's contract. The Trust had a small number of trainee doctors. Other providers had been fined for breaching the regulations. There were no issues to report within the Trust.

14.2

The Board approved the report.

15. Training & Education Report

15.1

Mr Rock reported that Ian Tegerdine had been appointed as Director of NWSDU. The SITS project was in development. Release Five was being implemented, which was very challenging.

The team had done well to get to the current point. There had been some key operational capacity challenges, which had had a significant impact. There had also been some issues relating to data migration. More people were being recruited to the Informatics team to support the process.

- 15.2 Mr Rock also reported that student recruitment had been positive. There had been around 50 deferrals and these people were being actively engaged to ensure places were taken up the following year. A proposal on the international strategy was being developed, with staff engagement key. An international trade trip to China was taking place, where the Trust would be able to meet with hospital administrators and key decision makers.
- 15.3 Ms Lyon asked the main reasons why students had deferred places. This information was not yet available. Ms Caldwell noted that the learning from the SITS project could be used across other areas of the Trust.
- 15.4 The Board noted the report.

16. Research Strategy

- 16.1 Dr Senior reported that he had received some feedback on the strategy already, including on KPIs, data on income expenditure and bid success rates. The Trust bids for research funding were all in partnership with academic institutions. It was important that the Trust had a presence, in order to contribute to clinical bids and student recruitment.
- 16.2 The non-executive directors supported the need for strong partnerships with institutions who were good at winning funding bids. It was felt that universities were best placed to meet the Trust's needs in this respect and would have the necessary expertise. However, it was noted that there were a finite group of people with whom to create these partnerships.
- 16.3 Ms Coulson stated that the Trust was well placed to develop its research culture and would need to identify niche strengths that were not easily replicable. A strategic vision would be needed to do this. Prof. Burstow stated that the golden threads through the whole piece of work would create the overall vision.
- 16.4 AP Prof. Burstow noted that the strategy would have an in depth discussion at the October meeting of the Board.

17. Notice of future meetings

- 17.1 The next meeting of the Board of Directors was noted as 31st October 2017, 2.00-5.00pm, Lecture Theatre, 120 Belsize Lane.

18. Any Other Business

- 18.1 No other business was raised.

Outstanding Action Part 1

Action Point No.	Originating Meeting	Action Required	Director / Manager	Due Date	Progress Update / Comment
1	Jan-18	Arrange annual event for interactive discussion of Serious Incident cases to share learning amongst all clinicians	Rob Senior	Sep-17	
2	Jan-18	Review the approaches for other providers in training new staff in the gender identity service	Sally Hodges		
3	May-17	Undertake an audit of the quality data - present plan in Nov 17	Louise Lyon	Nov-17	
4	May-17	Allocation of tasks and priorities to the Non-Executive Directors to include leads for Unexpected deaths and Quality	Paul Burstow	Nov-17	
5	May-17	Confirm when the target for mandatory training with regard to clinical risk will be met.	Rob Senior	Jun-17	

Board of Directors : October 2017

Item : 6

Title : Portman Clinic Service Line Report

Purpose:

The purpose of this report is to give an overview of the activities of the Portman Clinic, including financial situation, key interactions with other parts of the trust, achievements, key service strengths and development opportunities, and areas of risk/concerns

This report has been reviewed by the following Committees:

- Management Team

This report focuses on the following areas:

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

For : Noting

From : Dr Jessica Yakeley, Director, Portman Clinic and Dr Julian Stern (Director, AFS)

OVERVIEW OF SERVICE

The Portman Clinic, situated within the Adult and Forensic Services Directorate, is an out-patient forensic psychoanalytic psychotherapy clinic offering psychotherapeutic assessment and treatment service to children, adolescents and adults who are disturbed by their delinquent, criminal or violent behaviours and/or whose sexual behaviour causes damage to others or to themselves. It also offers consultancy, teaching, training and supervision, and has an active research programme.

The Clinic was founded in 1931 as the Psychopathic Clinic, the clinical arm of the then Institute for the Scientific Treatment of Delinquency. All of the Clinic's case records remain in existence and are archived in the London Metropolitan Archives. This provides a wealth of fascinating material for historical research, which is currently being documented by a Wellcome Institute funded archivist.

Staffing

The current Director, Dr Jessica Yakeley, was appointed in August 2016, taking over from her predecessor, Stan Ruszczyński. The clinical staff have core disciplines in psychiatry, psychology, nursing, social work, probation or adult/child psychotherapy. There is also a full time researcher, full time MBT project manager, full time clinic manager, full time receptionist and 3 other admin staff; in addition, honorary clinical staff, D59 students, child psychotherapy and psychiatry trainees who are supervised to do clinical work.

Clinical services

Presenting problems

Most patients who are referred have had several interventions by local services but need the specialist provision offered by the Portman Clinic. Audit of adults (over 18) accepted for treatment between 2010 and 2016 years showed that 67 % present with paraphilias and other problematic sexual behaviours (e.g. paedophilia, use of child internet pornography, fetishism, exhibitionism, addiction to adult pornography), 19% with violence (antisocial behaviour, domestic violence/ interpersonal violence, physical assault, sexual assault, rape, murder; 4% with gender identity issues, and 10% with a combination of sexual and violent behaviours.

Types of treatment

Patients are seen either in individual treatment, group treatment or as a couple if the presenting problem is related to their couple relationship. Treatment sessions are usually weekly and, given the disturbances and failures in these patients' developmental histories, often resulting in a mistrust of and difficulty in using professional care provision, treatment tends to be more long term. For many patients, approximately 3 years tends to be what is required for the establishment of some degree of stability in the reduction of anti-social behaviours, but a few patients are seen for longer.

The current Clinic Director initiated and developed a mentalization-based treatment (MBT) programme specifically for violent men with a diagnosis of antisocial personality disorder (ASPD) in 2009 within the Portman's core clinical service. In 2013 the Clinic was commissioned by NHS England to develop, implement and deliver MBT services within the National Probation Service across 13 sites as part of the government's Offender Personality Disorder Pathway. These services are now part of a RCT run by UCL, with training and supervision provided by the Anna Freud Centre.

Our child psychotherapists see children, adolescents and young adults for psychotherapeutic assessment and treatment, actively working with their families, carers and the wider network. They also provide a risk assessment service for children and young people presenting with harmful behaviours to local authorities and other agencies within the system.

Number of patients

Of the 250-300 referrals per year, one third to one half progress to assessment, and half of these are offered and accept treatment (i.e. around 20% of those referred). At any one time there are approximately 130-140 patients in regular treatment. Just over half are seen in group psychotherapy. The Clinic always has more referrals than it can deal with and tends, to a limited degree, to over-perform on its contract, which suggests that the distinct service offered by the Clinic meets clinical needs not available in local generic services.

Commissioning and referral sources

The Clinic is commissioned by NHS England for its clinical services, and therefore has a national catchment area. 75-80% of referrals come from within Greater London. Most referrals come from GPs or secondary mental health services, as well as referrals from probation, social services, youth offending services, local authority education services, and the private sector, and importantly, the clinic accepts self-referrals.

Patient demographics

85%-90% patients referred are male, partly because women are often seen as 'less dangerous' to the community as they tend to enact this type of disturbance by harming themselves, their children and sometimes their partners. The average age at referral is 35, the youngest patient referred was age 4, and the oldest age 80.

DNA rates

Over the 4-year period 2013-7 the DNA rate ranged from 6.3% to 7.5%, an impressive figure given that many of the Portman's patients are known to be difficult to engage in treatment.

Clinical quality, outcome data and patient feedback

Audit and quality improvement projects

- Last year we carried out an extensive audit of clinical activity over the past 3 years (2013-16). This audit included demographics of patients, presenting problems, referral source, referral rates, waiting times, proportion of patients accepted for assessment and then treatment, DNA and cancellation rates of patients in treatment, outcomes of treatment and patient experience.
- We are currently auditing safe and timely discharge of our patients, as part of our current CQUINs – we achieved the target for Q2 2017/18.
- We are also auditing accurate recording of suicide and self-harm risk in the patient's record, as part of the CQC visit action plan.

Experience of Service

All patients aged over 18, following assessment and at six-monthly intervals in treatment, are asked to complete an Experience of Service Questionnaire (ESQ). Patients under 18 and their carers are asked to complete the - Experience of Service Questionnaire (CHI-ESQ). feedback for the most part is very positive.

Work with Service Users (SUs) and Experts by Experience

Work with SUs and experts by experience may be complicated due to the confidential nature of our patients' difficulties. However, in the last few years we have been actively developing opportunities for their greater involvement. Our first service user/expert by experience was recruited from our original ASPD group –he presented to the Board in 2014, sat on an interview panel in the Trust and has been involved as an expert by experience in the ASPD project. SUs are integral to every stage of the MBT/ASPD project: in the original planning of the service specification and bid; a SU is part of staff complement at every site delivering group therapy to engage offenders; there is a SU on the trial steering committee; service users piloted measures for the RCT; and peer researchers are collecting the measures in the RCT.

Outcome monitoring

Routine outcome monitoring demonstrating the clinical effectiveness of our treatments is conducted on all patients accepted for treatment. This includes a range of measures, including a patient-reported outcome measure (the CORE), a clinician reported outcome measure (the SWAP – a measure of personality diagnoses, traits and functioning) & measures done jointly with the clinician and the patient together to ascertain the frequency of problematic behaviours.

Evidence of effectiveness of treatment in over 18 patients

Over 65% of patients show a reduction in the frequency of their problematic behaviours after 6 months. Analysis of data since 2010 of the SWAP shows a general trend of reduction in personality disorders and problematic traits. At the same time there is a statistically significant increase in the psychological functioning of patients, well as a statistically significant increase in high-functioning depressive personality scores, indicating an increase in patients' personality strengths and capacities in combination with dysphoric affect. This indicates patients' progress in become aware and getting in touch with their ambivalent emotions, which underlie their problematic behaviours, which longer-term psychotherapy is aimed at working through.

Complaints

Very few complaints. 2016/17-one complaint only, not upheld.

Incidents

A low rate of reportable clinical incidents. In 2016/17 there were 3:

- A patient impulsively took overdose after a night of drinking & was taken to Whittington Hospital A&E;
- A patient self-harmed (cutting through the previous night) and was feeling low, offer of transfer to A&E were declined. Parent contacted and collected young person;
- Young person disclosed in their session that they had tried to hang themselves with a belt. Returned home with a friend and reconnected to Crisis Team.

Consultancy

For many years the Clinic has provided consultancy & supervision to prisons, probation, approved premises, youth offending institutes, forensic mental health institutions, high, medium & low secure units, social services & generic multi-disciplinary teams. The overall aim is to provide a supportive and reflective forum to help professionals, from a psychodynamic and relational viewpoint, in understanding and managing their patients & clients.

Current consultancy includes:

- Feltham Young Offenders Institute
- HMP Brixton, Pentonville, Wormwood Scrubs, Grendon and Wandsworth prisons

- Oxleas NHS Foundation Trust – consultation to the Bracton Centre
- Leeds & York Partnership NHS Foundation Trust – consultation to the Hull Psychotherapy Service
- Supervision to all quadrant teams of probation officers and mental health professionals of London Probation Pathways (LPP) involved in the Offender Personality Pathway
- East London NHS Trust – consultancy to John Howard Centre
- SLAM NHS Trust – consultancy to River House
- New Horizons Youth Centre – supervision to the team
- Nottinghamshire NHS Foundation Trust – consultancy to Wells Rd & Mandala Centre
- Leeds & York Partnership NHS Trust – teaching
- Risk assessments commissioned by various organisations such as Harrow Council Children's Services, Swale CCG and other local authorities

Education and Training

Stephen Blumenthal the DET Forensic Portfolio Manager oversees a number of trainings and courses with significant input from Portman Clinic:

- D59F 2-year clinical forensic psychodynamic psychotherapy training leading to a BPC qualification as a Psychodynamic Psychotherapist.
- P7 - *Advanced course in the understanding of forensic psychotherapy and risk*
- P20 – *Risk a relational Perspective* – 8 week course delivered in London and Leeds
- P1 *Introducing psychoanalytic ideas on violence, delinquency and sexual deviation*
In development:
- *Foundations in Psychodynamic approaches to Risk and Complexity*
- A bid with Unitas to contribute to a Masters programme as part of training the Youth Justice workforce

From 2007 to present we played an active role in teaching and training on the Personality Disorder Knowledge and Understanding Framework (PDKUF) programme, having been one of the original partners in developing and initiating the programme. We also have a psychiatry trainee specialising in forensic psychotherapy, part of the West London & Portman Higher Training Scheme in Forensic Psychotherapy, as well as supervising a number of honorary clinicians (psychiatrists and psychotherapists) wishing to gain further experience in forensic psychotherapy, who take on one or more of our patients for therapy.

Research

In recent years we have been involved in a number of research projects, including:

- Research by Stephen Blumenthal and Stan Rusczyński at Ashworth High Secure Hospital in which they found that weekly consultation to the staff increased the number of personal engagements between staff and patients;
- Research by Stephen Blumenthal et al on risk assessment showed how emotive factors, ("countertransference"), interfered disproportionately to risk assessment even for experienced forensic practitioners;
- A study by Jessica Yakeley and Heather Wood interviewing patients to ascertain their experiences of psychotherapy at the Portman & their views on what changed and how.

Current research:

- Research by Heather Wood and Stephen Blumenthal, advised by Peter Fonagy, at Grendon Prison Therapeutic Community on the Implicit Association Test. They have identified that an implicit association between violence and enjoyment (sadism) is associated with people who are more antisocial, advancing our understanding of risk

- Research with the Ministry of Justice looking at the outcomes of our offender patients in terms of re-conviction rates during and post treatment against matched controls from their data base of offenders. This will enable us to investigate the efficacy and cost effectiveness of our treatments.
- The MBT/ASPD service is now part of a randomized controlled trial across all sites, funded by the NIHR. Jessica Yakeley is a Principal Investigator of this RCT led by Professor Peter Fonagy at UCL. All sites have now entered the trial and recruitment is currently on target.

Going forward, we are developing the Portman into an actively functioning **research clinic** aiming to build an evidence base for the efficacy of treatments in our unique population that has been under-researched in the literature (especially child internet pornography and paraphilias), as well as patient satisfaction with our service and cost effectiveness. This will also generate sufficient data for us to apply to funding bodies to carry out RCTs. We have appointed a full time, very experienced, researcher, Felicitas Rost, to lead on the above, with honorary research assistants working under supervision. A battery of diagnostic and outcome measures has been successfully piloted with a small cohort of patients, and this has proved to be practical and acceptable to patients, having incorporated their feedback into the adjustments of the process of measure administration as the research proper gets underway. The research team have now started interviews at assessment, treatment and end-of-treatment stages for all consenting patients accepted for treatment.

FINANCIAL SITUATION

£'000	Prior Year Outcome	Current Year To Date	Full Year Forecast	Full Year Budget
Income	(1,395,153)	(721,220)	(1,439,526)	(1,447,091)
Staff Costs	1,101,905	511,942	998,042	1,027,045
Non Staff Costs	36,307	13,467	27,214	35,830
Contribution	(256,941)	(195,811)	(414,270)	(384,216)
- Margin	18	27	29	27
Staff WTE	15.8	13.8	14.6	14.1

KEY INTERACTIONS WITH OTHER PARTS OF THE TRUST

We are an integral part of AFS, and work closely with many parts of trust including:

- CYAF in joint working & bidding for new business e.g. Syrian project, forensic CAMHS
- GID (and potentially GIC) in providing consultation and supervision for complex cases
- Business Development in developing and bidding for new business opportunities
- Finance including Contracting
- DET as described above
- Medical Education
- Senior management and leadership in contributing to Trust Strategy; as well as other directorates, IMT, Nursing, Medicine, Quality and Patient Experience

ACHIEVEMENTS, KEY SERVICE STRENGTHS AND SERVICE DEVELOPMENT OPPORTUNITIES

- The MBT service - shortlisted for the HSJ awards in Innovations in Mental Health category-winner to be announced on 22.11.17. The services are now part of the largest treatment RCT to date of individuals with ASPD.
- Media projects – we are in the process of planning a two-part radio programme on the work of the Portman for BBC Radio 4.
- MBT project - we have been commended by our commissioners for our expertise in developing this service
- We are actively exploring & bidding for new business opportunities in the forensic mental health together with other organisations with whom we have developed good relationships e.g. BEH Trust, other mental health trusts, the Anna Freud Centre. These include in-reach mental health services in prisons, delivering interventions in prison, & domestic abuse programmes. The recent appointment of a child psychotherapist has increased our capacity to accept more risk assessments. Currently co-ordinating a bid with other mental health trusts in the STP for a forensic CAMHS service.
- We are in dialogue with the Chair of the Independent Advisory Panel for Deaths in Custody, prison governors and senior figures in the Safer Custody Programme of HMPPS to deliver training and consultation around suicides in the prison sector.
- The Wellcome Trust-funded London Metropolitan Archive project is reviewing and documenting all the Portman files in existence since 1933, revealing a wealth of information available for further research. This will be presented at conference on the project planned for early next year.
- Research programme as described above
- Publications- papers in peer-reviewed journals & books , recently *Risk – A Relational Approach*. Routledge 2018, -Stephen Blumenthal, Heather Wood & Andrew Williams.

AREAS OF RISK AND/OR CONCERNS AND RELATED ACTION PLANS

CQC (Care Quality Commission)

The CQC inspection in January 2016 raised concerns requiring action. A CQC Action Plan was developed, monitored by the Executive Management Team & the Clinical Quality Safety & Governance Committee. We have implemented all relevant recommendations/requirements, which the CQC were satisfied with when they re-inspected in November 2016.

Relocation

Prior to the planned relocation of the whole Trust in 2021, the Trust are considering an earlier sale of the Portman building. We have concerns regarding the clinical risks that our patients, particularly those with a history of illegal violent and/or sexual behaviours to children and adults, may pose to other patients and staff of the Trust. This would require specific structural adaptations to any new accommodation (e.g. separate entrance, separate toilets, separate child waiting room, wheelchair access etc.). We are also concerned that having to move twice in a relatively short period of time may cause disruption and instability to patients, as well as staff. Any planned early relocation would require full consultation with all Portman staff and careful work to ensure that any risk was mitigated.

Electronic Records

The Clinic is migrating all clinical information to CareNotes, to be completed by March 2018. Close work with IMT will ensure that the Portman has a closed off area of the electronic record system that limits access to Portman clinicians only, due to the very confidential nature of our patient's difficulties. This will require training of staff; safe scanning of previous notes; & a period of implementation and addressing of any difficulties relating to the migration process.

Board of Directors : October 2017

Item : 8

Title : Organisational Objectives 2018/19

Purpose:

Following our discussions at the Board Away Day, I have developed with EMT a set of draft high level objectives for the organisation for 2018/9.

These attempt to:

- Reflect priorities we agreed at the Away Day in particular in relation to income generation and development.
- Set out a unified set of objectives which can provide a common basis for our strategic plan, Board and CE objectives for 2018/9.
- Provide an overarching framework of core objectives to be cascaded through the appraisal process and reflected in team and individual objectives across the organisation.

The Board are asked, at this stage, for their comments on the headline objectives. Reflecting this a more detailed workplan, with key targets and milestones will be developed to be agreed by the Board in the New Year alongside the

2018/9 budget. The revised objectives will also drive work on an updated BAF as discussed at the Director's Conference in September.

For : Discussion

From : Paul Jenkins Chief Executive

Tavistock and Portman NHS Foundation Trust Strategic Plan – 2018/9

Draft High Level Objectives

Mission and Values

Mission

For nearly a 100 years, the Tavistock and Portman has represented a unique tradition in thinking about mental health and well-being, grounded in psychoanalytical, psychodynamic and systemic thinking. This has involved an interest in the unconscious as well as conscious aspects of mental distress, the investigation of the impact for individuals of experience in early lives and a focus on the importance of relationships and social context in promoting mental health and well-being.

The Tavistock and Portman has developed these traditions through the delivery of high quality clinical services for young people and adults, the provision of training and education, research and thought leadership and organisational consulting. The organisation has played a key role as innovator, developing new interventions, services and models of care.

The Tavistock and Portman aims to continue to this tradition and to work with others in applying it to find solutions to contemporary challenges facing health, care and other sectors.

Aims

In doing so the Tavistock and Portman will aim to:

- Continue to deliver and develop high quality and high impact clinical services

- Offer training and education which meets the evolving needs of individuals and employers and helps transform the workforce in health, care and other sectors.
- Be a UK centre of thought leadership and research.
- Support the development of new models of care and innovation approaches to addressing systemic issues in the delivery of care and other services.

Values

As an organisation:

- We will work with people with lived experience of mental health problems to use their contribution to inform our activities and decision making.
- We will be caring and compassionate and demonstrate our understanding of the impact of mental distress on individuals and families and communities.
- We will be passionate about the quality of our work and will be committed to transparency, the use of evidence and improvement.
- We will value all our staff and their wellbeing and foster leadership, innovation and personal accountability in our workforce.

- We will embrace diversity and work to make our services and training as accessible as possible.
- We will be outward facing, making an active contribution to the development of public policy work with others who share our values and can enable us to deliver our mission.

Draft Objectives 2018/9

Objective 1 – People

Support our workforce to deliver the Trust's Mission in line with our values:

- Implement the People Strategy with the aim of supporting the resilience, development and performance of our staff.
- Position the Trust as a respected authority on workforce development.
- Implement the Race Equality Strategy.
- Develop our Estates Strategy to deliver the right facilities for the work of the Trust.

Objective 2 – Services

Maintain and develop our clinical, educational and training and consultancy services, adapting as appropriate to the changing environment:

- Implement the Clinical Quality Strategy.
- Strengthen our collection and use of data to inform decision making.
- Work across our clinical and educational services to develop relevant and responsive service models, including through the use of technology.
- Seize opportunities to extend our existing services and meet our target for AY 2018/9 student recruitment.

- Contribute to the development of North London Partners in Health and Care.

Objective 3 – Growth and Development

Develop and implement a strategy for growth which delivers a sustainable financial future for the Trust and extends the reach of its distinctive approach to mental health:

- Advance the Trust's position in national and transnational education including through the launch of a Digital Academy.
- Develop an effective model for systemic support for organisational wellbeing and secure its implementation in at least one setting.
- Respond to the national tender for adult gender services with the aim of establishing the Trust as an international centre of excellence for gender work.
- Implement our social investment model for FDAC and explore other opportunities for innovative financing of our services.
- Raise our public profile in line with our forthcoming Public Affairs Strategy and building on the outputs of the Research Strategy.

Objective 4 – Finance and Governance

Meet regulatory requirements critical to the on-going well-being and independence of the Trust:

- Continue to meet regulatory standards with QAA and CQC.

- Meet our Control Total for 2018/2019.

Board of Directors : October 2017

Item : 9

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. AGM

- 1.1 The Trust's held its AGM on 4th October with a focus on our work on gender identity. The event included a facilitated discussion and question and answer session about issues relating to our services for young people and adults involving both senior clinicians and by experience.
- 1.2 The event was attended by 82 individuals, a significant increase on 2016. 54 attendees stayed on for the formal AGM.

2. Race Equality Strategy

- 2.1 Following agreement at the September Board we launched the Trust's Race Equality Strategy on 2nd October. The event was well attended and included contributions from a number of external speakers including Oyebanji Adewumi, Associate Director for Inclusion – Barts Health NHS Trust and Roger Kline, Research Fellow at Middlesex University Business School.
- 2.2 It was encouraging to hear their positive view about the strategy but it will be important to recognise the need to follow through the strategy across the organisation and demonstrable progress against the targets we have set ourselves in the document.

3. Life Chances Fund Announcement

- 3.1 On the 18th October an announcement was made of the Trust's successful bid to the Life Chances Fund for the development of the FDAC model through social investment. To mark this the service was featured on the BBC's Victoria Derbyshire Show with live interviews with Steve Bambrough, the Associate Director responsible for the service and one of the FDAC parent graduates and a filmed interview with another parent graduate.

4. Psychological Trauma and Workplace Resilience Framework

- 4.1 On October 3rd the National Workforce Skills development Unit hosted a major stakeholder event to inform the development of a framework to support actions to address psychological trauma and improve staff resilience in the health and care workforces.
- 4.2 In the last month I have also had meetings with the Dean and Registrar of the Royal College of Psychiatrists and the Chief Executive of NHS Employers on this and other workforce issues.

5. Mental Health Liaison

- 5.1 On 4th October I chaired a stocktake meeting for the STP on the issue of mental health liaison with the aim of agreeing a consistent approach across North Central London for the development of liaison services.

6. University Mental Health

- 6.1 On October 11th I chaired the first meeting of an expert task and finish group established by Universities UK to develop best practice in relation to service models across universities and the NHS to support student mental health.

Paul Jenkins
Chief Executive
23rd October 2017

MONTHLY FINANCE AND PERFORMANCE REPORT

Period 6

Sep-17

Section

- 1 Summary I&E
- 2 Highlights
- 3 Balance Sheet
- 4 Funds flow
- 5 Capital Expenditure

FINANCE AND PERFORMANCE REPORT

SUMMARY I&E

Section 1

Period 6

30 September 2017

	2016/17 Actual Month	2017/18 Actual Month	2017/18 Budget Month	Variance 2017/18 v 2016/17	Variance Actual v Budget
	£'000	£'000	£'000	£'000	£'000
Income	4,712	4,652	4,640	(60)	11
Staff costs	(2,753)	(2,931)	(3,094)	(178)	163
Non-staff costs	(1,709)	(1,496)	(1,318)	213	(178)
Operational costs	(4,462)	(4,427)	(4,411)	35	(15)
EBITDA	250	225	229	(25)	(4)
- Margin	5%	5%	5%		
Interest receivable	1	1	1	(1)	(0)
Interest payable	0	0	0	0	0
Depreciation / amortisation	(54)	(67)	(65)	(14)	(2)
Public Dividend Capital	(49)	(61)	(48)	(13)	(13)
Restructuring costs	2	41	0	39	41
Other			0	0	0
Net surplus	151	138	116	(13)	22
- Margin	3%	3%	3%		

	2016/17 Actual YTD	2017/18 Actual YTD	2017/18 Budget YTD	2017/18 F'Cast YTD	Variance 2017/18 v 2016/17	Variance Actual v Budget	Variance Actual v Budget
	£'000	£'000	£'000	£'000	£'000	£'000	%
Income	24,616	24,645	25,034	25,034	28	(389)	(2)%
Staff costs	(15,930)	(17,801)	(18,476)	(18,476)	(1,871)	675	4%
Non-staff costs	(6,759)	(5,563)	(5,386)	(5,386)	1,196	(177)	3%
Operational costs	(22,689)	(23,364)	(23,862)	(23,862)	(675)	498	2%
EBITDA	1,927	1,281	1,172	1,172	(647)	109	0
- Margin	8%	5%	5%				
Interest receivable	6	3	4	4	(2)	0	0%
Interest payable	0	0	0	0	0	0	
Depreciation / amortisation	(344)	(396)	(391)	(391)	(52)	(5)	1%
Public Dividend Capital	(291)	(289)	(290)	(290)	2	1	(0)%
Restructuring costs	(113)	(18)	0	0	95	(18)	
Other		0	0	0	0	0	
Net surplus	1,185	581	495	495	(605)	87	17%
- Margin	5%	2%	2%				

COMMENTARY

As at 30 September actual net surplus of £581k is £87k ahead of the Budget and ahead of the NHSI Month 6 target £442k .
Thus the Trust is on track to secure Q2 of STF funding.

Income is £389k below budget, due to shortfalls in Child Psychotherapy trainees and unwinding of centrally held income targets
Staff costs are £675k below Budget (in part because of lower Child Psychotherapy trainees).

Non-pay costs are £177k worse than budget (primarily in CYAF), reflecting increased activity due to additional revenue

FINANCE AND PERFORMANCE REPORT
Period 6
30 September 2017

HIGHLIGHTS
Section 2

RATINGS

Year To Date

**Full Year
Forecast**

Net surplus
Cash flow
Agency spend
SOF rating for finance and resources
Supplier payments

GREEN
GREEN
GREEN
GREEN
AMBER

GREEN
GREEN
GREEN
GREEN
GREEN

STAFF NUMBERS (WTE)

**YTD
Budget**

**YTD
Actual**

Variance

665

654

(11)
(2)%

PROVISIONS / ACCRUALS

31-Mar-17

30-Sep-17

Holiday pay accrual
Bad debt provision
Restructuring
Adult GIC Employee Claim
Other staff related
Camden Shed'

305
305
179
15
65
50

305
305
179
15
65
50

CREDITORS / BETTER PAYMENT PRACTICE CODE

YTD

Target

Actual

Number of invoices
Value of invoices

95%
95%

89%
92%

FINANCE AND PERFORMANCE REPORT

Period 6

30 September 2017

Prior

Year End
£'000

April
£'000

May
£'000

June
£'000

July
£'000

Aug
£'000

Sept
£'000

Oct
£'000

Nov
£'000

Dec
£'000

Jan
£'000

Feb
£'000

Mar
£'000

BALANCE SHEET

Section 3

Intangible assets

191

188

199

194

216

211

205

Land and buildings

18,381

18,432

18,673

18,720

18,507

18,558

18,562

IT equipment

1,329

1,345

1,311

1,354

1,553

1,598

1,697

Other

0

0

0

0

0

0

0

Property, Plant & Equipment

19,709

19,777

19,984

20,074

20,060

20,156

20,258

Total non-current assets

19,900

19,964

20,183

20,268

20,276

20,366

20,464

Trade and other receivables

5,518

3,740

2,979

3,760

3,210

2,795

3,296

Accrued Income and prepayments

2,098

3,614

4,701

3,763

3,230

3,298

4,030

Cash / equivalents

2,152

5,279

3,224

2,480

4,747

3,635

2,477

Total current assets

9,768

12,634

10,905

10,003

11,187

9,728

9,804

Trade and other payables

(2,272)

(2,456)

(2,374)

(1,997)

(2,082)

(2,122)

(1,991)

Accruals

(3,289)

(3,221)

(2,921)

(2,687)

(2,290)

(2,482)

(3,105)

Deferred income

(3,010)

(5,684)

(4,583)

(4,273)

(5,665)

(3,987)

(3,538)

Provisions

(254)

(254)

(254)

(210)

(210)

(210)

(210)

Total current liabilities

(8,824)

(11,616)

(10,132)

(9,167)

(10,247)

(8,802)

(8,845)

Total assets less current liabilities

20,844

20,982

20,955

21,103

21,216

21,293

21,422

Non-current provisions

(82)

(84)

(81)

(82)

(82)

(81)

(81)

Total assets employed

20,761

20,898

20,875

21,021

21,133

21,212

21,342

Public dividend capital

3,474

3,474

3,474

3,474

3,474

3,474

3,474

Revaluation reserve

12,263

12,263

12,263

12,263

12,263

12,263

12,263

I&E reserve

5,024

5,162

5,138

5,284

5,397

5,475

5,605

Total taxpayers equity

20,761

20,899

20,875

21,021

21,133

21,212

21,342

MONTHLY FINANCE AND PERFORMANCE REPORT

Period 6

30 September 2017

FUNDS FLOW

Section 4

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
	Act	Act	Act	Act	Act	Act	Act	Act	Act	Act	Act	Act	Act
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Net Surplus	138	(25)	146	113	78	131							581
Depreciation / amortisation	75	54	65	67	67	67							396
PDC dividend paid	45	45	45	45	49	61							289
(Increase) / Decrease in receivables	261	(326)	158	1,083	347	(1,233)							290
Increase / (Decrease) in liabilities	2,792	(1,484)	(965)	1,080	(1,445)	43							19
Increase / (Decrease) in provisions	2	(3)	2	0	(2)	0							(2)
Net operating cash flow	3,312	(1,739)	(550)	2,388	(906)	(930)	0	0	0	0	0	0	1,573
Interest received	0	1	1	0	1	1							3
Interest paid	0	0	0	0	0	0							0
PDC dividend paid	(45)	(45)	(45)	(45)	(49)	(61)							(289)
Cash flow available for investment	3,268	(44)	(44)	(44)	(49)	(61)	0	0	0	0	0	0	(286)
Purchase of intangible assets	3	(11)	5	(22)	5	5							(15)
Purchase of property, plant & equipment	(142)	(262)	(154)	(53)	(162)	(170)							(944)
Net cash flow before financing	3,128	(2,056)	(744)	2,268	(1,111)	(1,156)	0	0	0	0	0	0	329
Drawdown of debt facilities	0	0	0	0	0	0							0
Repayment of debt facilities	0	0	0	0	0	0							0
Net increase / (decrease) in cash	3,128	(2,056)	(744)	2,268	(1,111)	(1,156)	0	0	0	0	0	0	329
Opening Cash	2,152	5,279	3,224	2,480	4,747	3,635							2,152
Closing cash	5,279	3,224	2,480	4,747	3,635	2,479	0	0	0	0	0	0	2,480

Board of Directors: October 2017

Item : 11

Title : In Year Reforecast

Summary:

Attached is a summary of the latest in-year reforecast

For : Discussion / Noting

From : Udey Chowdhury, Assistant Director, Finance

IN -YEAR REFORECAST**October 2017**

	2017/18 Budget Year £'000	2017/18 Re-F'Cast Year £'000	Change F'Cast v Budget £'000
Income	50,243	50,743	500
Staff costs	(37,466)	(36,939)	527
Non-staff costs	(10,465)	(11,385)	(920)
Operational costs	(47,931)	(48,324)	(393)
EBITDA	2,312	2,419	107
- Margin	0	0	
Interest receivable			
Interest payable			
Depreciation / amortisation	(781)	(792)	(11)
Public Dividend Capital	(580)	(579)	1
Restructuring costs		(18)	(18)
Other			
Net surplus	951	1,030	79
- Margin	2%	2%	

COMMENTARY

October reforecast indicates Trust ahead of Budget due, principally, to higher income in CYAF reflecting substantial increase in Named Patient Agreements and work with Syrian families.

Staff costs are below Budget representing unfilled vacancies in the first half of the year. These vacancies are expected to be eliminated in the second half and, indeed, above Budget spend (in H2) is anticipated as some services seek to 'catch up' their H1 shortfall. As at end September staff numbers were 2% below Budget

There are overspends in non-staff costs in CYAF and Corporate (HR, IM&T, Research).

All Directorates are currently forecast to be positive against Budget with the exception of Education and Training which is suffering from underperformance in both Short Courses and Portfolio Programmes.

The Reforecast includes £60k for international consultancy work for Education & Training (included in Corporate non-staff costs); £60k for backfill relating to FDAC and Adult GICS; and £30k for legal advice relating to FDAC SIB

Risks

There continue to be a number of risks inherent in the Reforecast, notably:

- * Possible additional costs associated with estates works
- * Need for Education and Training to find in year savings to meet revised forecast
- * Pressures on staffing costs - notably in Finance and IT - in order to deal with staff changes (in the former) and increased level of demand in the latter

Board of Directors : 31 October 2017

Item : 12

Title : Organisational Development and People Strategy Report –
Quarter 2 – 2017/18

Purpose:

This paper summarise progress being made against the organisational development and people strategy delivery plan.

Incorporated within this paper are the HR directorate's workforce indicators such as staff in post, turnover, stability, sickness and vacancy rates. The report also summarises mandatory training compliance.

This report focuses on the following areas:

(delete where not applicable)

- Quality
- Workforce

For : Noting

From : Craig de Sousa, Director of Human Resources

Organisational Development and People Strategy Report Quarter 2 – 2017/18

1. Introduction

The Trust board approved, in April 2017, the organisational development and people strategy with a detailed delivery plan.

This paper summarise progress being made against the delivery and plan and incorporates HR directorate's workforce indicators such as staff in post, turnover, stability, sickness and vacancy rates. The report also summarises mandatory training compliance.

2. Highlights in the second quarter

Appraisal process

In previous years many staff have fed back to us that the appraisal process needed a complete review. Last year a new system was designed and implemented in Q4 last year and Q1 this year.

Through the quarterly staff friends and family test we took the opportunity to ask staff about their reflections on the new paperwork and whether this had facilitated better conversations.

It is pleasing to be able to the report that the broad consensus is that the new process has gone a long way to improving the quality of appraisal conversations. The feedback highlighted that the look back and look forward approach is helpful and staff feel that they have greater clarity about their roles and objectives.

There was, however, some less positive feedback. There was some feedback from staff that some managers are still treating the process as a tick box exercise and that it might be beneficial to commission further appraisal training. The HR business partners are aware of this and will be discussing with the service areas how best to deliver this.

The Tavistock and Portman Academy

A formal working group has been established in quarter two and a project brief has been agreed with a scope of work.

Through the initial meetings it has been agreed to give a focus on the nursing discipline and how best engage this staff group with obtaining opportunities to start the pathway to become educators and future faculty.

The Trust was also fortunate to obtain £25,000 from Health Education England to support this stream of work.

Tracking and Reporting on Training

Earlier this year we started the process of undertaking a large cleanse of workforce information system. The work was a preparatory stage before starting to use the system to record all training and development activity.

Unfortunately, the national system provider was commissioned to deliver a number of substantial upgrades to the system. As a result of these changes we made the decision to pause implementing the system until the upgrade has been fully completed in October 2017.

3. Work undertaken in Q2 that does not feature in the strategy

HR procedures

The senior HR team have been continuing to thoroughly review our procedures and, where possible, streamline them and make them much more user friendly.

One of the key procedural changes, which has been triggered from last year's NHS staff survey, has been a total review of the Trust's approach to bullying and harassment. A new procedure is in the final stages of being agreed, at the time of writing this paper, which removes the need for hearings and also allows an approach for staff to share concerns confidentially and have those dealt with.

Recruitment performance

At the beginning of the year the Trust migrated to a new electronic recruitment platform which 98% of NHS organisations across London have adopted. The new system has had a number of benefits making recruitment much more visible, trackable and reportable.

As with all new systems there have been some initial implementation problems which are being worked through and managers have made some suggestions for improvements which we are feeding back to the supplier.

The table below details what recruitment lapse time performance has been for the past two quarters measured from the date a vacancy is requested through to when an unconditional offer of employment is made. The London NHS average time to recruit is 8 weeks.

Quarter 1	Quarter 2
4 weeks	8 weeks

The variance between the two quarters has occurred because of two factors.

- i. a number of services in quarter two undertaking large scale recruitment campaigns and taking longer to shortlist higher quantities of applications; and
- ii. a seasonal issue where disclosure and barring service checks take longer because of schools undertaking recruitment activities and a peak in the number of criminal record checks which need to be undertaken.

The above performance is exceptionally good and demonstrates a marked improvement from the previous year when recruitment was taking anything between 12 and 18 weeks.

Self service implementation

The transactional HR team spent a lot of time and effort in 2015/16 reviewing and revising its processes to make them consistent with a regional programme of streamlining work which has happened over the past three years.

The next stage of this work is to give staff greater access to their information, their payslips and pension statements. In September IBM, who provide our integrated HR and payroll solution, mass created accounts very every staff member. In quarter three the HR team will commence the process of rolling out the system.

4. Progress against the organisational development and people strategy delivery plan

The following table presents the 2017/18 element of the organisational development and people strategy delivery plan and details that planned delivery dates and what progress is being made against each of the areas.

	On target / complete
	Progressing but behind target
	Significantly behind target
	Not started

		2017/18			
Specific priorities	Action required	Q1	Q2	Q3	Q4
Workforce planning	Improve and cleanse our existing workforce information	X	X		
	Invest in workforce planning skills			X	
	Develop an annual, directorate and trust level, workforce planning process which is led by managers supported by HR and finance				X
Career pathways	Informed by our workforce plans, look at our clinical, non-clinical and leadership roles and map our desired career pathways				
	Recruit for the future and develop competency frameworks that allow easier progression				
Succession planning	Map the current natural successors for director, heads of service and senior faculty posts				X
	Implement a succession plan review it annually				X
	Extend the succession planning process to lower tiers within the organisation				

		2017/18			
Specific priorities	Action required	Q1	Q2	Q3	Q4
	Implement a robust and objective talent management process that identifies current and emerging leaders in the organisation.				
Marketing our offering as an employer	Making best use of our website and social media, promote careers at the Trust	X	X		
	Ensure that we capture talent from our students	X	X	X	
Robust performance and appraisal system	Review the appraisal process		X		
	Map appraisal outcomes to the talent and succession plan				
Leadership and management development	Continue to deliver the internal leadership programme	X			X
	Commit to sponsoring staff to undertake national leadership programmes				
	Use the annual appraisal process to commission relevant and timely education and training programmes for our staff	X			
The Tavistock and Portman Academy	Scope the potential and create an academy model	X	X	X	X
	Embed and evaluate the fellowship programme	X	X	X	
	Support, track and monitor our future academic leaders				
Research and Development	Working with the medical director and clinical directors, establish a research and development job offering				X
	Encourage and promote research opportunities				
	Establish an academic faculty				

		2017/18			
Specific priorities	Action required	Q1	Q2	Q3	Q4
	Develop a recognition process for joint work				
Developing our commercial skills	Identify areas where the Trust has commercial potential	X	X		
	Scope the skills and capabilities needed to win new contracts and / or commercialise our services			X	
	Invest in commercial skills development				X
Establish a physical and mental health and wellbeing steering group	Constitute a group			X	
	Agree an annual plan				X
	Implement reporting mechanisms				
	Embed actions in the quarterly HR reporting with an evaluation of activity				
Promote healthy lifestyles	Work collaboratively with the Trust's occupational health service to promote health lifestyles				X
	Implement monthly healthy lifestyle campaigns using internal communications				
	Hold an annual health and wellbeing event				
Create cultural change	Develop a narrative about what is positive about the trust and where we need to focus for improvement.			X	X
	Commit and provide senior oversight to the diversity and inclusion agenda	X			
	Report regularly on action being taken and positive stories				X
	Embed diversity and inclusion as an integral part of all leadership development programmes	X	X		
	Develop a role specification		X		

		2017/18			
Specific priorities	Action required	Q1	Q2	Q3	Q4
Attract and select diversity champions	Seek applications			X	
	Create a specialised development programme				X
	Encourage the champions to develop workplace best practice and share through the diversity and inclusion committee				X
Track career progression of leadership development participants	Record all non-mandatory training data on ESR	X	X		
	Report annually on training uptake		X		
	Create a talent pool of leadership candidates to lead projects and be first to be offered secondments			X	X
Create opportunities for coaching and mentoring	Commission coaching and mentoring services for our staff			X	X
	Monitor and report on the number of staff receiving developmental support				X
	Track the career progress of those accessing support				

5. Workforce indicators

The following workforce indicators are obtained from ESR with each data item being accurate at the last day of each month.

Period: April 2017 - September 2017								
Report Title	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
Staff in Post								
Full Time Equivalent Staff in Post (FTE)	570.27	575.52	578.69	574.83	578.69	580.19	579.02	579.30
Headcount	677	681	683	680.33	681	685	687	684.33
Vacancy Rate	14.76%	13.31%	12.83%	13.63%	12.98%	12.75%	12.93%	12.89%
Turnover	21.07%	21.16%	20.93%	21.05%	19.98%	19.14%	19.29%	19.47%
Stability Index	79.97%	80.17%	80.17%	80.10%	80.00%	78.15%	78.06%	78.74%
Health, wellbeing and morale								
Sickness Absence Spot Month	0.79%	0.72%	1.57%	1.03%	1.53%	1.28%	0.20%	1.00%
Sickness Absence 12 month rolling average	1.56%	1.46%	1.47%	1.50%	1.43%	1.39%	1.27%	1.36%
Training and compliance								
DBS Compliance	98%	98%	98%	98%	99%	99%	99%	99%
Appraisal Compliance	0%	24%	42%	22%	83%	89%	89%	87%
Establishment FTE (From Finance)	669	663.87	663.87		665	665	665	

6. Mandatory Training Compliance

Description	Quarter 1 2017/18	Quarter 2 2017/18
Mandatory Training Compliance – INSET Attendance	100%	100%
Local Induction Checklists Completed	–	90%

Description	Quarter 1 2017/18	Quarter 2 2017/18
Basic Life Support	99%	99%
Conflict Resolution Training	100%	100%
Ladder Safety	100%	100%
Manual Handling	100%	100%
Recruitment and Selection Training	34%	35%
Safeguarding Children – Level 2	94%	81%
Safeguarding Children – Level 3	94%	81%
Clinical Risk Training	16%	16%
Information Governance	100%	78%

7. Conclusions and recommendations

Members of the relevant committees are asked to note the contents of this report.

Craig de Sousa
Director of Human Resources
 October 2017

Board of Directors: October 2017

Item : 13a

Title : Q2 Dashboards and Quarterly Quality Commentary

Purpose:

Key points to note are:

- The Board level dashboard was, from Q1 2017/18 being managed by the Quality Team with information in the Quality Commentary providing specific service level responses.
- We continue to perform well in almost all areas.
- There is an increase in patients seen compared to the previous year. This is for the most part due to our taking on the adult Gender Identity Clinic from April 2017. If the trajectory continues this would be over double the numbers seen in 2016/17.
- Gender Identity Clinic waiting time data has been presented separately owing to the length of the waiting list. Further detail is available in the *Waiting Time Analysis By Team Board Report*
- HR - Sickness data has increased slightly by 0.4% on the previous quarter however, this is not robust data. The new electronic staff system now includes sickness information and is slowly being rolled out across the Trust.
- Quality – Safety: Child safeguarding alerts remain elevated, which reflects the introduction of the new system for reporting.
- There were two serious incidents reported externally in Q2. One was a confidential information leak reported to the ICO and the second a suspected suicide.
- Effectiveness: the Trust-wide DNA rate has risen to 11%. This is above the 10% target. Actions taken by services to address issues are included in the Quarter 2 Quality Report Commentary.
- DET CPD metrics have been updated.
- Single Oversight Framework: Three data quality indicators continue to have a red rating. An action plan is in place to address these.

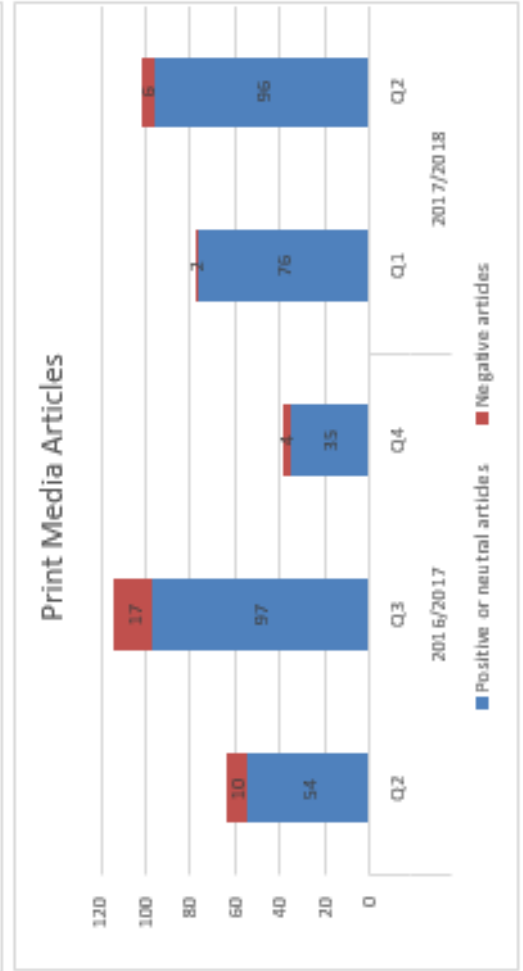
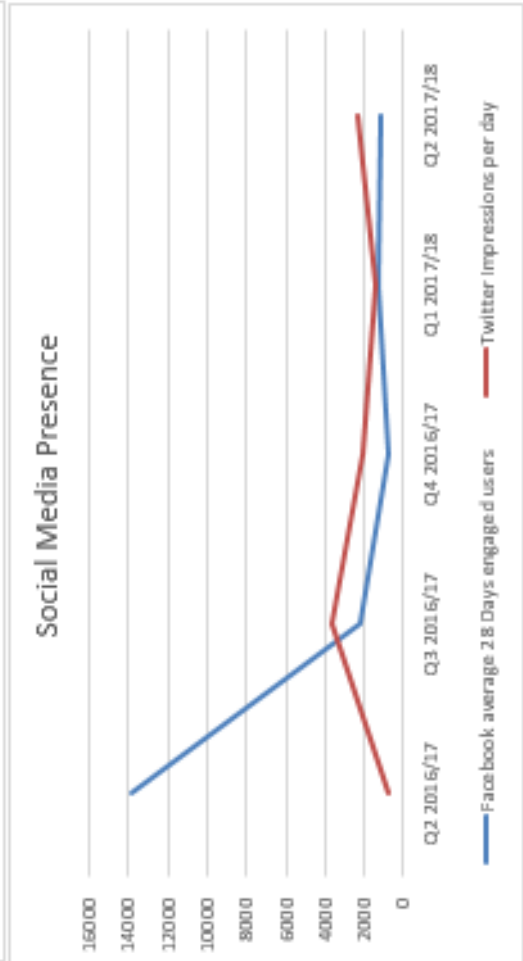
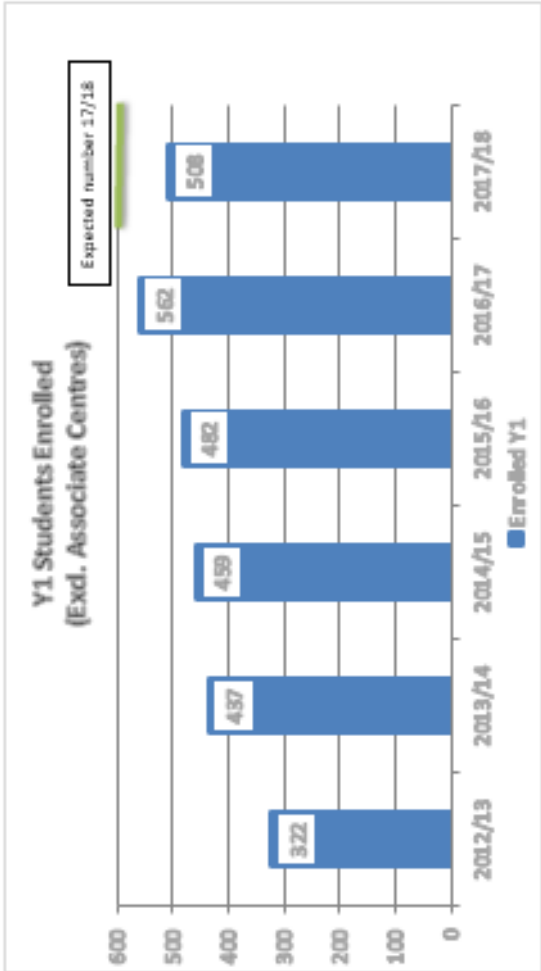
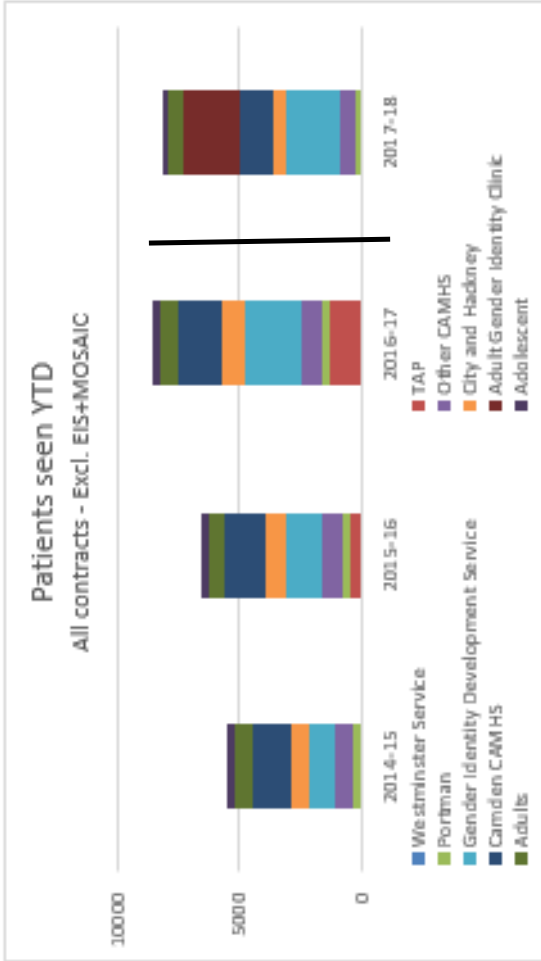
The Dashboards were reviewed at the CQPE Working Group on 19th October 2017.

For : Discussion

From : Marion Shipman, Associate Director Quality and Governance;

Sukijit Sindhu, Assistant Psychologist and Data Officer, Kerri Johnson-Walker, Data Quality Manager

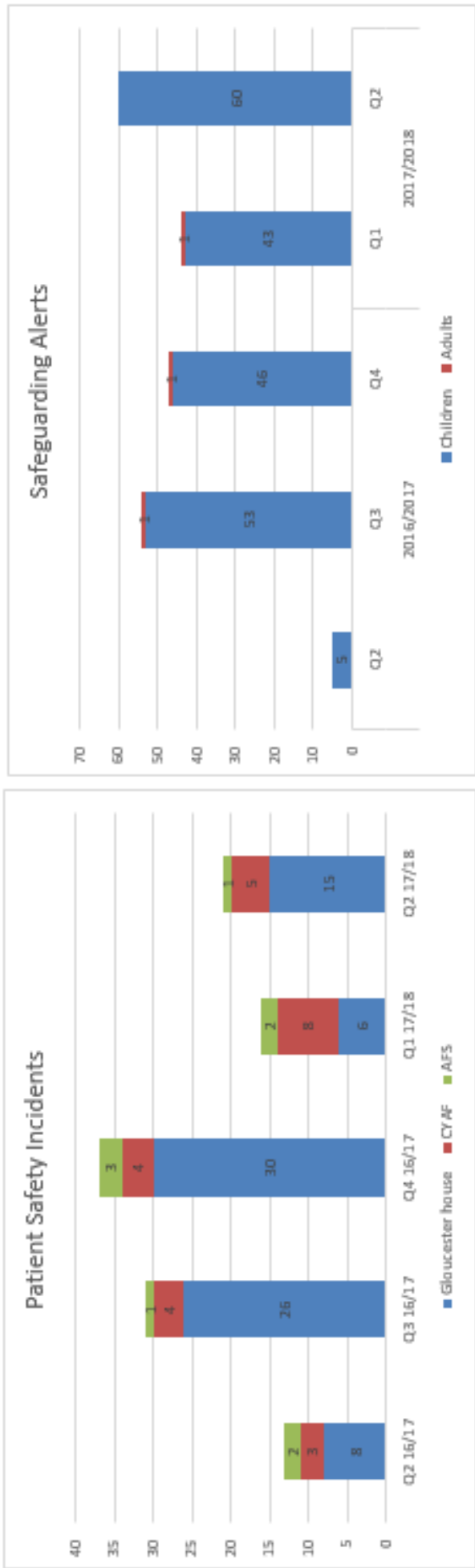
Q2 17/18 – Quality – Trust Reach



Q2 17/18 - Quality – Well-Led

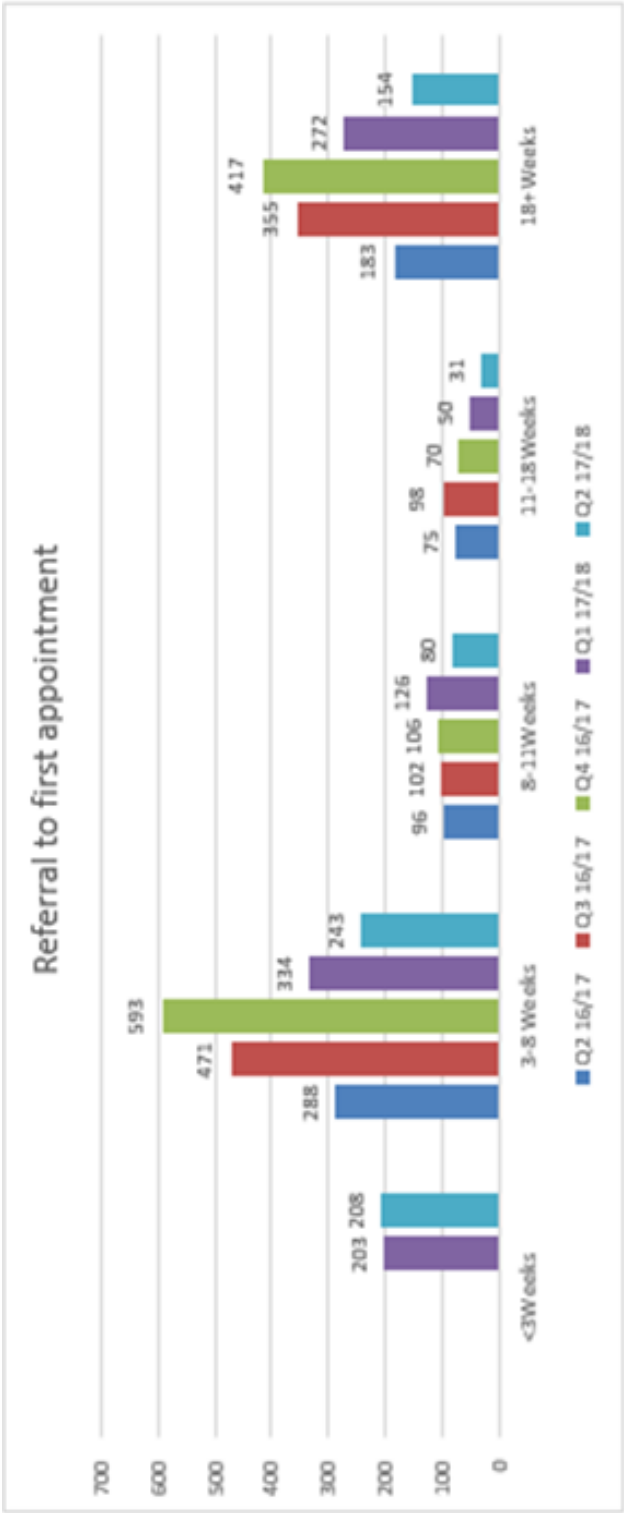
MORALE		TRAINING		MANAGEMENT
Staff sickness		Staff appraised		Support from immediate managers
1.4%	4.0%	100%	87%	Trust 2014/15 Score
Trust	Benchmark (1.6/1.7) - all NHS Trusts	2016/17	Q1	Trust 2015/16 Score
Source: TP NHSFT HR		Source: TP NHSFT HR		Trust 2016/17 Score
				3.85
				MH Trust 2016/17 Average
				Source: NHS Staff Survey
Staff motivation at work		Staff opinion on quality of appraisals		
Trust 2014/15 Score	3.91	Trust 2015/16 Score	3.05	% staff reporting good comms between senior mgmt and staff
Trust 2015/16 Score	3.99	Trust 2016/17 Score	3.05	
Trust 2016/17 Score	3.87	MH Trust 2016/17 Average	3.15	Trust 2014/15 Score
MH Trust 2016/17 Average	3.91	Source: NHS Staff Survey		Trust 2015/16 Score
Source: NHS Staff Survey				Trust 2016/17 Score
Staff recommend Trust as place to work		Mandatory training: % staff		MH Trust 2016/17 Average
76%	69%	96%	92%	Source: NHS Staff Survey
Q1	Q2	Q1	Q2	Recognition and value of staff by managers and the organisation
National Average 16/17	61%			Trust 2015/16 Score
Source: TP NHSFT HR		Source: TP NHSFT HR		Trust 2016/17 Score
Disclosure and Barring Service Compliance		Staff opinion of training		MH Trust 2016/17 Average
% of staff with a compliant DBS Check	99%	Trust 2015/16 Score	3.97	Source: NHS Staff Survey
Source: TP NHSFT HR		Trust 2016/17 Score	4.01	
		MH Trust 2016/17 Average	4.06	
		Source: NHS Staff Survey		

Q2 17/18 – Quality – Safety

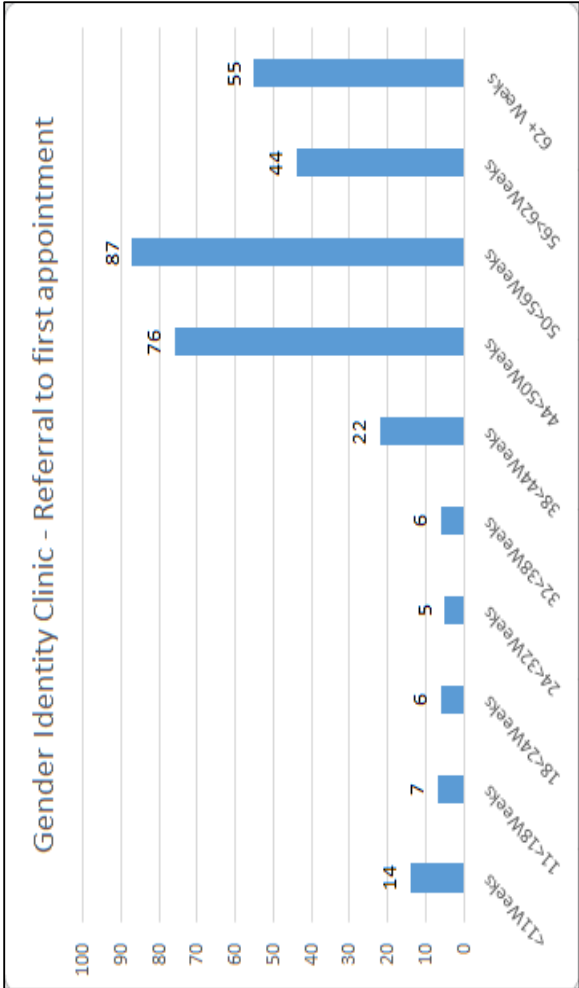


Serious Incident Investigations: reported to STEIS and the Information Commissioner Office (Q2 – 16/17)	
FDAC – possible suicide	
Whole Family - Confidential information leak	

Q2 17/18 – Quality- Responsive

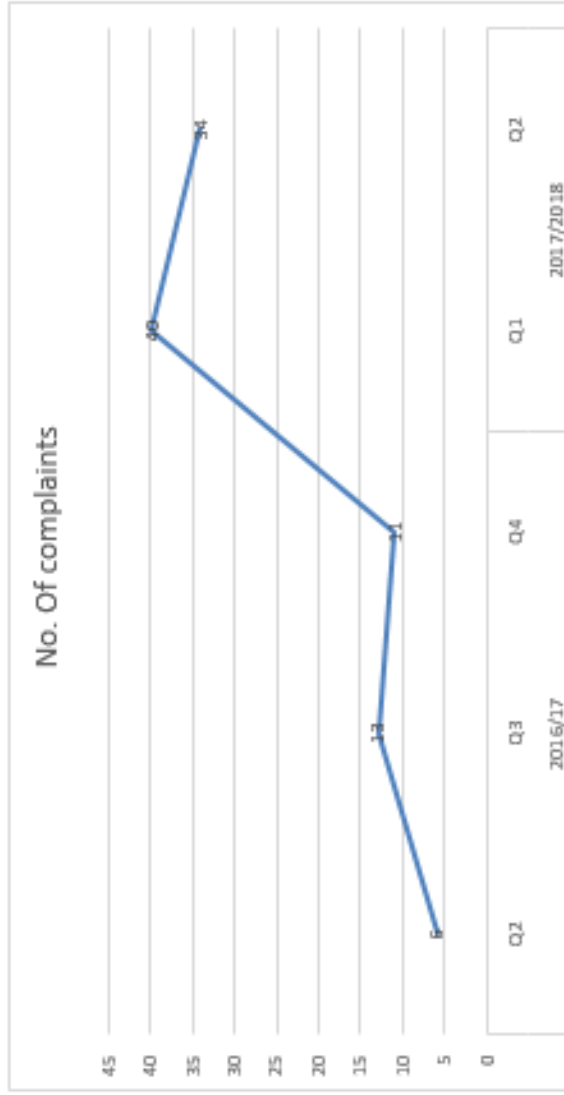


Q2 16/17	642	first attendances
Q3 16/17	1026	first attendances
Q4 16/17	1183	first attendances
Q1 17/18	985	first attendances
Q2 17/18	716	first attendances



Q2 17/18 – Quality- Responsive

		2016-17				2017/18	
		Q1	Q2	Q3	Q4	Q1	Q2
ESQ	Views and worries were taken seriously (Q4)	93%	93%	94%	94%	100%	98%
	Involved in important decisions about my care (Q13)	86%	87%	86%	86%	97%	97%



Please note the increase in complaints after Q1 2017/18 relates almost entirely to the GIC service which joined the Tavistock and Portman in April 2017.

Q2 17/18 – Quality – Effective

		2016-17				2017-18		Target Value
		Q4	Q1	Q2	Q3	Q4	Q1	
KPI	DNA Rate	7%	9%	10%	9%	10%	10%	10.00%
Patient Experience	I received helpful info prior to 1 st visit (Q6)	78%	81%	81%	80%	80%	94%	75%
	Help I received at Trust is good (Q15)	93%	94%	93%	93%	93%	99%	92%
Patient Satisfaction	Recommend Trust to others (Q11)	89%	91%	91%	91%	91%	98%	80%

*The reporting definition for outcomes in earlier dashboards requires clarification to provide accurate data. The definition will be clarified and Outcome collection and improvement rates reported from Q3.

Q2 17/18 – Directorate of Education and Training

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"		
Benchmark	Tavistock		Benchmark	Tavistock		Benchmark	Tavistock	
2013/14	88.3%	92.8%	2013/14	72.4%	82.3%	2013/14	80.3%	87.1%
2014/15	87.0%	93.0%	2014/15	77.9%	86.2%	2014/15	77.0%	81.3%
2015/16	83.0%	94.0%	2015/16	81.0%	91.0%	2015/16	78.0%	87.0%
2016/17	85.0%	81.0%	2016/17	78.0%	86.0%	2016/17	76.0%	87.0%
*excludes associate centres			*excludes associate centres			*excludes associate centres		

Benchmark UK data: www.hefce.ac.uk/lt/nss/results (Summary UK) [2017];
<https://www.heacademy.ac.uk/institutions/surveys/postgraduate-taught-experience-survey> (2016)

*Please note this data is provided in September annually, and is based on the academic year. Information will be updated in the Q3 dashboard.

Dashboard Prepared by Sukijit Sindhu, Assistant Psychologist and Data Officer

Q2 17/18 – Directorate of Education and Training

Year	17/18 AY Plan to date*	Comments*	16/17 AY Actual	15-16 AY Actual	14-15 AY Actual	13-14 AY Actual
Course numbers	CPD/E-learning		94	70	58	45
	Bespoke work		38	10	18	14
	Conferences		4	16	18	18
	Perinatal		2	n/a	n/a	n/a
	Visitors Programme					
Students	2031	17-18 plan set at minimum numbers	2279	2063	2738	2079
Income	Income	17-18 forecast £910k	£692,710	493,090	556,261	501,917
	Income growth on previous year	17-18 forecast 32% increase on 16-17	40%	-11%	16%	35%
	Contribution	17-18 contribution based on income-direct costs (16-17 included indirect costs therefore reduced contribution)	£197,122	123,616	158,104	160,769
	Staff number	3.8	3.5	2	3	3

Q2 17/18 – 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 1 (%)	Current / Future Target
Valid NHS number	95%	96.2 %	Current
Valid Postcode	95%	99.8%	Current
Valid Date of Birth	95%	100%	Current
Valid Organisation code of Commissioner	95%	99.5%	Current
Valid Organisation code GP Practice	95%	99.1%	Current
Valid Gender	95%	99.8%	Current
Ethnicity	85%	83%	Current
Employment Status (for adults)	85%	26.3%	Current
Accommodation status (for adults)	85%	26.1%	Current
ICD10 coding	85%	N/A	N/A

•The trust is working towards a 99% target

Quarterly Quality Report Q2 2017/18

1. Introduction

- 1.1 This report refers directly to the Quarterly Quality Report submitted to commissioners which includes KPIs, CQUINs, quality priorities and other performance related indicators. This report does not directly refer to all of the data collected in the above dashboard.
- 1.2 As requested by the Board of Directors the following paper provides a summary and narrative for quarter 2 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 Trust wide, with the exception of CQUINs that apply to London Contracting only.
- 1.3 The following metrics are summarised below:
 - 1.3.1 Waiting times
 - 1.3.2 Did not attend (DNAs)
 - 1.3.3 MHSDS data
 - 1.3.4 Quality Priorities
 - 1.3.5 CQUINs
 - 1.3.6 Trajectory

2. Summary

- 2.1 Data is validated by services and is as accurate as possible. Standard operating procedures (SOPs) /Validation and reliability of the data have improved due to new checklists being implemented and new processes within the Quality Team. 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 times have been reported differently in the financial year 2017-18 to be brought in line with how it is reported internally to board. RTT (Referral to Treatment) times are now also recorded, treatment being defined as the second attended appointment.
Adult teams: Overall Adult Complex Needs Service has improved their waiting times. Their breaches were well under the 10% Trust target in Q1 but have risen slightly in Q2; however they are still within the 11 week waiting time target. City and Hackney continue to reduce their breaches a significant amount whilst also keeping their RTT (Referral to Treatment) waiting times low. Portman have seen more people in Q2 17/18 than they did in quarter 1, where there appeared to be a dip in patient numbers, only 1 patient has breached the target waiting times of 11 weeks.
CYAF Teams: Camden CAMHS has performed consistently well throughout 2016/17 which has continued to Q2 2017/18, with a high volume of patients. In quarter 1 Adolescent had seen an improvement in the amount of breaches however this has now deteriorated and has shown similar results to that of Q4 16/17. Other CAMHS continues to exceed the 10% breach target of 8 weeks consistently. GIDS still displays a high number of breaches above the 18 week, even though they have seen 124 patients less than last quarter, their waiting list has grown by 388

patients since Q4 16/17. This is the second quarter the trust has reported on GIC waiting times with a very low number of patients seen with in the target waiting time of 18 weeks.

2.3 DNA rates are an average figure and expected to be no larger than 10%. The definition used for DNA figures is **Numerator:** Total DNA / **Denominator:** Total Appointments (Total Attended + Total DNA appointments). All services in the Tavistock and Portman breached the 10% DNA trust target, GIC and Camden TAP reported the highest levels of DNAs.

2.4 The trust has now decided to report on MHSDS (Mental Health Service Data Set) on a quarterly basis to see where demographics of patients are not collected. MHSDS is submitted twice for each month, the analysis presented is for May, June and July. The reason for this is that it is the refreshed data that is sent nationally. For many of the categories, including gender, date of birth, referral information, GP information, contact information, marital status, ethnicity and current postcode targets were met. However areas of concern were completion of accommodation status (40%) and employment status (40%), even though these are up from 25% last quarter.

*Please make a note that for the MHSDS a 'not requested' option is marked as complete.

2.5

2.5.1 Quality Priority 1: Improve the Physical Health of Patients Receiving Treatment.

- The programme has been further developed this quarter by utilising the feedback from the online survey to influence the design of the Living Well Programme 2017. Four, one -hour sessions have been planned for those aged 19+ based on Stress, Alcohol, Drugs and Tobacco, Diet, Exercise and Sleep, and Mindfulness. The same four topics have also been designed into a 3 hour session for those aged 13-19 years old, which will be held during the half term week.
- The development of a health and well -being champion role was explored with a view to bringing together improving physical health for both staff and patients, as well as improving and maintaining the mental health aspect for staff only. However, this was not taken forward as physical and mental health and well-being for staff is being actively led by HR. Significant work has continued to engage all staff across the Trust in improving the physical health for patients.
- Efforts have been made to develop knowledge of the interaction between an individual's physical and mental health, including the benefits of referring and attending the Living Well Programme across all staff within the Trust. An online training programme was developed to enable staff to support the Living Well Programme which included advice on initiating conversations around smoking and alcohol, and providing very brief advice.
- There has been a clear emphasis placed within the training programme for clinicians to provide patients with information regarding the interaction between their physical and mental health. As well as referrals from clinicians, patients are able to self-refer into the Living Well Programme. Information is also being designed to place on the Trust's Website regarding physical health. Evidence-based workbooks have been specifically designed to complement the learning conducted within the Living Well Programme for patients. Patients who require more support to make a behaviour

change within the Living Well Programme will be able to access further individualised support if required.

2.5.2 Quality Priority 2: Improve the Identification and Management of High Risk Patients :

- There were a number of Government/Public Health England publications during Q3/Q4 2016/17 and Q2 2017/18 which have relevance across the Trust in the context of improving clinician knowledge of self harm and suicide. The patient safety lead has cascaded these publications internally and incorporated key information into a revised risk assessment skills training. Presentation on risk assessment and risk management is included in the Trust INSET days and in the induction event for clinical trainees.
- Relevant policies and procedures for sign off by Executive Management Team. A Learning from Deaths Policy is also in draft form.
- Re-audit has been completed. This will be discussed at Patient Safety and Clinical Risk Work stream Meeting in October 2017 and an action plan agreed. However the next re-audit will take a different format and will be carried out in clinical teams and findings collated.
- During Q2, 2 ligature point audits were undertaken and a quotation for the work required in one of the services (Gloucester House) has been requested.

2.5.3 Quality Priority 3: Embed meaningful use of outcome monitoring in services.

- Within AFS, some members of the focus group have now withdrawn. The issue of recruitment is currently being addressed between clinical governance and PPI teams. The Quality Improvement initiative will also feed into this process. This will allow us to seek feedback on patients experiences on completing OM.
- A further analysis has been carried out to understand why there are delays in entering data from form completion to it being entered on to CareNotes. This identified some cases of outliers in terms of delays in forms being entered. This is being analysed further to understand and address these delays.
- The dashboard scoping exercise is being progressed by the IM&T department to improve access to patient and team level data.
- 37% of patients who qualify had a paired Time1 and Time 2, of these 7 only 4 patients improved (57%) – A review of how GBMs are generated and completed is taking place as part of the reducing the burden.
- 67% of patients who had a Time1 and Time 2 CORE showed improvement.

2.5.4 Quality Priority 4: Improve the use of equalities information to ensure clinical services are responsive to the needs of patients, carers and families.

- Establish reference group(s) from staff, patients, and other stakeholders to develop and oversee the priority work plan gaps will be addressed from findings in Q3.
- There has been delay on the implementation on the new equalities forms; it has been brought to the attention of the trust that there may be a legal issue identified with asking natal gender. – However the assessment/intake forms now include the 9 protected characteristic as well as MHSDS reporting requirements. Work will continue through quarter 3 to ensure the CareNotes system also reflects this information.

2.6 The Living Well CQUIN includes completion of the physical health form this has been amended from the past financial year to include all patients from 13 years rather than from 14 years.

There have been Quarterly targets set for each quarter throughout this financial year for Q2 the target was 60% which has been met (62.3%). The Physical Health Practitioner received 4 referrals. This will satisfy the CQUIN for Q2

- 2.7 The Safe and Timely Discharge CQUIN requires an audit to be conducted quarterly. The Portman have made significant progress in this CQUIN, in Q4 16/17 they had only met the second part of this CQUIN (completing mandatory fields in GP discharge letters) by 17%, however have exceeded the target of 80% in quarter 2, and met the first part of the target (for discharge letters to be sent within 2 week of discharge) with 100%.
- 2.8 The Transitions out of Children and Young People's Mental Health Services CQUIN
An engagement plan and update on the tasks that have been completed in Q2 and what was intended to be carried out in Q3 has been completed. Islington commissioners are happy with the progress that has been made.
- 2.9 GIDS Telemedicine CQUIN It is important to note that the timescales of the CQUIN are set in advance and do not necessarily in practice correlate with the pace of the project. There is an item in Q3 for example (patient feedback on the model of intervention) that has already taken place. This provides evidence that we have given due regard to the service users in the design of the telemedicine model, which was felt to be a more important first step than training which is very straightforward – see "Client survey feedback".
Staff engagement is a very important aspect of the project and following the feedback forum on 15th August the Project Manager will be visiting all regional teams on 10th October to further the staff engagement process. As mentioned, this forms part of training and the Project Board do not envisage any delays to the overall CQUIN delivery, which is to start running sessions in Q3 and continuing and evaluating this into Q4. – The IT systems need to be in place early Q3 for ensure this CQUIN is on track, patients need to be seen by the end of Q3 and although this will satisfy Q2, with slow progress in Q3 it will be unlikely we will satisfy Q3.
- 2.10 GIDS Transfer arrangements across the Gender Identity Pathway CQUIN I often grouped with the GIC Transfer arrangements across the Gender Identity Pathway CQUIN. Medical students who will join the GIC in October are being tasked with devising a user feedback survey. Once agreed, the GIC will identify those patients who have transferred from the GIDS and been seen for at least one appointment and roll out the survey to them. This will satisfy the CQUIN for Q2
- 2.11 GIC 7 point implementation plan CQUIN An integrated Oversight Group for Gender Services has been established. Chaired by the Director of Children, Young Adults and Families (CYAF), participants include NHS England commissioners, Gender Identity Development Service (GIDS) Director, and GIC Clinical Lead and other senior staff. Meetings have been held regularly: on 26 April, 21 June, 5 September and the next is scheduled for 29 November.

The Charing Cross Gender Identity Clinic (GIC) is part of the Children, Young Adults and Families Directorate. As its clinical governance matters most closely reflect that of the gender service for

children, a bespoke gender-focused clinical governance group has been initiated. In July a meeting was held to establish terms of reference, and the first meeting took place on 22 September. Representatives are from both the GIC and GIDS and include administrative and clinical staff. The GIC has nominated a Gender Identity Specialist, to be the clinical governance lead for the service. The Gender Clinical Governance Group will report upwards into the Clinical Quality, Safety and Governance Committee (CQSGC), a Board sub-committee.

The GIC continues to hold monthly Clinical Improvement Group meetings, to which all clinicians are invited. It has a rotating chair, and the agenda includes items such as CQUINs, the CQC action plan and learning from complaints.

Staff are encouraged to report incidents, with an emailed reminder of the importance of doing so and the reporting process sent on 12 September. Frances Endres, the General Manager of Gender Services hosted a refresher session of how to fill in the Incident Report to all the administrators on the 20 September.

A bespoke GIC staff engagement survey was sent to staff in early September. We now have the results and they were extremely positive. There were 13 responses and the responses were excellent from an engagement aspect.

There were overwhelmingly positive responses to the following questions:

Q4 Are you proud to be a member of your team? (100% said yes)

Q5 Does your team inspire you to do your best work? (92% said yes)

Q6 Does your team help you to complete your work? (100% said yes)

Q9 In the last 12 months have you had a conversation with your manager about fulfilling your potential at work?(92% said yes)

The clinic was closed for the first two working days in April to allow for a comprehensive induction and for all mandatory training sessions to be completed at the same time by GIC staff. There were also well-attended (and well received) welcoming tea and cakes where GIC staff were joined by colleagues from across the Trust.

Anecdotally, we have felt some shift in the culture of the clinic. The Director of Children, Young Adults and Families Service led two 'listening' events earlier in the year, encouraging clinical and administrative staff alike to share their anxieties, concerns and difficulties. It was notable that the tone of the second of these was significantly more positive than the first, but it is possible that staff did not want to share any difficult feedback openly.

The whole clinic was invited to attend an away afternoon on 20 July 2017. The agenda included team-building, presenting the new administrative structure and considering ideas for improvement. The afternoon was very well received – 11 staff members completed the survey, with eight scoring it a 5/5 'excellent', two scoring it a 4/5 and one scoring it a 3/5. Feedback included "Allowed space to speak and share. All presentations directly relevant and pitched appropriately" and "Love the 'can-do' ethos".

Clinical staff have been encouraged to attend the two-day BAGIS CPD conference in October in order to further develop their skills and knowledge in the gender identity specialism.

The Trust's Health and Safety team have supported the GIC in responding to feedback that they would welcome a staff yoga session (but didn't have space in the clinic) by funding a nearby space for a Wednesday lunchtime session, which commenced 13 September.

3. Data commentary

3.1 Waiting Times

Service	Q1 Performance	Q2 Performance	Trajectory (+/-)
Adult Complex Needs	91%	90%	Decreasing
City and Hackney PCPCS	98%	98%	Stayed the same
Portman	95%	96%	Improved
Camden CAMHS	93%	94%	Improved
Other CAMHS (Excluding first step)	75%	75%	Stayed the Same
Adolescent	84%	74%	Decreasing
GIDS	26%	25%	Decreasing
GIC	3%	6%	Improvement
Westminster	67%	70%	Improvement

3.2 DNAs

Service	Q1 Performance	Q2 Performance	Trajectory (+/-)
Adult Complex Needs and Portman	7.7%	10.5%	Decreasing
City and Hackney PCPCS	12.5%	12%	Improved
Camden CAMHS, Other CAMHS and Adolescent	10.2%	10.7%	Decreasing
GIDS	26%	25%	Decreasing
GIC	3%	6%	Improvement
Westminster	5%	13%	Decreasing

Board of Directors: October 2017

Item : 10b

Title : Waiting Time Quarterly Report

Purpose:

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

This report has been reviewed by the following Committees:

- Clinical Quality and Patient Experience Group Meeting

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

Waiting Times Analysis by Service

1. Introduction

- 1.1 As requested by the 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 1st July 2016 to 30th September 2017.
- 1.2 The following services and the relevant referral to first appointment 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, 11 weeks for over 18s
 - 1.2.6 Adolescent = 8 weeks, 11 weeks for over 18s
 - 1.2.7 GIDS = 18 weeks
 - 1.2.8 GIC = 18 weeks
 - 1.2.9 Westminster = 6 weeks
- 1.3 This report shows the time to first attended appointment from referral received and subsequently, as asked by the commissioners, referral to second attended appointment (defined by the Commissioning group as a 'treatment' appointment). Please note although the targets above apply to referral to first appointment there are no targets for Referral to Treatment (2nd appointment).
- 1.4 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 have been excluded from the analysis.

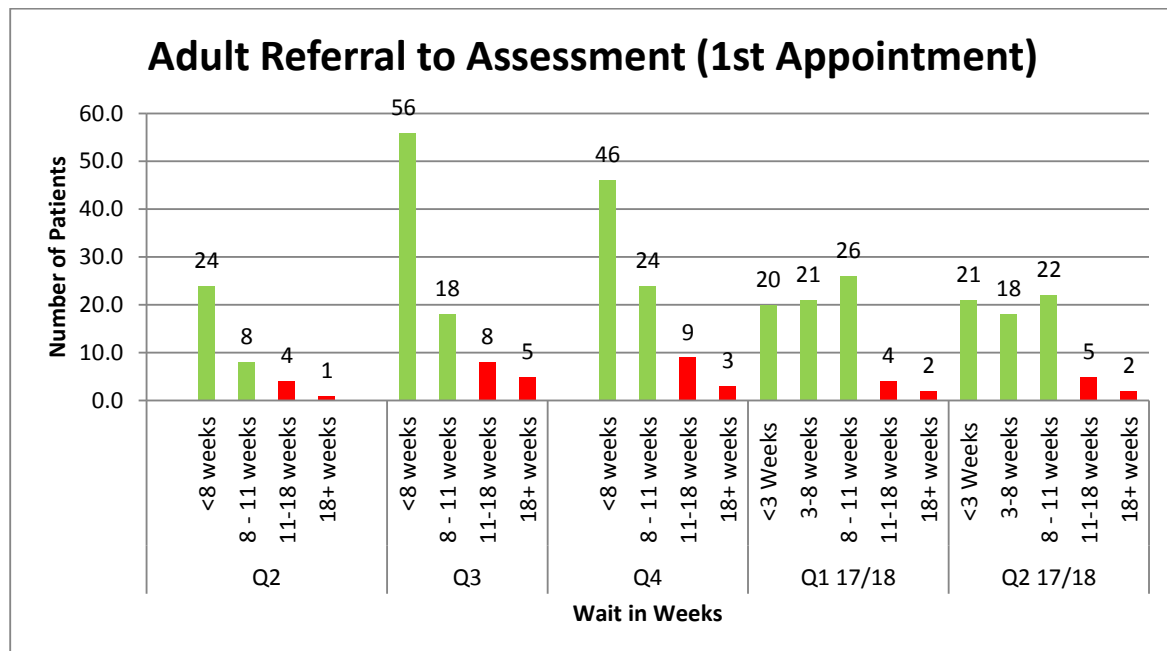
Summary

- 1.6 Appendix 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.
- 1.7 Appendix 2 shows the number of patients that have been seen for a second time (treatment appointment) in the quarter and how long they waited at a team level. There are no specific targets this is a monitoring exercise.
- 1.8 Adult teams: Adult Complex Needs Service has seen 90% of their patients within their 11 week waiting time target, which had been exceeded in Q4 2016/17. City and Hackney have reduced their breaches a significant amount whilst also keeping their RTT (Referral to Treatment) waiting times low. Portman have seen more people in Q2 2017/18 however only 1 person has breached the target waiting times of 11 weeks.
- 1.9 Other CAMHS, and Westminster FAS Family Assessment Team all report higher breach percentages than the trust target of 10%.
- 1.10 GIDS (Gender Identity Service, under 18) and GIC (Gender Identity Clinics, over 18s) have been presented with a wider range of wait time (In weeks) the reason for this is to show improvements when they are made, it is predicted both services will take some time to meet their target waiting time of 18 weeks.
- 1.11 Camden CAMHS has performed consistently well throughout 2016/17 which has continued in to Q1 of 2017/18, with such a high volume of patients.
- 1.12 A visual presentation of RTT (Referral to Treatment) waiting times has also been included in this year report, as this is something the commissioners now request from us. Please note that GIC has been excluded from this analysis because of the nature of their service only providing assessment for ongoing treatment. With this taken in to consideration only GIDS have a

large proportion of patients waiting over 18 weeks for their second appointment (defined as treatment)

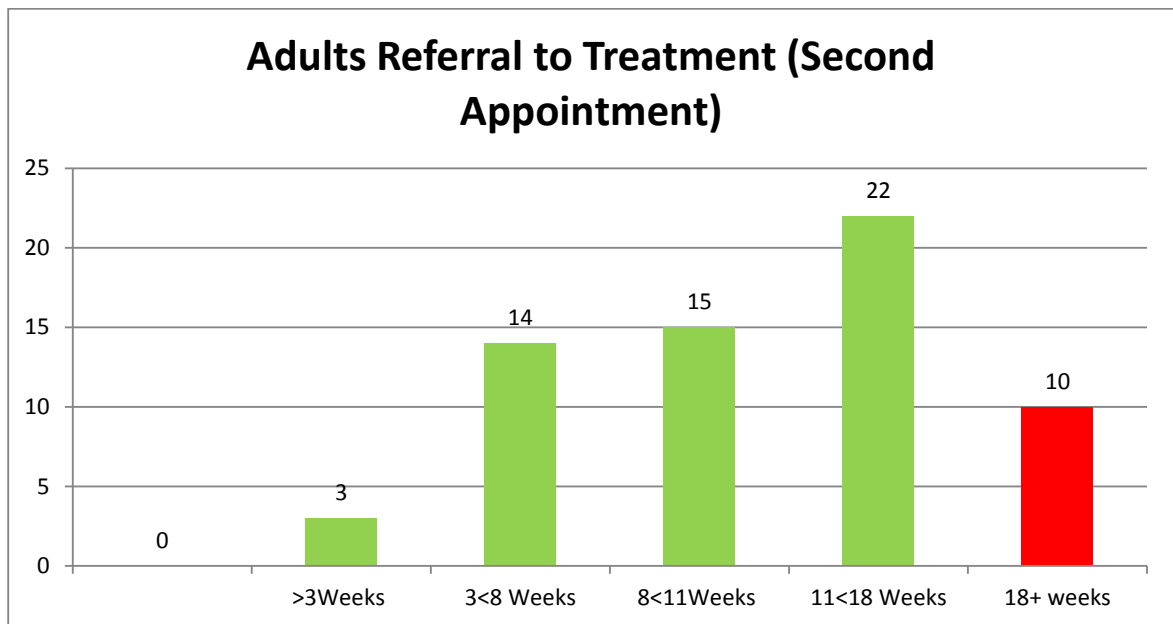
2. Detailed analysis and commentary

2.1 Adult Complex Needs (All Teams included in analysis)



Number of new patients seen in Quarter 2 is 68. 10 % of patients breached the 11 week waiting times target, which is a slight increase on the previous quarter.

Total open referrals waiting at the end of quarter: 87



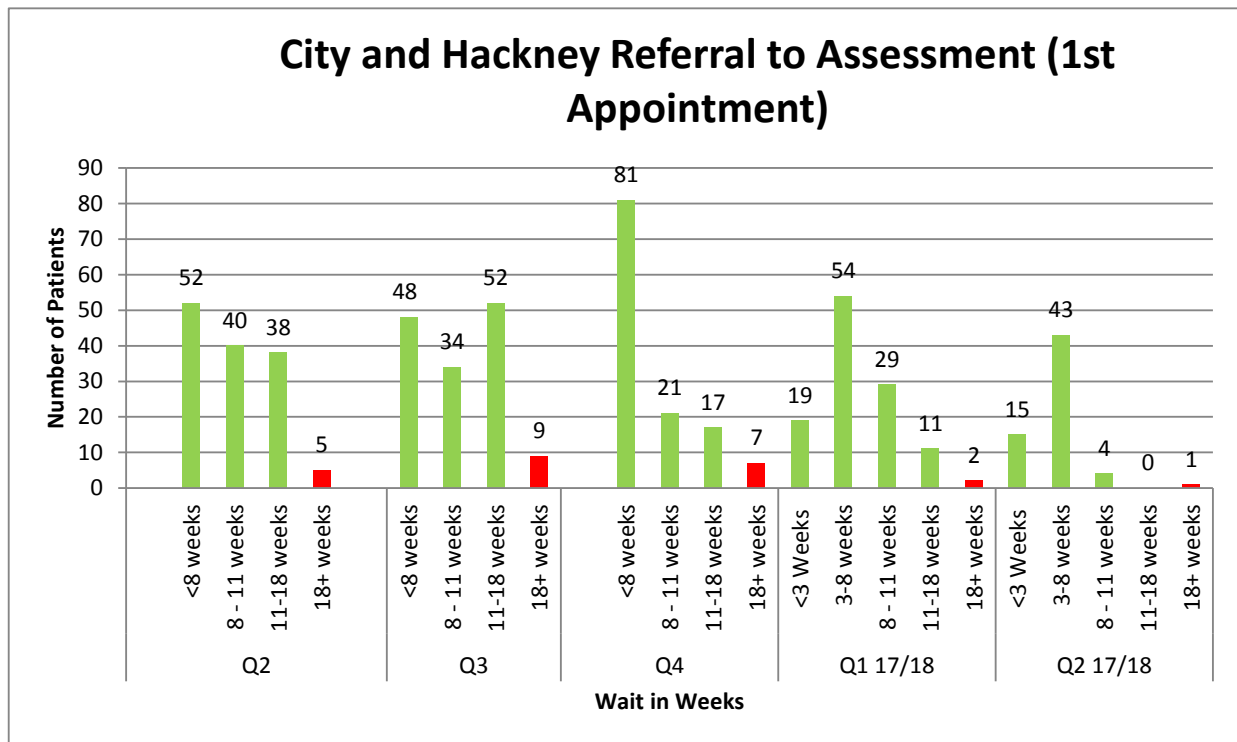
84% of patient in the Adult Complex Needs service were seen in treatment (second appointment) with in the national waiting time target of 18 weeks.

The performance against waiting time targets has shown a slight deterioration (10%, a slight increase on the last quarter). This is likely to have occurred partly due to the staff taking annual leave over the August period.

The same numbers of patients were seen as for Q1. This has been made possible by the arrival of new medical trainees and appointment of new junior staff replacing staff at the end of their training in Q1. In addition a number of honorary staff was appointed in Q1, which increased capacity in the Trauma/Fitzjohns/Couples Units. The waiting time for long term treatments however is increasing. This has especially affected the Fitzjohns and Trauma units. We are in the process of considering possible options in order to attempt to reduce waiting times for those two units.

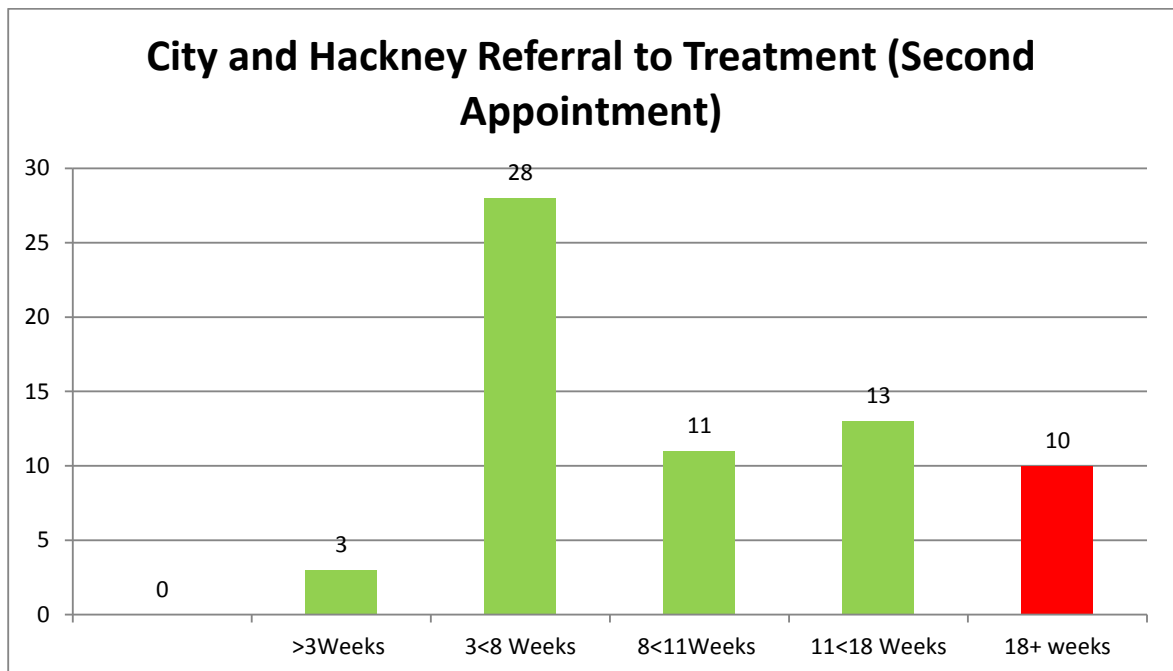
Andrew Williams, Head of AFS

2.2 City and Hackney Service (PCPCS)



The waiting time target for City and Hackney is 18 weeks with 97.9% meeting this target in Q2. In the Quarter 2 City and Hackney saw 48 patients from the waiting list.

Total open referrals waiting at the end of quarter: 58



85% of patient in the City and Hackney PCPCS were seen for treatment (second appointment) with in the national waiting time target of 18 weeks.

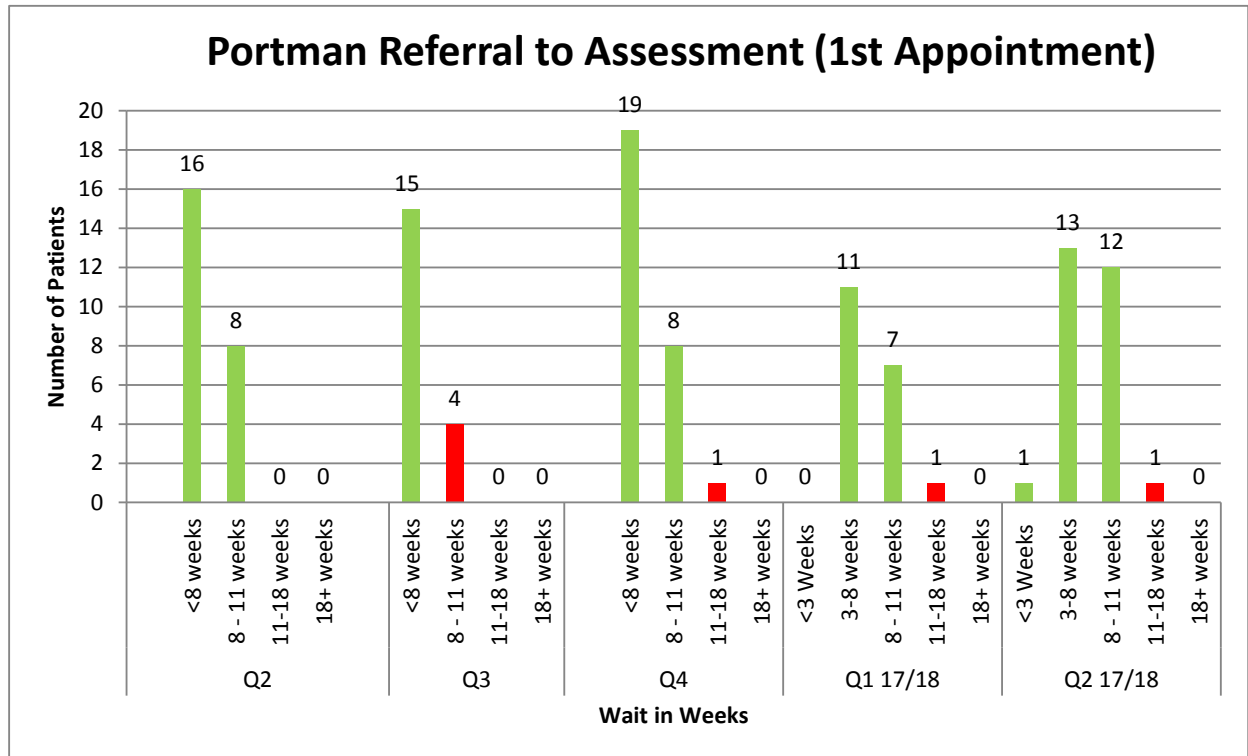
We are generally pleased with the broader picture but aware that commissioners will notice apparent reduced capacity and wonder why. The changes in part relate to our agreement with the CCG about how the service needed to re-arrange its intake criteria and process in order to manage a very high demand for clinical services. Having successfully worked through this change process we are now faced with lower than previous referrals and space in caseloads that had been previously reserved for assessments which we are now using more towards treatment slots which will in turn bring down out waiting list and waiting times.

The service has adjusted to these trends and in the last few weeks we have been safely able to allocate a greater proportion of treatments than assessments. We did need a degree of caution because it is not possible to know from very recent trends whether referral rates would consistently remain lower than previous years. Clinicians are also responding to requests to offer vacancies to treatment cases where assessments are not being allocated so frequently.

One final intervention which we are introducing this month (pilot version) and planning to implement by December is a change to our somewhat clunky and outmoded team diary to all staff using an Outlook diary for bookings that is shared with admin. This will give a greater level of transparency and clearer communication about vacant slots and enable us to slot patients into vacancies in a safe, planned and timely fashion.

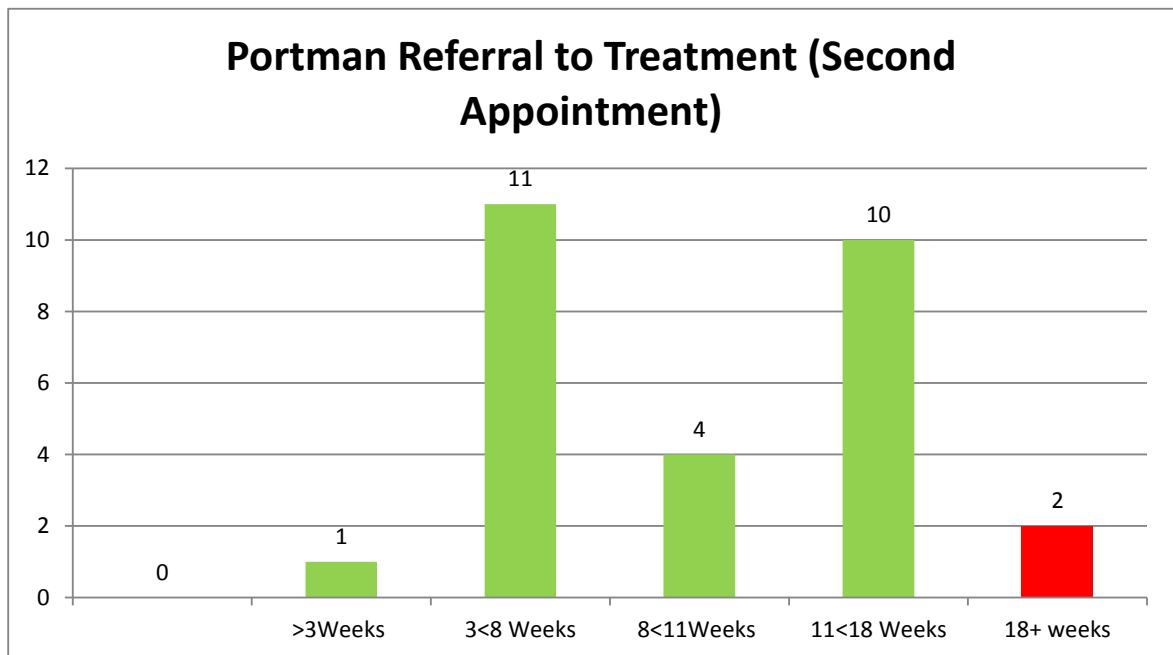
Tim Kent, Service Manager of City and Hackney PCPCS

2.3 Portman Clinic



The waiting time target for Portman is 11 weeks with 96% meeting this target in Q2, which is a pleasing figure and an improvement on last Quarter. Portman have seen 26 patients from their waiting list in this quarter, 7 more patients than the previous quarter.

Total open referrals waiting at the end of quarter: 8



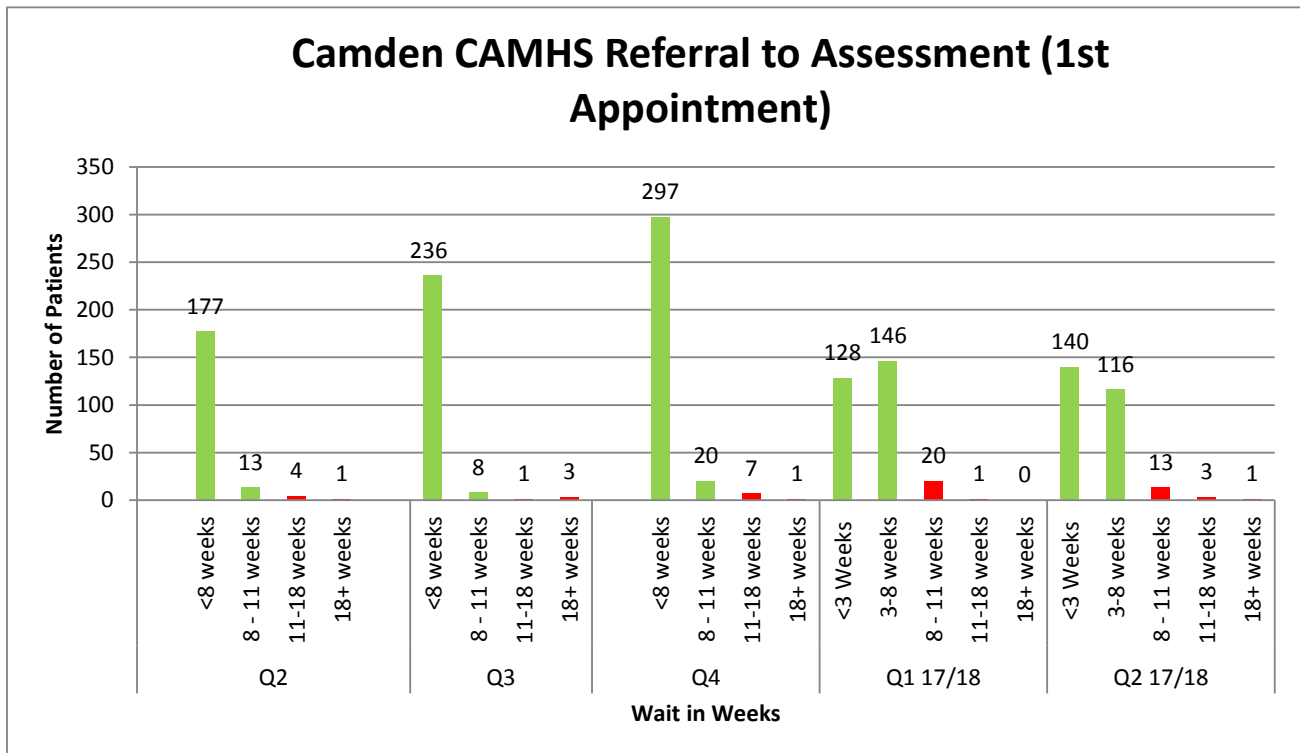
93% of patients in the Portman service were seen for treatment (Second appointment) within the national waiting time target of 18 weeks.

During all of this quarter, all patients, bar one, were seen well within the 11 week target following referral. The one patient who was not seen within this time scale was a patient referred over the summer when there was a staff shortage due to clinicians on annual leave, compounded by one clinician on prolonged jury service. This patient was seen within 13 weeks, and has subsequently completed his assessment and has been offered therapy at the Portman.

We continue to 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.

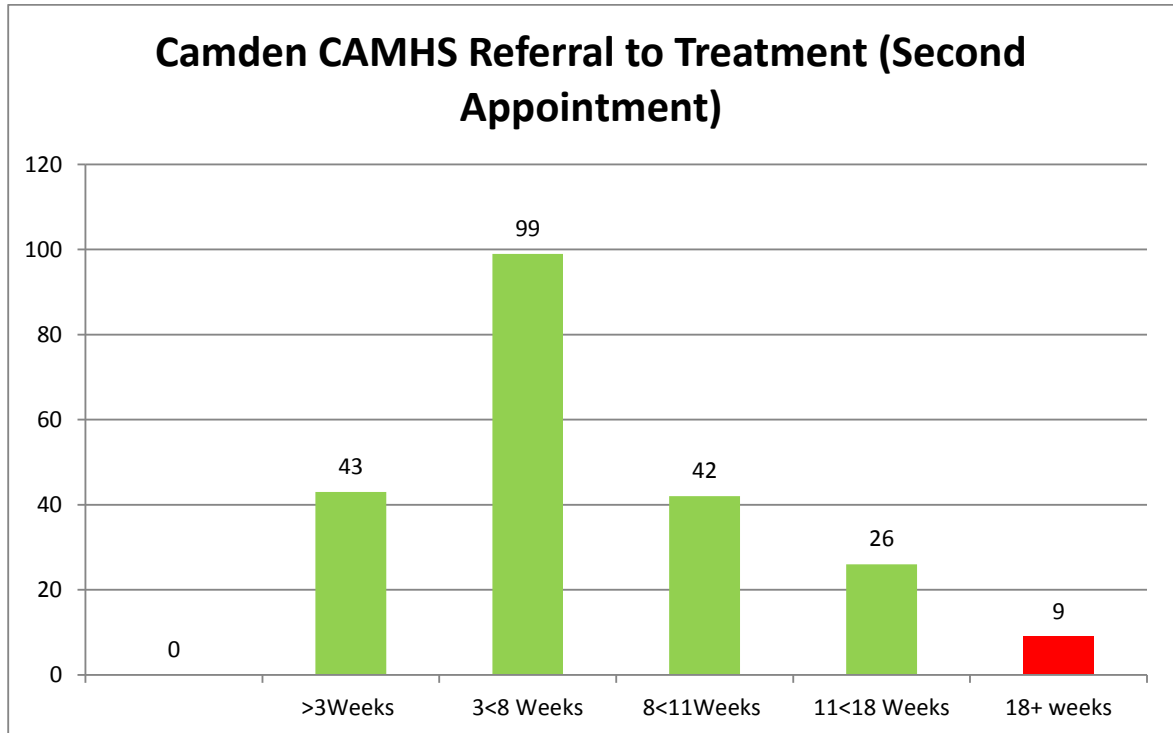
Jessica Yakeley, Director of the Portman Clinic'

2.4 CYAF (Camden CAMHS – All Teams Selected)



The waiting time target for Camden is 8 weeks with 94% meeting this target in Q2; Improvement has been gradual but steady over the previous quarters. A very pleasing result.

Total open referrals waiting at the end of quarter: 82

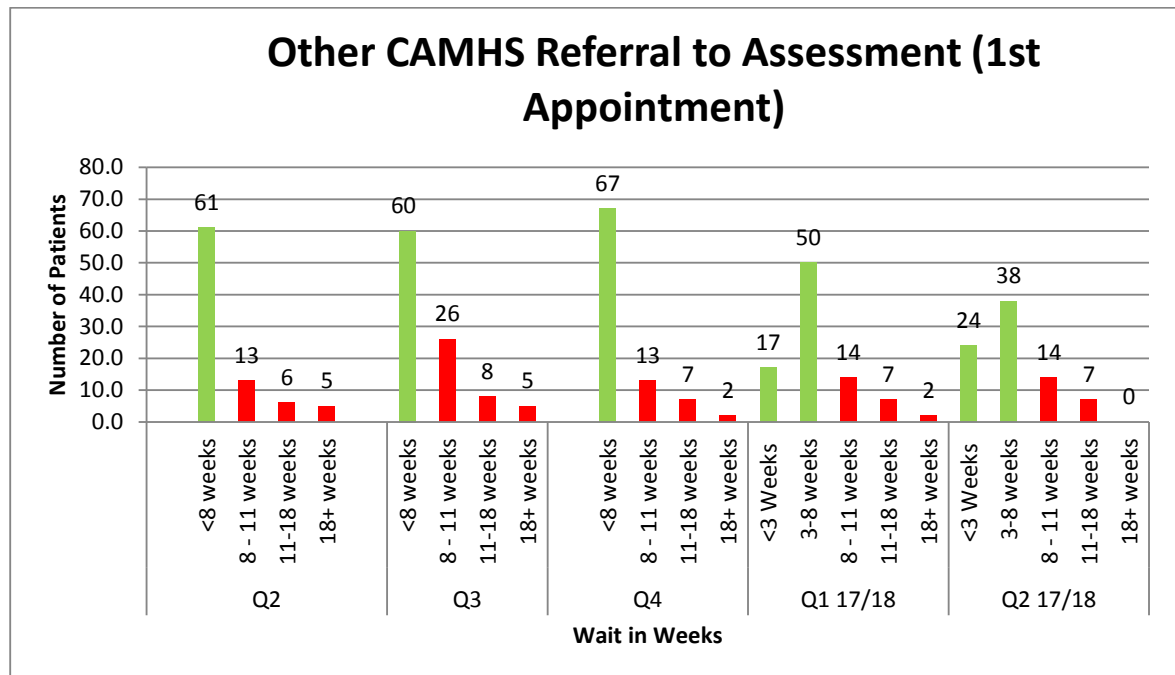


96% of patients in the Camden CAMHS teams were seen for treatment (second appointment) with in the national waiting time target of 18 weeks.

We are extremely pleased with these results, which relate directly to the work we have undertaken over the last two years to ensure CAMHS is fully integrated with other services in Camden. We understand that our results have placed us in the top three high achievers nationally for access to services and waiting times through the recent CAMHS benchmarking process.

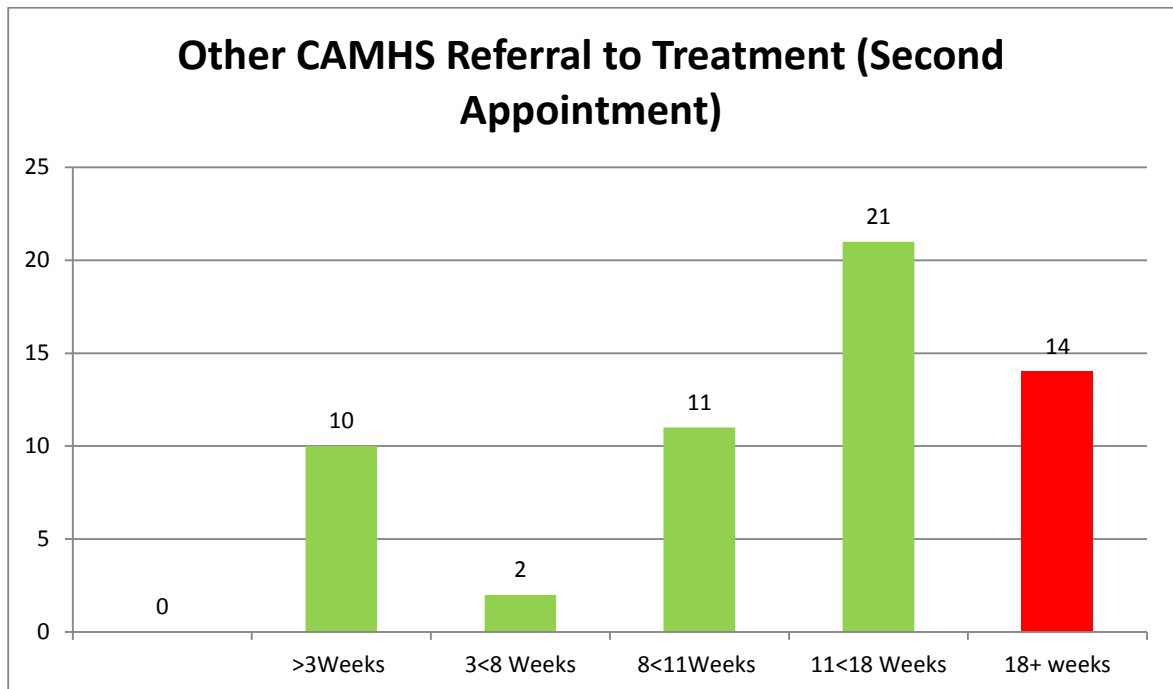
Sally Hodges, Director of CYAF

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



The waiting time target for Other CAMHS is 8 weeks with 75% meeting this target in Q2. Identical to Q1.

Total open referrals waiting at the end of quarter: 77

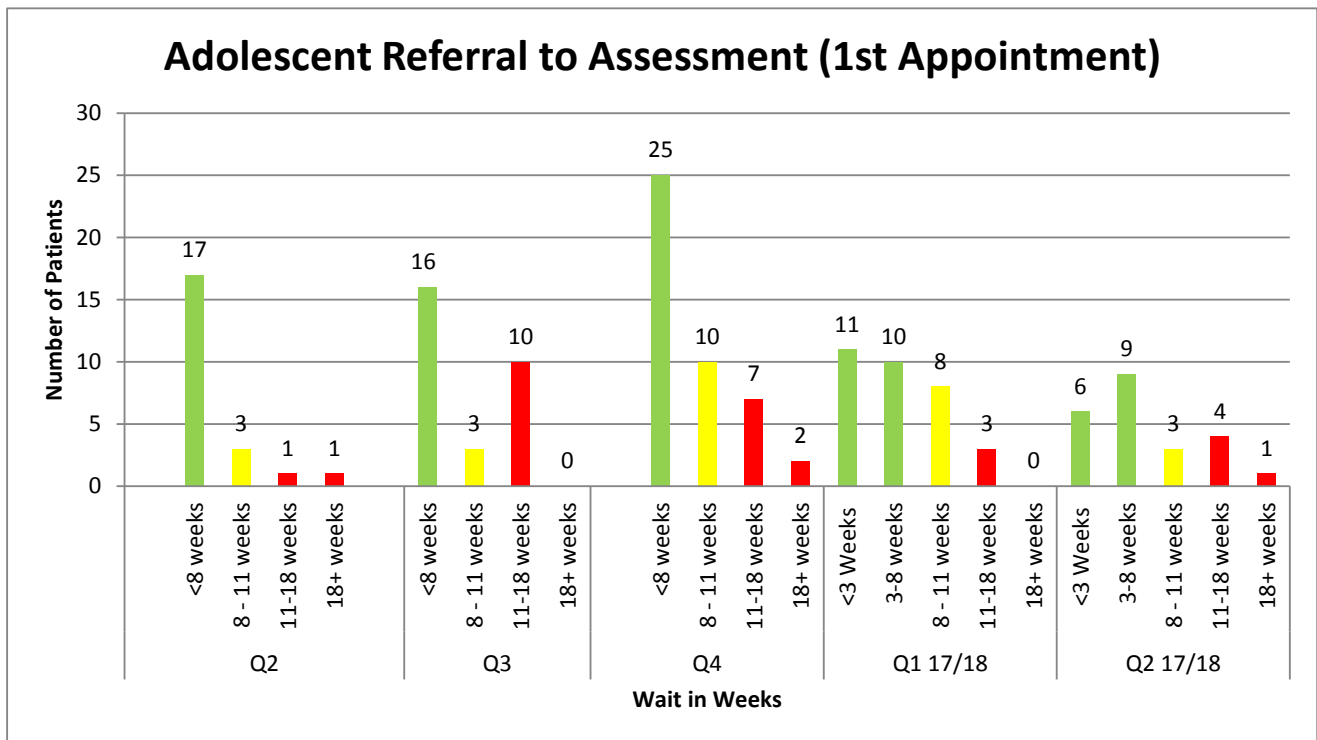


76% of patients in the Other CAMHS teams were seen for treatment (second appointment) with in the nation waiting time target of 18 weeks.

There has been increased waiting times due to patient choice as a result of their holiday arrangements, reduced staff availability due to staff annual leave and changes to CAR clinic arrangements within FMHT. In addition, there have a been a number of external causes due to insufficient information being provided by referrers, the need to clarify funding implications, challenges in engaging children, young people and their families in the initial meeting potentially due to their ambivalence at attending, and also due to human error.

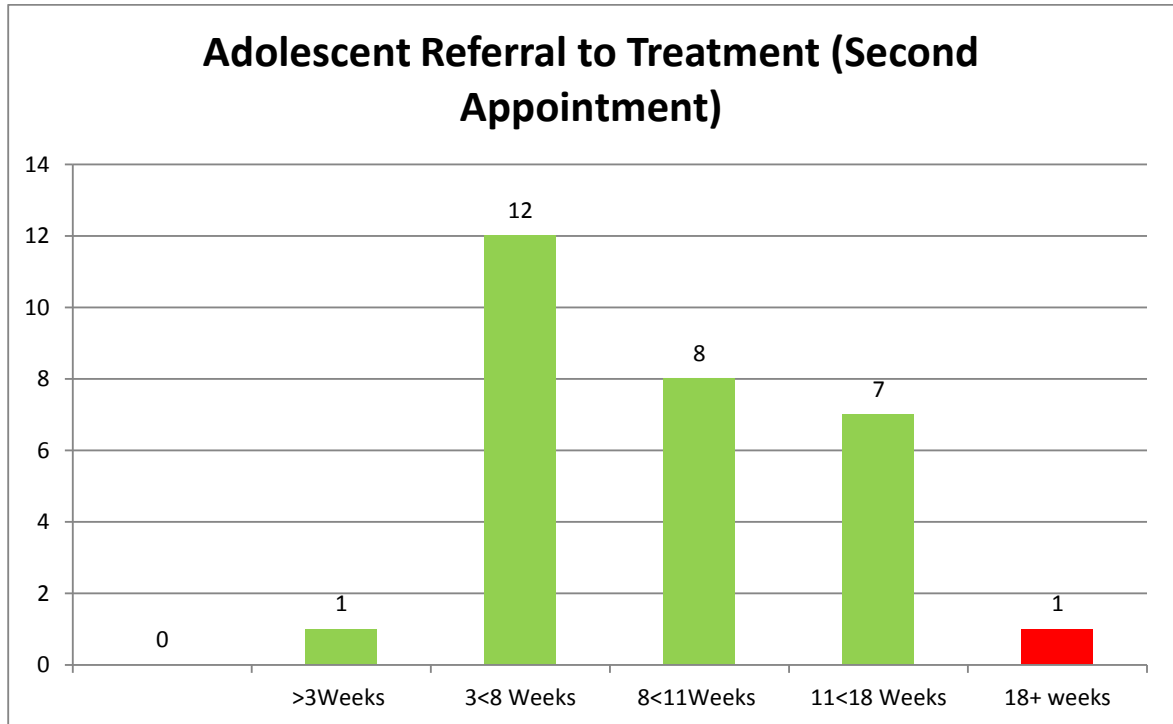
Rachel James, Associate Clinical Director.

2.6 Adolescent Service



The waiting time target for Adolescent is 8 weeks for those under 18 and 11 weeks for those over 18. With this taken in to consideration 74% of patients were seen with in target waiting times. Although there was a vast improvement in the last quarter, figures have fallen again in Q2.

Total open referrals waiting at the end of quarter: 14

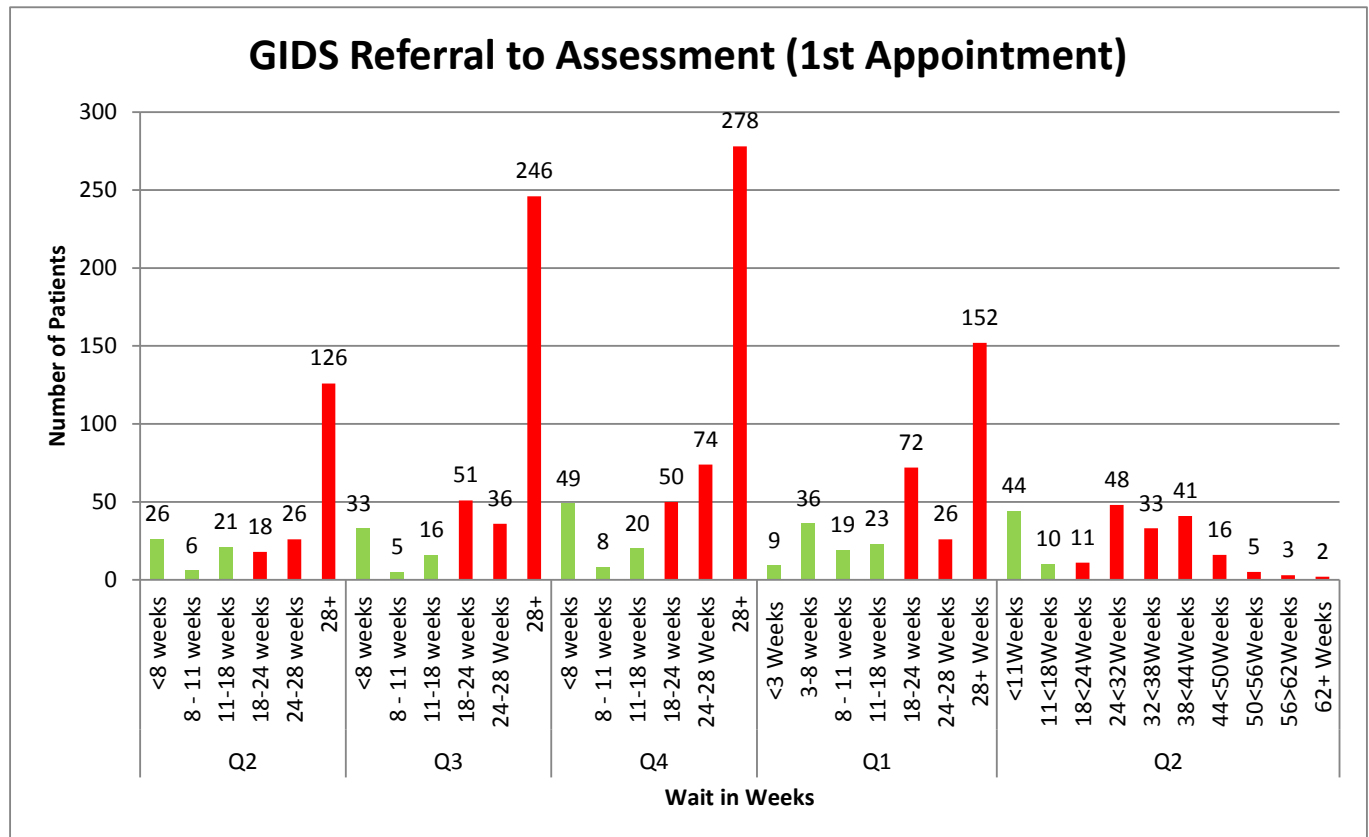


97% of patients were seen for treatment with in the national waiting time target of 18 weeks.

‘As a Service we endeavor to keep waiting times as short as possible for patients. However, because of the summer holidays, some patients were not available to attend their assessment appointment within the waiting time target, which in turn contributed to the breaches in the waiting times for the AYAS this Quarter.’

Justine McCarthy Woods, Service Lead, Adolescent and Young Adult Service

2.7 Gender Identity Development Service

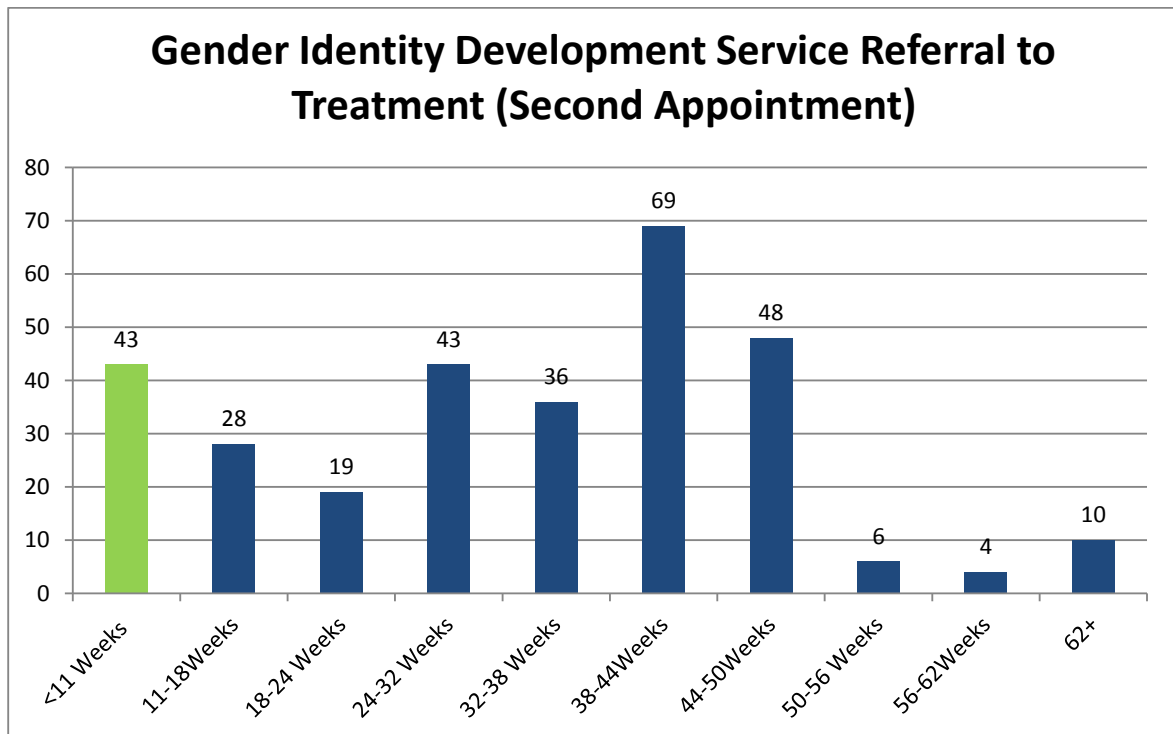


**Please note the difference in reporting the Wait in weeks, this has been agreed with Frances Endres. It will show more clearly when improvements are happening with in the service*

The number of new patients seen in Q2 has fallen by 124 when compared to Q1 and 272 compared to Q4 16/17.

25% of patients were seen with in the 18 week target time for GIDS, identical to Q1.

Total open referrals waiting at the end of quarter: 1191, 388 more than Q4 of 16/17.



**Please note the difference in reporting the Wait in weeks, this has been agreed with Frances Endres. It will show more clearly when improvements are happening with in the service*

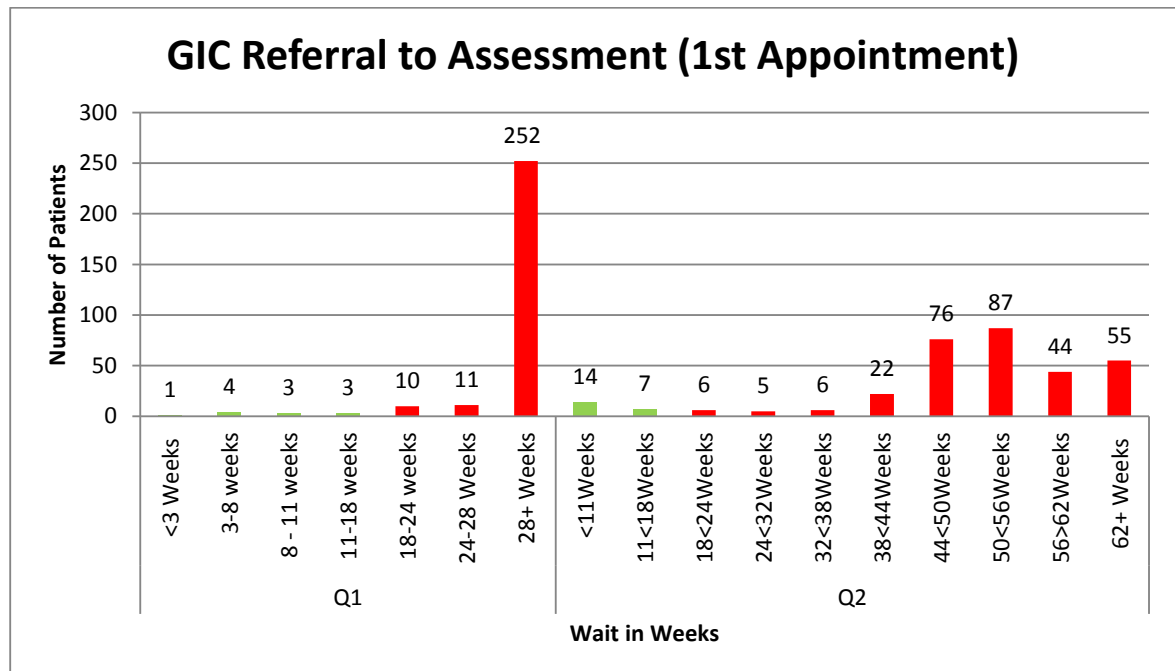
23% of GIDS patients were seen with in the national 18 week waiting time target.

The waiting times were reducing and were around 26 weeks, but didn't drop lower than this. This was due to the increase in referrals again, above those that were modelled with NHS England. There had been an assumption of 125 referrals a month, but this is now averaging 200 per month. We are working closely with our commissioners to manage this and their expectations and they have been told we are looking at, at least, another year before we can reach the 18 week target. They are aware this is due to the increase in referrals again and the restraints on staff training and space. We were addressing this with another round of recruitment, but the number of first appointments offered has reduced because a number of clinical staff have left, or are leaving the service. This means that existing cases need to be re-allocated, reducing the capacity for taking on newer referrals. Recruitment is active and we have just appointed several new staff across London and Leeds, but as training is required on the job, it takes a number of months before new staff are fully up and running. There are a number of projects underway which have been developed to improve access to the service and will potentially have a positive impact on the waiting list. Projects include more outreach clinics, assessment clinics, group first appointments for carefully selected young people and telemedicine. In addition we are working closely with Charing Cross adult GIC to improve transfer from the GIDS to the adult GIC. Timely

transfer of young people to adult services would reduce staff caseloads, which in turn creates space for new referrals to be picked up.

Keyur Joshi, GIDS Service Manager

2.8 Gender Identity Clinic (GIC)



**Please note the difference in reporting the Wait in weeks, this has been agreed with Frances Endres. It will show more clearly when improvements are happening with in the service*

The waiting time target GIC is 18 weeks with 6% meeting this target in Q2. This is a new service with a huge number of referrals, although has seen a slight improvement on the previous quarter.

Please note anyone with a 42 week wait or under is likely to have had cancelled their original appointment and their waiting time would have been restarted from this date.

Total Waiting at the end of Quarter: 2246 **retrieved from Frances Endres*

The system of booking appointments that the Tavistock inherited was very complex, had errors built in from a previous data migration, was not open or transparent and focused heavily on face-to-face 'core' clinical time, with clinicians reporting feeling overworked and burned out. The system was not set up to handle clinician illness and had a very high proportion of rescheduled appointments.

As the Gender Identity Clinic often books appointments a year in advance, changes to the appointment system are often felt many months in the future. Improvements to the system will likely take significantly more than a year to be seen in reporting.

On a positive note, a number of vacant clinical posts have recently been filled so, although they are still being trained, new capacity is due to come on line over the coming months and has already started to make a difference.

Focus on safety

When the Tavistock & Portman took on the Gender Identity Clinic, clinicians made very clear that they were concerned about aspects of patient safety they felt had not been considered in the past as the focus was primarily on waiting times.

In particular, they highlighted that 30 minute appointments were a concern. One key problem was that up to 20% of the GIC's appointments are rescheduled. Sometimes due to clinician availability, 30 minute appointments would be shifted to a different clinician, who had never seen the patient before. Clinicians felt deeply uncomfortable forming a clinical opinion on a case within 30 minutes.

As a result of our focus on improving safety, the guidance about 30 minute appointments has changed. Clinicians can continue to book patients in to see a patient for 30 minutes themselves if that feels clinically appropriate. If 60 minutes feels more clinically appropriate, they are able to schedule it for 60 minutes. Any time a 30 minute appointment is shifted to a clinician that has never seen the patient before, it is automatically extended to 60 minutes. This is a positive development but could have a small negative impact on waiting times.

Overall, in the past it felt that the service was aiming to book patients' first appointment as quickly as possible, with less of a focus on second or subsequent appointments. There was a year-long wait for a first appointment with, often, a year-long wait for a second appointment. The service was not felt to be treating patients in its care well. The Tavistock has shifted some capacity to focus more on second and subsequent appointments, but this again will have a negative impact on waiting times to first appointment (though should bring down the wait to second and subsequent appointments over time and mean that once treatment has started it progresses briskly).

Pooling

There has been one key initiative with an extensive consultation process that has now been implemented. This has been known as the 'pooling' project. The clinic had uneven waiting lists for different clinicians. Looking at queuing theory, the more waiting lists there are, the longer everyone waits. An example could be the post office – one queue where the person at the front gets directed to the first available server is much faster overall than five separate queues.

It was not uncommon at the GIC for only one clinician being listed as being able to see a patient. This built in problems if this clinician was then unavailable for a period – patients would wait for the clinician to return when perhaps they could be seen equally well by a colleague. The idea behind pooling was to consider if a group of clinicians could be nominated as able to see the patient based on their particular attributes, and the appointment could then be scheduled with the clinician from that group with the shortest waiting time. This is only used when clinically appropriate.

Anecdotally, from looking at clinician diaries it does appear this has helped increase the number of appointments scheduled with clinicians with the shortest waiting lists and evened out the wait-times across the service. This should bring the average down overall. However this system was to some extent already in place for first appointments, so will have the greatest impact on the waiting time for second appointments.

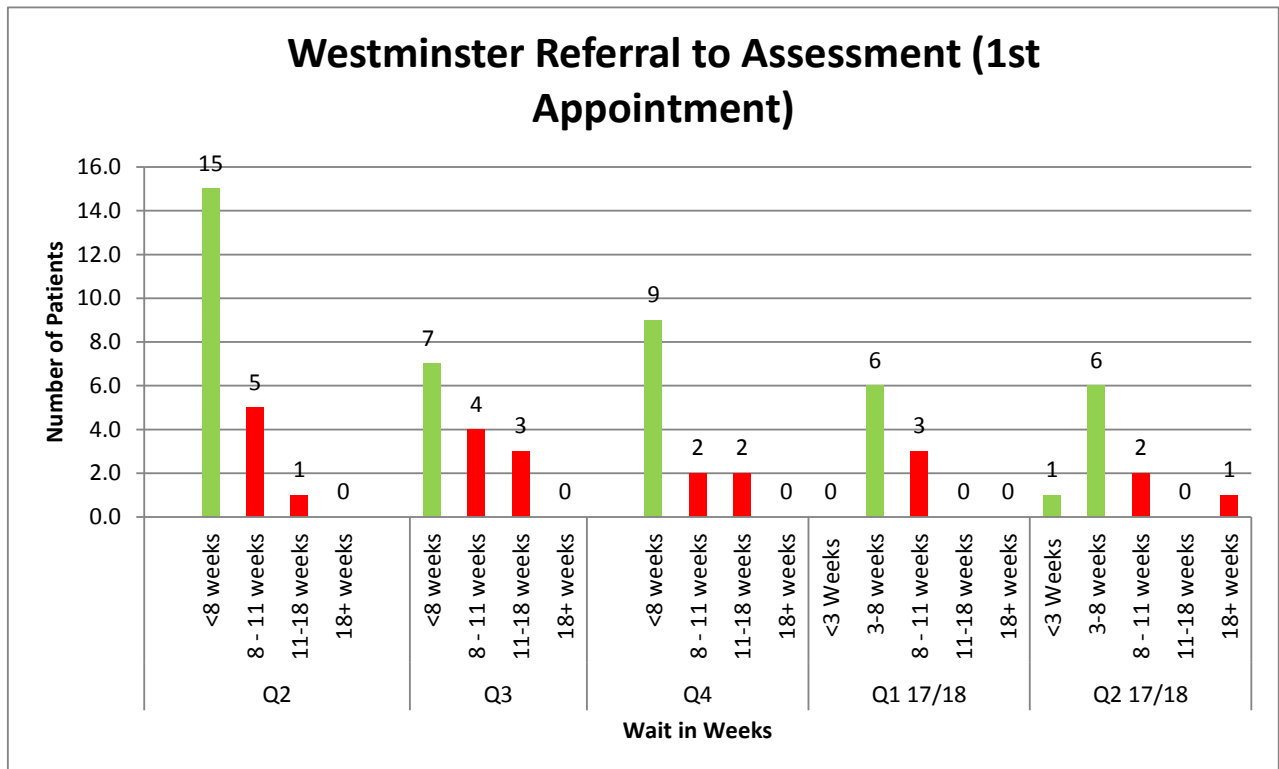
Training

Second and subsequent appointments are booked very far advance. In the past, to some extent the service had waited for clinicians to be trained before scheduling them the crucial ‘signer’ appointments (appointments in which a trained clinician is able to sign off on physical interventions). As a result there would be a lag of some months before the clinician would have the appointments they were now trained to deliver booked into their diary. This was lost capacity.

With the recent recruits, a system has been put in place that is finding the balance between having the appointments booked in ready for the newly-trained, while being conservative enough to allow for delays in their training schedules. The first newly trained ‘signers’ (able to sign for surgery) will start their full diaries in October and learning from their experiences will inform the planning of clinician diaries in future.

Due to the nature of the service it would not be helpful to measure Referral to treatment as this service does not provide treatment to many of their patients. 100% of patients were seen at a second appointment after the national RTT target of 18 weeks.

2.9 Westminster Service



The waiting time target for FAS is 8 weeks, 70% meeting this target in Q2, a small improvement from Q1.

Number waiting at the end of the quarter: 6



91% of patients in the Westminster Service were seen for treatment (second appointment) within the national waiting time of 18 weeks.

Waiting times at Westminster FAS remain a complex picture and the variables are not all within our control. Cases can wait if the statutory social worker or lead solicitor 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.

Additionally, the clients referred to the service have usually been compelled to engage due to court or local authority pressure and the clients are sometimes ready to engage willingly or discuss their difficulties. This can lead to missed appointments at the beginning of the process and therefore delays for the next referrals.

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 gate keeping by the service leads in the children's services.

Steve Bambrough, Associate Clinical Director, Westminster Family Service

Kerri Johnson-Walker, Data Quality Manager

13th October 2017

Board of Directors : October 2017

Item : 10c

Title : IM&T Strategy and Programme Q2 Report

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.

In May 2017 it was agreed that a prioritised project list for 2017/18 would supplement the existing plan generated by the IMT Strategy. It was also agreed that a five year Transformation Strategy, also encompassing digital transformation be developed for presentation for a future Trust Board.

This report summarises the IMT Programme Summary Report, covering to 13th October 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 Q1 Update

Provided by David Wyndham Lewis, Director of Transformation and Technology, covering to end of 13th October 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.

In May 2017 it was agreed that a prioritised project list for 2017/18 would supplement the existing plan generated by the IMT Strategy. It was also agreed that a five year Transformation Strategy, also encompassing digital transformation be developed for presentation for a future Trust Board.

One early constituent project of the draft Transformation Strategy, Trustwide Scheduling, has been approved by Trust Board and has commenced.

Summary

The most recent IMT Programme Summary Report, covering to 14th September 2017, shows the programme as amber. The report emphasises continuing and further delays to multiple projects as a concern, with risks to timely delivery noted against several projects. The delays are primarily attributed to a combination of limitations of capability and capacity within the IMT team. In addition the Email Replacement project is currently marked as red for cost, with the project on hold pending a revisit of full project costs; the project team notes that the revenue costs of the technical implementation were underestimated as part of the original business case with phase 2 and 3 workstreams excluded in error.

The IMT Programme Summary Report now represents a converged view of the projects initiated as part of the IMT Strategy (January 2016) and those projects since initiated under the remit of the IMT Steering Committee. It also includes both Trustwide Scheduling and the implementation of MyTAP (a.k.a SITS / Student Information Management System).

IM&T Programme Update – Projects Commissioned in 2016 Strategy

The projects commissioned as part of the 2016 strategy and continuing following the May 2017 review are listed below :

Project Title	Status	Project Update
AD / DNS / DHCP Upgrade		Initiation postponed to early 2018
Data Leak Protection		Significant delays associated to lack of capacity within the ICT team and technical dependency on Email Replacement
Data Warehouse and Dashboard		Business case in draft for presentation to WMT and Trust Board however is delayed by circa one month. Business case is for investment in 2018/19 year.

Email Replacement		Project on hold subject to full review of planned costs for project. Phase 1 completed however additional work to complete phase 2 and phase 3, to be undertaken by an external supplier, had not been included in the business case
Endpoint Hardware Refresh 2017/18		Deployment is now progressing and expected to complete within year.
ITSM Toolkit Replacement and Service Improvement		ITSM toolkit (Hornbill) has gone live and is now in use. Some process and cultural issues with use of the tool were expected and have occurred. Work to address these is continuing.
Network Replacement		Procurement has completed and contract is now signed with Insight and ANS as main subcontractor. Project now divides into two workstreams; one will deliver the network infrastructure replacement and the second the implementation of the managed service support arrangements. Workstreams will start in October 2017.
Project and Programme Management Improvement Project		PPM toolkit (CA PPM) has gone live. First project to be implemented within the toolkit will be Trustwide Scheduling. Planning for 2018/19 programme will be undertaken entirely within the toolkit. Some delays to the go live are a concern but now recovering.
Risk, Incident and Quality Management		First phases have gone live in the period. Some delays to go live are a concern but now recovering.
Secure Email Configuration		Phase 3 of email replacement. Cannot progress until Email Replacement is complete.
SITS & DET Systems Integration		Initiation postponed to early 2018 to follow MyTAP completion.

IM&T Programme Update – Projects Commissioned in May 2017 Review

The projects commissioned as part of the May 2017 review or as part of separate programmes but with significant IMT impact are listed below:

Project Title	Status	Project Update
Electronic Referrals		Initiation postponed to early 2018
Health and Social Care Network		The list of Trust sites and connections has been provided to the “Once for London” procurement scheme. Project initiation postponed until early 2018 when that procurement is expected to complete.
Integration Platform		Expected to be closed as an individual project and incorporated into Transformation Strategy (in particular Patient Engagement project)
Portman and Other Digital Outliers Migration		Project initiation is progressing well with both the approach and timeline incorporated into a draft project brief. A project board will be formed in the next period.
Remote Patient Care GIDS Proof of Concept		Cinos Communication has been engaged for the proof of concept. Project is progressing well with staff and patient engagement works complete and positive.

		Some delays to commissioning of infrastructure required for proof of concept.
Remote Patient Care		Will be initiated following of from creation of blueprint for new operating models as part of Remote Patient Care GIDS Proof of Concept.
Remote Sites Infrastructure		Project has been fully initiated in September 2017 however is substantially delayed. Bounds Green infrastructure is now progressing however costs are higher than expected due to now necessary inclusion of telephone infrastructure as well as network. This may result in a recommendation to reduce scope to Bounds Green and FDAC Kent only until a further case can be made for additional funding.
SCCM Configuration for Asset, Patch and Image Deployment		Phase 1 is now complete with asset management including patch management now live. Phase 2 which will include patch and image deployment will commence in early 2018.
Student Information Management System		Project is nearing completion in November 2017. Risks & issues have been highlighted in regard to both ongoing operational support and future development path. A new recommended governance model and support arrangements are to be presented to Training and Education Programme Board.
Trustwide Scheduling		The project board has now approved the Project Initiation Document. The project team is nearly fully recruited with two posts outstanding. Work is progressing well on interviews with stakeholders around the Trust – 91 are scheduled with a further 18 planned. The ITT for the scheduling system has been issued. Market engagement with suppliers has been positive.

Concerns / Escalated Issues

Recruitment to the Information Governance and Security Manager role had been delayed with these tasks falling to the Deputy SIRO. The role has now been recruited with a start date of the 27th November. As noted previously this has not created any issues as yet but is creating some pressure in the system with regard to speed of turnaround on IG queries. Additional IG training for all Trust staff is being sourced from other NHS Trusts while this role remains empty. Face to face training has been well attended with circa 75% compliance now achieved across the Trust and expected 100% compliance by end of Q3.

Additional pressures, notably new business opportunities, will continue to generate significant delays within the IMT Programme. Works to deliver the IMT components of the successful bid for London FDAC are now being planned and are expected to delay the majority of the IMT programme by between six and eight weeks.

Revision of the IMT Strategy

The revision to the IMT Strategy to create a 5 year Transformation Strategy has been previously delayed to allow additional time for consultation. Operational pressures, particularly those related to

the Estates and Facilities department, has meant these consultation exercises have not taken place as planned, resulting in a further delay.

Board of Directors : October 2017

Item : 15

Title : Medical Education Training Strategy 2016-2019

Summary: This paper describes the current context in which Medical Education is functioning and the Trust's contribution to Medical Education from undergraduate to specialist registrar level. The Board is trusted to consider the Trust's strategy in relation to wider Medical Education

This report focuses on the following areas:

(delete where not applicable)

- ☐ Quality
- ☐ Patient Safety
- ☐ Clinical Risk

For : Discussion and Noting

From : Dr Rob Senior, Medical Director
Dr Jessica Yakeley, Director of Medical Education

Medical Education Training Strategy

2016-2019

A. Introduction: The Tavistock and Portman NHS Foundation Trust

The Tavistock and Portman NHS Foundation Trust (the Trust) is a specialist outpatient mental health trust focusing on psychological and developmental approaches to understanding and treating mental health. It provides a range of general and specialist clinical services for children, families and adolescents (CAMHS comprises the majority of the Trust's patient services) and adults, and includes forensic services. The Trust is also Britain's leading provider of multidisciplinary postgraduate training in mental health and social care. Students choose to train here because of the Trust's reputation for excellence in the field of mental health education, training, research and consultancy.

The Trust has a national and international reputation based on excellence in service delivery and clinical innovation, and high quality clinical training and workforce development. It is active in research into the origins of mental health problems, models of social care, and aims to establish the evidence base for its treatment methods. The Trust seeks to influence and develop new ideas through research, publication and participation in policy making.

With just under 600 staff and an income of £41m in 2014/15, the Trust strategic aims are to:

- To remain a national and international centre of excellence, dedicated to the highest standards and continued innovation in the provision of mental health treatment, education and training, organisational consultancy, and research;
- To increase access to our patient services, training, research and consultancy activity;
- To provide fully multi modal and multi-disciplinary services in CAMHS, adult psychological therapies and training;
- To ensure that the Trust actively makes its services accessible to the socially disadvantaged and those that experience discrimination;
- To contribute to mental health policy both locally and nationally, focusing on children and adolescent services, and adult and forensic psychotherapies;
- To contribute to improving knowledge and practice in mental health, via research, training and consultancy.

B. Medical Education in Context

I. Key national reports and documents that have shaped medical education

1. The Francis Report (February 2013)

Following the 'appalling care conditions' found at the Mid Staffordshire Foundation Trust,

Lord Francis was commissioned to look at why the serious problems (between January 2005 and March 2009) at Mid Staffordshire Foundation Trust were not identified sooner and the appropriate actions taken and to outline what lessons could be learned to enhance patient care. The key message was that the National Health Service (NHS) needed to put the patient first and everything else should flow from that principle. Poor standards of care should not be tolerated and staff would be expected to speak out when they felt patient care was being compromised. The individuals and organisations who provide care for patients should be properly accountable for what they do and ensure that the public is protected from those not fit to provide such a service; Lord Francis also recommended that there should be one regulatory body and that the role of the Care Quality Commission (CQC) was to be reviewed.

In relation to training, one of the recommendations was that the recruitment, education, training and support of all the key contributors to the provision of healthcare should be enhanced, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do.

The full review is available at <http://www.midstaffpublicinquiry.com>

2. The Berwick Review (August 2013)

The Berwick Review focused on improving the safety of patients with the aim that “the NHS in England becomes the safest health care system in the world [with] a culture firmly rooted in continual improvement.” It recommended that patient harm should be reduced by leaders prioritising above everything else quality and safety of patient care, increasing involvement of patients and carers, complete transparency and responsive regulation.

In relation to education and training, the key messages were that the NHS should become a learning organisation in which its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS; an ethic of learning should be embraced; and mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives.

The full report can be read at https://www.gov.uk/government/Berwick_Report.pdf

3. The Shape of Training Report (October 2013)

The Shape of Training Report, following the independent review led by Professor David Greenaway, aimed “to make sure we continue to train effective doctors who are fit to practise in the UK, provide high quality care and meet the needs of patients and the public. As part of this review, we looked at the desired outcome of training – what kinds of doctors are needed, and the means by which we get there.”

Key messages in the report included training more doctors who are capable of providing safe and effective general care in broad specialties across a range of different settings, due to a growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient expectations; increasing flexibility and opportunities for doctors to change roles and specialties throughout their careers, and for academic doctors to move in and out of clinical training; continue to train doctors in more specialised areas or to credential in specific areas to meet local patient and workforce needs, and that full registration should move to the point of graduation from medical school.

The full report can be read at: http://www.gmc-uk.org/Shape_of_training_FINAL_Report.pdf_53977887.pdf

4. The Broadening the Foundation programme (February 2014)

Following the report by Professor John Collins, the Broadening the Foundation Programme addresses the need for newly qualified doctors to be able to respond to the evolving needs of the 'whole patient' and to be able to develop their capabilities across a range of settings, including the community. This requires training a flexible workforce that is capable of providing care in a range of settings over the course of their careers.

One of the key recommendations is that at least 80 per cent of foundation doctors should undertake a community placement or an integrated placement from August 2015. The report also includes previous targets for significant increases in foundation psychiatry placements, so that 45% of foundation doctors will experience a 4-month placement in psychiatry.

The full report is available at <https://hee.nhs.uk/Broadeningthefoundationreport.pdf>

5. Promoting Excellence: Standards for Medical Education and Training. (July 2015)

In July 2015, the GMC set standards to promote excellence for medical education and training and provide patients' safety. There are 10 standards, grouped into 5 main themes:

- Learning environment and culture
- Educational governance and leadership
- Supporting Learners
- Supporting Educators
- Developing and implementing curricula and assessments

These standards came into force in January 2016.

Details of the standards can be found at <http://www.gmc-uk.org/education/standards.asp>

II. The national structure of medical education

Health Education England (HEE) was formed in 2013 and is responsible for providing leadership and oversight of workforce planning, education and training. HEE has the objective of driving the highest quality public health and patient outcomes through a network of multidisciplinary Local Education Training Boards (LETBs), responsible for commissioning, quality, as well as professional development and libraries services.

LETBs commission Lead Providers (LPs) to oversee the training programmes, manage trainee rotations, review their progress and control the quality of education in the Local Education Providers (LEPs) which deliver local education and are responsible for local quality of training.

C. Medical Education in the Trust (T&P)

The Trust falls under the Health Education North Central and East London (HENCEL) LETB.

University College London Partners (UCLP) is the Lead Provider for the Higher Psychiatry Trainings for Child and Adolescent Psychiatry for North London and for Medical Psychotherapy for North East London, and is responsible for the development of postgraduate medical education across the partnership. UCLP's mission is to deliver health improvement and wealth creation for the UK through excellence in discovery, innovation and education. UCLP's approach to postgraduate medical education is patient led, population focused, developed in partnership and delivered at pace.

The Trust is a LEP within our local rotations and runs three higher specialty training programmes in psychiatry (Child and Adolescent Psychiatry, Medical Psychotherapy and Forensic Psychotherapy), a placement in Adolescent Psychiatry for core trainees on the UCLP Core Psychiatry Training Programme, and an undergraduate programme for medical students. Consultant Psychiatrists act as educational supervisors (ES) and clinical supervisors (CS) to our trainees.

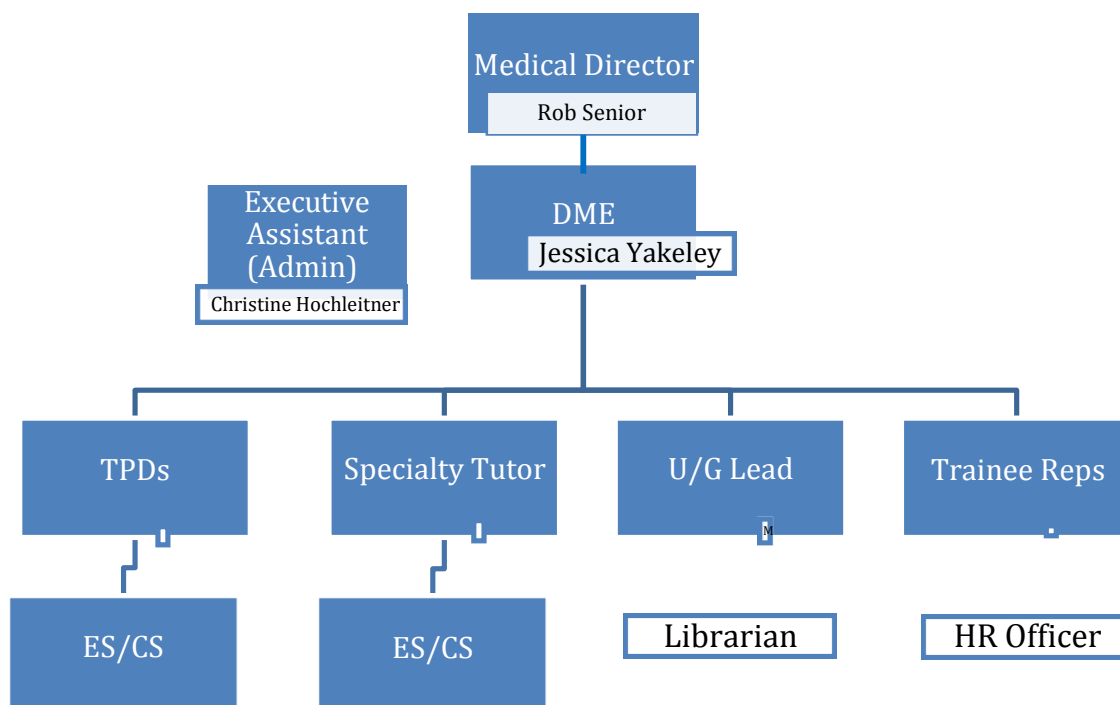
Current numbers of medical staff in the Trust:

Undergraduate students	Balint Groups SSC in Psychotherapy SSC in Adolescent Mental Health	10 each year 3 each year Up to 10 per year
Postgraduate students	FY Core trainees Child and Adolescent STs Medical Psychotherapy STs Forensic Psychotherapy STs	tba 4 per year 11 (T&P) 4 (TP) + 3 outside Trust 1 (TP) + 1 outside Trust
Consultants	Adult CAMHS Forensic	5 15 4
SAS doctors	Adult psychotherapy	4

I. The Medical Education Team

The Director of Medical Education (DME) leads on the delivery of medical education, ensuring that GMC standards are met and that the strategic direction set by HEE, the LETB and UCLP is supported.

Organisational diagram of medical education roles within the Trust:



Current Training Programme Directors (TPDs), Educational (ES) and Clinical Supervisors (CS):

Adult psychotherapy	Child and Adolescent Psychiatry	Forensic Psychotherapy
Niloufar Harris (TPD)	Myooran Canagaratnam (TPD + U/G Lead)	Carine Minne (TPD)
Dave Bell ES/CS Tony Garelick ES/CS Julian Stern ES/CS Jo Stubley ES/CS	Susanna Fairweather ES/CS Mona Freeman ES/CS Sheva Habel ES/CS Vicky Holt ES/CS Emilios Lemoniatis ES/CS Mellini Mahadevan ES/CS Caroline McKenna ES/CS Eleni Paliokosta ES/CS Kim Raftopoulos (Specialty Tutor) Alex Sales ES/CS Liz Searle ES/CS Robert Senior (Medical Director) Mike Shaw ES/CS Julian Stern ES/CS Rob Tandy ES/CS Andrew Wiener ES/CS Andrew Williams ES/CS Sarah Wynick ES/CS	Andrew Williams ES/CS Jessica Yakeley (DME)

II. Main functions of the Medical Education Team in T&P

1. Provide education and training for undergraduate medical students
2. Ensure high quality of education and training for postgraduate trainee doctors
3. Provide a supportive learning environment for medical education and training
4. Improve the infrastructure to support medical education and training
5. Develop the Faculty to support medical education and training within T&P
6. Work with the Department of Education and Training (DET) to foster multidisciplinary training
7. Establish an internal CPD programme for the senior doctors of the Trust to support their revalidation needs.

D. Strategic aims and objectives of Medical Education at T&P for 2016-2019

The medical education team will continue to deliver high quality medical education and training experience to trainees at all levels (undergraduate/postgraduate), offer opportunities for consultants to develop as trainers, improve patient safety and support the Trust's strategic aims.

In particular, Medical Education will aim to:

- Promote high quality postgraduate training and education
- Expand undergraduate medical education
- Introduce Foundation Training opportunities
- Maintain and develop our Faculty of Trainers
- Expand links with Department of Education and Training (DET)
- Provide a range of CPD opportunities
- Maintain and develop governance and quality assurance

I. Promoting high quality postgraduate medical training and education

As a specialised mental health trust with no wards or in-patient beds, we have few core trainees and relatively few higher trainees in three sub-specialties of psychiatry (Child and Adolescent, Medical Psychotherapy and Forensic Psychotherapy) and no trainees in General Adult Psychiatry. The Training Programme Directors are based at the Tavistock and Portman and co-ordinate placements in other Trusts. Places on our training schemes are popular and sought after, and frequently attract more applicants in the national recruitment rounds than there are places for. Our GMC Trainee Survey results are consistently very good, ranking us highly compared to other trusts nationally, and we receive excellent feedback from our trainees via other channels, e.g. Quality Visits from the LETB and School of Psychiatry.

We aim to maintain and improve the quality of our post-graduate medical training by:

- Modernising the training schemes
 - We will ensure that our training schemes cover all aspects of the curricula set by the Royal College of Psychiatrists.
 - All placements on the rotations will have up-to-date job descriptions.
 - Our established dual trainings (Medical Psychotherapy and Adult Psychiatry; Forensic Psychotherapy) will continue to be developed, taking into account trainee feedback, and new dual trainings (e.g. Medical Psychotherapy and Child and Adolescent Psychiatry) established.
 - We will continue to work closely with our neighbouring trusts which offer placements on our rotations.
 - We will improve our opportunities for trainees to develop skills and experience in leadership, conducting research and quality improvement projects.
- Developing innovative educational programmes
 - New placements for trainees will be developed within the Trust's new innovative community clinical services (e.g. City and Hackney Primary Care Psychotherapy Consultation Service, Camden Team around the Practice)
 - Develop simulation and technology in medical education in collaboration with UCLP and neighbouring local education providers
 - Establish educational leads for innovative programmes
 - Offer more placements to trainees in different psychiatric and medical specialties from other Trusts and rotational training schemes as 'special interest sessions'
 - Involve patients and carers in the design and delivery of educational opportunities
- Promoting research in education
 - Develop the Trust's existing expertise and research in Balint groups and Student Psychotherapy Schemes, and link in with the Royal College of Psychiatrist's National Student Psychotherapy Strategy
 - Forge links with the Trust's Research committee to develop new research projects in medical education
 - Support trainee's involvement in medical education research, including presentation and publication of papers.

II. Expanding undergraduate medical education

Although many of our consultant psychiatrists and higher trainees in psychiatry lecture and teach on the medical student academic programme at our local medical school (UCL), we have

not, to date, offered many placements or electives for medical students in the Trust. This may be because of the specialised nature of many of our clinical services, the fact that we have no wards or in-patient beds, and the relatively small size of the medical discipline in the Trust compared to other disciplines (e.g. psychology, systemic psychotherapy, child psychotherapy). However, our expertise in psychological and developmental approaches to understanding mental health and illness, and our expertise in specific therapeutic frameworks and modalities (e.g. psychoanalytic, systemic, attachment) places us in an optimal position to offer medical students experiences in whole person medicine and psychotherapeutic psychiatry. Providing attractive placements and teaching opportunities will contribute to improving the perception of psychiatry within the medical student population and raise its popularity as a specialty, going some way to address the longstanding recruitment into psychiatry.

We will expand our involvement in undergraduate medical education by:

- Offering clinical placements for medical students -
 - within our clinical services in line with the medical student 'horizontal' curriculum during their psychiatry placement;
 - in line with the developmental approach of the 'vertical modules' of the curriculum;
 - tailored within our clinical services for medical students from other medical schools in the UK and abroad;

All Clinical placements will be quality assured via student feedback and LDA criteria.

- Developing Student Selected Components (SSCs) for medical students -
 - Offering SSCs in our different psychiatry specialties (one already exists in Child and Adolescent Psychiatry), tailored to the experience and maturity of the medical students;
 - Involving our higher trainees in the design and delivery of SSCs;
 - Liaising with the medical school(s) to deliver SSCs focused on topical and relevant areas of the curriculum (e.g. patient safety);
 - Offering opportunities within the SSC for the medical students to design and deliver quality improvement projects.
- Develop and expand our psychotherapeutic and experiential methods of teaching medical students -
 - Continue to offer and evaluate Balint groups for medical students in liaison with colleagues at the Camden and Islington NHS FT, the Balint Society, and the Royal College of Psychiatrists National Student Psychotherapy Scheme Strategy;
 - Develop and evaluate the Student Psychotherapy Scheme within our Adult Services, in liaison with colleagues at the Camden and Islington NHS FT and the Royal College of Psychiatrists National Student Psychotherapy Scheme Strategy.
- Expand our contribution to teaching medical students locally and nationally
 - Offer innovative placements and teaching relevant to the medical school curriculum drawing on our existing expertise e.g. in communication skills, developmental psychopathology;
 - Improve our links with the Deans, Sub-Deans and Tutors at UCL Medical School and other medical schools;
 - Encourage our higher trainees to be involved in medical student teaching;

- Continue our work on the working group of the Royal College of Psychiatrists National Student Psychotherapy Scheme Strategy;
- Investigate funding streams for undergraduate teaching (e.g. SIFT);
- Increase recognition of undergraduate teaching in consultant job plans.

III. Introducing Foundation Training placements

In 2013-2014, we participated in the London Pilot Foundation School Day Release Programme in Psychiatry by offering two four-month placements led by Consultant Psychiatrists for Foundation Trainees (FT) in Child and Adolescent Psychiatry, and in Psychotherapy and Primary Care Psychiatry. The former placement was a unique service offering experience in developmental conditions across the lifespan with an emphasis on multimodal treatment approach involving psychological interventions alongside medication. The latter was a placement in the City & Hackney Primary Care Psychotherapy Consultation Service (PCPCS) offering an innovative service model commissioned by GPs with a multi-disciplinary and multi-modal community focus, and emphasis on co-morbidities and a holistic approach. The placement provided the FT with experience in working with long term and acute conditions, patients with MUS (Medically Unexplained Symptoms) and personality disorders, close working with family and GPs. We received excellent feedback from the FTs who did these placements.

We aim to:

- Offer new placements for FTs in North Central Thames Foundation School (NCTFS)
 - Develop exciting, innovative and high quality placements for FTs in our clinical services offering experience which will be relevant to their future medical careers as GPs or specialists in all areas of medicine and surgery, focussing on integrated care and multi-disciplinary training;
 - Offer placements that will encourage some FTs to pursue a career in psychiatry;
 - Liaise with Head of NCTFS to ensure placements are relevant and compatible with the FT curriculum;
 - Liaise with the Head of the School of Psychiatry and DMEs, TPDs and trainers in London to ensure that we are working together to provide the best possible experiences within psychiatry for doctors at this early stage in their career.
- Create a Foundation Training Lead within the Trust
 - Identify a Training Lead leading in the development of a training programme for the foundation trainees;
 - The lead will develop a close working relationship with the NCEL Foundation School;
 - The lead will facilitate other consultants in the Trust to offer placements and be Clinical Supervisors to Foundation Trainees.

IV. Maintaining and developing our Faculty of Trainers

The Tavistock and Portman has around 25-30 consultant psychiatrists at any one time, some employed part-time, and the majority enthusiastically involved in post-graduate medical training, as accredited clinical and educational supervisors, or more formal educational roles such as TPDs.

We aim to develop our Faculty of Trainers by:

- Enhancing our Faculty Development Programme
 - Developing in-house courses for clinical and educational supervisors e.g. Managing the trainee in difficulty;

- Participating and contributing to UCLP Faculty Development courses;
 - Training non-medical supervisors in work place-based assessments (WPBA);
 - Involving trainees in faculty development;
 - Encouraging interested trainers to pursue further qualifications in medical education.
- Appraisal of trainers
 - ensuring that discussion of educational roles, including clinical and educational supervision, and educational portfolio, is included in consultants' annual appraisals for revalidation;
 - checking all clinical and educational trainers are up-to-date with the training requirements for the GMC Register of Accredited Trainers and appraised every three years by the Director of Medical Education.
 - Increasing trainers' involvement in external educational roles including:
 - Interviewing in national recruitment rounds;
 - ARCP panellists;
 - Examiners;
 - Lecturers in training courses;
 - Membership of Royal College of Psychiatry Faculty Education and Curriculum Committees;
 - Educational roles within other organisations, e.g. Lead Provider, School of Psychiatry.

V. Expanding links with T&P Department of Education and Training

The Tavistock and Portman has a longstanding national and international reputation as one of the leading institutions offering a multitude of courses at different levels to over 2,000 students and professionals working in health, education, the criminal justice system and **social care** each year. It is Britain's leading provider of multidisciplinary postgraduate training in mental health and social care. This includes courses that:

- Help maintain emotional resilience, thoughtfulness and compassion in stressful work-place environments for a broad range of professionals;
- Develop psychotherapeutic skills for professionals whose broader responsibilities may include the psychological well-being of their clients or patients ;
- Enable participants to acquire knowledge about specific topics relevant to professionals working in health, education, the criminal justice system and social care;
- Provide a recognised professional qualification, e.g. psychotherapy, social work ;
- Develop intermediate and advanced practice within specialist disciplines, e.g. systemic psychotherapy, psychodynamic psychotherapy, social work.

In 2014-2015, the Department of Education and Training has undergone significant changes in leadership and structure to ensure that its educational activities are of the highest quality and embrace modern technology and methods of delivery. During this time, the Trust has also entered into a very positive partnership with the University of Essex, and are in the process of moving our courses to their validation.

To date, medical education structures, including budgets, in the Trust have been independent from DET due to the separate and specific commissioning, regulation and quality assurance of undergraduate and post-graduate medical trainees.

We are aiming to expand links between Medical Education in the Trust and DET by:

- Enhancing liaison and communication between leaders and trainers in both DET and Medical Education
 - Having regular meetings between the DME and Dean of DET;
 - Inviting Dean and Associate Deans of DET to attend Medical Education Board meetings.
- Increasing educational opportunities within the Trust for our trainees and consultants
 - Negotiate subsidised fees for our trainees to do internal courses such as Group Relations conference;
 - Encourage our trainees to undertake further professional qualifications e.g. M1, Child Psychotherapy, Systemic Therapy;
 - Encourage our consultant body to contribute to teaching on internal courses and trainings;
 - Increase opportunities for our trainees and consultants to participate in, develop and deliver multi-disciplinary trainings.

VI. Providing a range of CPD opportunities for medically qualified professionals within and outside the Trust

As mentioned above, the Trust offers a wide range of CPD activities and courses at different levels of advancement and intensity, for professionals of different backgrounds and working in a variety of settings. We would like to attract more doctors from outside of the Trust, both within the UK and abroad, including General Practitioners and psychiatrists as well as other medically qualified consultants who have a general or specialist interest in mental health or in understanding their clinical or organisational work from a psychodynamic or systemic perspective.

We will aim to:

- Develop further CPD opportunities including:
 - An array of in-house courses and workshops;
 - Consultation and supervision for individuals or groups of doctors at any stage of their professional life;
 - Additional training opportunities, such as participating in the work of a number of specialist units;
 - A comprehensive conference programme including topics of general medical interest or aimed at specific medical groups.
- Identify a Lead (within DET or Medical Education) for the co-ordination of visiting doctors' placements within the Trust.
- Increase CPD opportunities for our consultants
 - Identify CPD activities within and external to the trust relevant to their PDPs and revalidation requirements;
 - Negotiate ring-fenced funding within Trust for medical discipline CPD with an identified amount per annum (minimum £500) per consultant ;
 - Facilitate sabbaticals;

VII. Improving governance and quality assurance

We are continually developing and evidencing the governance and quality assurance of our educational activities, including developing our trainer/trainee handbook (currently in its 4th edition) and regular newsletter (both commended by the Deanery as examples of innovative

practice to be shared with others), writing new policies e.g. 'Managing the Trainee in Difficulty', ensuring mechanisms for trainee feedback from academic programmes, and establishing clear structures and lines of communication between trainees and trainers. Results of the GMC annual trainee surveys show that our Trust consistently performs exceptionally well every year compared to other trusts nationally. In 2011 we came second in the London Deanery Elisabeth Paice Awards for best PGME Team.

We will aim to improve our governance and quality assurance by:

- Consolidating Links with commissioners and lead providers
 - Regular links with UCLP and HENCEL
 - Monitor, act and report on quality indicators for medical education and training
- Acting and monitoring action plans from:
 - GMC surveys
 - Quality visit reports
 - Trainer survey
 - Trainees' feedback via Medical Education Board.
- Internal governance
 - Medical Education Board is main governance vehicle;
 - Annual reports to the Trust Medical Director and the Trust Board;
 - Educational leads to conduct quality assurance projects and cycle of improvement for Medical Education within the Trust.
- Improving communication between trainers and trainees
 - Regularly update trainer/trainee handbook to reflect continuous changes in Medical Education as well as input from trainees
 - Regularly publish Medical Education newsletters with contributions from trainers and trainees;
 - Develop forums for trainee discussion and feedback.
- Developing the infrastructure of Medical Education within the Trust
 - Establishing a dedicated and separate space for the Medical Education office, including a spare desk for trainees and allowing confidential discussions to take place;
 - Ensuring that the needs of Medical Education will be met within any new building and are incorporated into the current relocation planning;
 - Sharing facilities where appropriate with DET e.g. information and education technology.

E. Implementation

Lead responsibility for the delivery of this strategy rests with the Director of Medical Education who is accountable to the Medical Director.

As this is a live document, it will be reviewed annually and updated as appropriate in response to directives from relevant regulatory bodies, commissioners of education and training, feedback from trainees, our training programme directors and clinical and educational

supervisors, and the wider Trust community. Progress towards achieving the objectives will be monitored by the Trust Medical Education Board and an annual report taken to the Trust board.

Written by Jessica Yakeley
March 2016

Board of Directors : October 2017

Item : 16

Title : Learning from Deaths Policy

Summary:

By December 2017, the Board is required by NHS England to have approved a policy for Learning from Deaths following events in Southern Health and a review by the CQC in December 2016.

In addition to the procedures that we follow for investigating and learning from serious incidents which are documented in our Serious Incident Procedure, I propose in this policy the addition of a quarterly Learning from Deaths review panel which will include a NED and a Governor, in addition to the Medical Director, Associate Medical Director and Clinical Directorate Representatives

This report focuses on the following areas:

(delete where not applicable)

- Patient Safety
- Risk
- Quality

For : Approval

From : Dr Rob Senior, Medical Director

Learning from Deaths Policy

Version:	1
Approved by:	Executive Management Team
Date Approved:	
Lead Manager:	Associate Medical Director for Patient Safety and Clinical Risk
Responsible Director:	Medical Director
Date issued:	September 2017
Review date:	September 2019

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1. Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) is a specialist mental health trust based in north London, providing out-patient mental health services for children, young people, families and adults, as well as providing multi-disciplinary training and education. Unlike most other mental health trusts, it has no in-patient beds or psychiatric wards. The Trust does not provide physical health care in hospital or community settings.

2. Background

New requirements:

In December 2016 the Care Quality Commission published *A review of the way NHS trusts review and investigate the deaths of patients in England*.

<https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf>

Subsequently in March 2017 the National Quality Board published guidance based on the recommendations from the CQC

report <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf> National Guidance on Learning from Deaths.

All trusts in England are now required to:

1. Publish an updated policy by September 2017 on how their organisation responds to and learns from deaths of patients who die under their management and care, including:
 - How their processes respond to the death of an individual with a learning disability, severe mental illness, an infant or child

death, a stillbirth or a maternal death.

- Their evidence-based approach to undertaking case record reviews.
- The categories and selection of deaths in scope for case record review (and how the organisation will determine whether a full investigation is needed).
- How the trust engages with bereaved families and carers, including how the trust supports them and involves them in investigations.
- How staff affected by the deaths of patients will be supported by the trust.

2. Collect specific information every quarter on:

- The total number of inpatient deaths in an organisation's care.
- The number of deaths the trust has subjected to case record review. (desktop review of case notes using a structured method)
- The number of deaths investigated under the serious incident framework (and declared as serious incidents).
- Of those deaths subject to case record review or investigated, estimates of how many deaths were more likely than not to be due to problems in care.
- The themes and issues identified from review and investigation, including examples of good practice.
- How the findings from reviews and investigations have been used to inform and support quality improvement activity and any other actions taken and progress in implementation.

3. Publish this information on a quarterly basis from December 2017 by taking a paper to public board meetings.

Further Developments:

The National Guidance on Learning from Deaths (2017) has advised that during 2017–18, there will be a number of further developments including that:

- The Care Quality Commission will strengthen its assessment of provider's learning from deaths including the management and processes to review and investigate deaths and engage families and carers in relation to these processes.
- NHS England, led by the Chief Nursing Officer, will develop guidance for bereaved families and carers. This will support standards already set for local services within the Duty of Candour and the Serious Incident Framework and cover how families should be engaged in investigations.
- Health Education England will review training of doctors and nurses

on engaging with bereaved families and carers.

- In addition, The Department of Health is exploring proposals to improve the way complaints involving serious incidents are handled particularly how providers and the wider care system may better capture necessary learning from these incidents

The National Guidance on Learning from Deaths (2017) gives specific details for recording processes relating to certain types of death for which review is mandated:

- People with learning disabilities: refer to Annex D of the *National Guidance on Learning from Deaths*; all deaths to be reported to the Learning Disabilities Mortality Review (LeDeR) programme.
- Mental health: refer to Annex E of the *National Guidance on Learning from Deaths*; under regulations, mental health providers are required to ensure that any death of a patient detained under the Mental Health Act is reported to the Care Quality Commission without delay.
- Children and young people: refer to Annex F of the *National Guidance on Learning from Deaths*.
- Maternity: refer to Annex G of the *National Guidance on Learning from Deaths*.

3. Scope

This policy sets out the Trust approach to meeting these requirements in the context of providing outpatient only services. The Trust Board is to be assured that all patient deaths in the Trust are reviewed and that changes are made in response to the lessons learned.

This policy applies to all clinical staff.

4. Purpose

The Trust will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of the Trust.

It describes how the Trust will support people who have been bereaved by a death at the Trust, and also how those people should expect to be

informed about and involved in any further action taken to review and/or investigate the death.

It also describes how the Trust supports staff who may be affected by the death of someone in the Trust's care. It sets out how the Trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

The aim of this process is to identify any areas of practice that could potentially be improved and to further support areas of good practice.

5. Roles and responsibilities

This section describes the specific responsibilities of key individuals and of relevant committees under this policy. Roles and responsibilities for incident management, complaints handling and serious incident management are detailed in associated policies and procedures.

5.1 Board of Directors

The Board is required to ensure that the Trust has a board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda. The National Guidance on Learning from Deaths (March 2017) outlines in Annex A that an executive director and in Annex B that a non-executive director will provide oversight of progress of implementing the Learning from Deaths agenda.

Non-executive director responsibilities relating to the framework include:

- Ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny.
- Championing quality improvement that leads to actions that improve patient safety.
- Assuring that published information fairly and accurately reflects the organisation's approach, achievements and challenges (refer to Annex B of the *National Guidance on Learning from Deaths*).

5.2 Chief Executive

The Chief Executive Officer has overall responsibility for patient safety and

for ensuring that the appropriate policies, procedures and guidelines are in place to reduce risk and safeguard patients.

5.3 Medical Director

The Medical Director has overall responsibility for this procedure in role as lead for clinical risk. The Medical Director will oversee the Learning from Deaths Review Panel which will meet quarterly to review any patient deaths and

ensure that processes for responding to a patient death are complied with in full.

5.4 Associate Medical Director – Patient Safety and Clinical Risk

The Associate Medical Director will ensure that all unexpected patients deaths are externally reported and investigated according to the Trust Procedure for the Investigation of Serious Incidents and also ensure that lessons learned are disseminated across all Trust services.

5.5 Service Leads / Managers are responsible for:

- ensuring that relevant individuals have been notified in person or by phone where a serious incident has been identified and an incident form has been subsequently completed
- ensuring that staff and patients receive adequate support (section 8). Advice should be sought from the Director of HR and/or head of discipline or Medical Director in the event that a member of staff is not fit to work after an adverse event or during an investigation
- undertaking an initial fact finding investigation
- ensuring that if confirmed as a serious incident that staff are aware an investigation will be conducted and understand what that process entails.
- ensuring that the Clinical Director and Associate Clinical Director are informed about any serious incident and involved, where appropriate, in the development of action plans emerging from investigations.

5.6 Clinical Directors

Clinical Directors are responsible for ensuring that the tasks of the service lead/managers are completed and that action plans with

implications for the Directorate as a whole are implemented and lessons learnt. The Clinical Directors together with the Medical Director will ensure that action plans of relevance to the whole Trust are implemented including an annual review meeting for staff of lessons learnt from serious incidents.

6. Definitions – The National Guidance on Learning from Deaths (March 2017)

The *National Guidance on Learning from Deaths* (March 2017) includes a number of terms and for the purpose of clarity these are defined below but not all will apply to this Trust.

Death certification

The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

As the Tavistock and Portman does not provided in patients services death certification does not occur.

Case record review

A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review

A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Serious Incident

Serious Incidents in healthcare are adverse events, where the

consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread

public concern resulting in a loss of confidence in healthcare services.

See the [Serious Incident framework](#) for further information.¹

Investigation

A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

Death due to a problem in care

A death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as ‘cause of death’). The term ‘avoidable mortality’ should not be used, as this has a specific meaning in public health that is distinct from ‘death due to problems in care’.

Quality improvement

A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.






Patient safety incident

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

- ¹ <https://improvement.nhs.uk/resources/serious-incident-framework/>

7. Associated Trust Policy Documents

This policy should be read in conjunction with the following associated documents, all available on the Trust intranet/internet.

- Procedure for the Investigation of Serious Incidents 
Serious Incident Procedure September 2017
- Prevention of Suicide Policy 
procedure-prevention-suicide.pdf
- Management of Self-harm Procedure 
procedure-self-harm-assessment-management.pdf
- Clinical Risk Assessment Procedure 
procedure-clinical-risk-assessment.pdf
- Procedure for Rapid Transfer of an Acutely Unwell Patient 
Rapid_Transfer_Procedure_Dec_16.pdf

8. Skills and Training

In order to support the implementation of this policy the Trust will review the skills and training of clinical staff particularly in relation to investigation methodologies.

9. Reporting

As set out by The *National Guidance on Learning from Deaths (March 2017)*, Trusts are required to publish information on deaths on a quarterly basis. As this Trust does not provide in patient care the data published will report on all unexpected patient deaths. Every death will have been investigated under the Trust Procedure for the Investigation of Serious Incidents using

root cause analysis methodology. Also, as required by the National Guidance on Learning from Deaths (March 2017) the Trust will provide information on how many deaths were judged more likely than not to have been due to problems in care. Reports to the Trust Board will include evidence of learning and actions taken as well as an assessment of the impact of these actions.

10. The process of responding to deaths of patients in our care

Summary

- All unexpected patient deaths at the Trust are investigated under the Trust Procedure for the Investigation of Serious Incidents and an investigation team is appointed by the Medical Director.
- The Trust's contractual Duty of Candour obligations will be fulfilled with careful consideration of the needs of family members when suicide is the suspected cause of death (see section 12. Supporting and involving families and carers)
- The Trust ensures that the deceased person's GP is informed of the death. This is undertaken by the relevant service director.
- The death is reported to other organisations who may have an interest.
- The Trust works jointly with other health care providers to review the care provided to people who are current or past patients but who were not under the Trust's direct care at time of death.
- Clinicians who have been involved in the patient's care are offered support from their line manager/team colleagues. They can also access more formal support through the Staff Consultant Service.

Responding to the death of a patient with a Learning Disability

The death of a patient with a learning disability should be reported through the Learning Disabilities Mortality Review Programme (LeDeR). <https://upload.leder.ac.uk/leder-notify/leder-notification.html>

11. Case notes review

Under the Trust Serious Incident Procedure the case notes of a patient who

has died will be reviewed by the appointed investigators. The methodology used for serious incident investigation including deaths is Root Cause Analysis. The Trust will review the relevance and suitability of alternative methodologies such as that being developed by NHS Improvement and The Royal College of Psychiatrists for reviewing the care of those who die with severe mental illness.

12. Supporting and involving families and carers

All unexpected patient deaths in the Trust are investigated under the Serious Incident Procedure. Following the death of a patient, the family of the deceased is contacted and offered support. This offer is followed up at various time points within the coming weeks/months. Specifically, families and carers are offered an opportunity to talk about the death and care in the time leading up to the death, and to raise concerns about any aspects of the person's care (verbal and written). The family is informed of the process of the investigation including their involvement should they wish and advised that they can have a copy of the investigation report. Feedback from families and carers will be shared at lessons learned events and at the Learning from Deaths Review Panel.

13. The Learning from Deaths Review Panel

This panel meets quarterly. It is chaired by the Medical Director. The membership includes the Associate Medical Director, Director of Quality and Patient Experience, a non –executive director with responsibilities relating to the Learning from Deaths framework and a member of the Council of Governors.

14. Board of Directors

The Board of Directors is accountable for ensuring the Trust has robust mechanisms in place to promote and facilitate learning from incidents and reduce risk of harm.

The Medical Director, as chair of the Clinical Quality Safety and Governance Committee will provide the Board with an anonymised summary of serious incident investigations, the lessons learnt and the resulting action plan in Part 1 of the Board. Incidents requiring investigation but not yet completed will be raised in Part 2 of the Board.

15. Clinical Quality Safety Governance (CQSG) Committee

The CQSGC has delegated responsibility to lead on clinical and corporate governance, clinical quality and safety and to provide assurance to the Board of Directors that clinical quality, safety and governance are being managed to high standards. It is chaired by the Medical Director. Reports are received from a number of leads of work streams managing the collection of evidence to provide assurance.

The lead for the Patient Safety Clinical Risk work stream provides assurance to CQSGC that the Trust has followed its processes for serious incident investigation, whilst being open with patients and relatives and supporting staff directly involved, and that action plans have been implemented and lessons learnt for completed investigations. Completed SI investigation reports will be received by the committee.

16. Patient Safety Clinical Risk (PSCR) Work stream

The PSCR work stream is chaired by the Associate Medical Director who is responsible for monitoring the Trust's management of patient safety and clinical risk across all clinical areas of the Trust. Serious incident investigations will be reviewed along with the implementation of action plans and sharing lessons to be learned. Compliance will be monitored by way of analysis of all reported serious incidents. Learning from such incidents will inform further review of this policy.

17. Process for monitoring compliance with this policy.

Compliance will be monitored by way of analysis of all reported serious incidents. Learning from such incidents will inform further review of this policy.

18. Equality Impact Assessment

The impact of this policy on staff, potential or prospective staff of the Trust, service users and the wider community has been fully assessed with neutral impacts identified.

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 31st October 2017, 2.00 – 4.30pm
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.9
4.	Matters arising Prof Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS				
5.	Service User Story Portman Clinic	To note	Video	-
6.	Service Line Report: Portman Dr Jessica Yakeley, Director of Portman	To discuss	Enc.	p.10
7.	Trust Chair's and NED's Reports Prof Paul Burstow, Trust Chair	To note	Verbal	-
8.	Organisational Objectives Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.17
9.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.22
10.	Finance & Performance Report Mr Terry Noys, Deputy CEO and Finance Director	To note	Enc.	p.25
11.	In Year Reforecasting Mr Terry Noys, Deputy CEO and Finance Director	To note	Enc.	p.31

12.	Organisation Development & People Strategy Report Mr Craig deSousa, Director of Human Resources	To discuss	Enc.	P-33
13.	Quality a. Quarterly Quality Dashboard & Commentary (including Performance Benchmark & KPIs) Report Ms Louise Lyon, Director of Quality & Patient Experience and Ms Marion Shipman, Associate Director Quality & Governance b. Waiting Times Quarterly Report Ms Louise Lyon, Director of Quality & Patient Experience c. IM&T Quarterly Report Mr David Wyndham-Lewis, Director of Transformation & Technology		Enc. Enc. Enc.	P-43 P-61 P-86
14.	Training and Education Report Mr Brian Rock, Director of E&T/ Dean	To note	To follow	
15.	Medical Education Strategy Dr Rob Senior, Medical Director	To discuss	Enc.	P-91
16.	Learning from Deaths Policy Dr Rob Senior, Medical Director	To discuss	Enc.	P-104
CLOSE				
17.	Notice of Future Meetings: <ul style="list-style-type: none">28th November, Board of Directors' Meeting, 2.00 – 5.00pm, Lecture Theatre5th December, Leadership Group Conference, 2.00 – 5.00pm, Lecture Theatre7th December, Council of Governors' Meeting, 2.00 – 5.00pm, Lecture Theatre			