

Board of Directors Part One

Agenda and papers

of a meeting to be held in public

2.00pm–4.30pm
Tuesday 27th June 2017

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

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 27th June 2017, 2.00 – 5.00pm
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES				
1.	Chair's Opening Remarks Prof Paul Burstow, Trust Chair		Verbal	-
2.	Apologies for absence and declarations of interest Prof Paul Burstow, Trust Chair	To note	Verbal	-
3.	Minutes of the previous meeting Prof Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	Outstanding Actions Prof Paul Burstow, Trust Chair	To note	Enc.	p.7
4.	Matters arising Prof Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS				
5.	Service User Story Mr E Henry - D55 Student	To note	Verbal	-
6.	Service Line Report: DET Social Care, Leadership & Management Mr Paul Dugmore, Portfolio Manager, Social Care, Leadership and Management	To discuss	Enc.	p.8
7.	Trust Chair's and NED's Reports Prof Paul Burstow, Trust Chair	To note	Verbal	-
8.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.22
9.	Finance and Performance Report Mr Terry Noys, Deputy CEO and Finance Director	To note	Enc.	p.31
10.	Training and Education Report Mr Brian Rock, Director of E&T/ Dean	To note	Enc.	p.37
11.	Objectives for the Board Mr Paul Jenkins, Chief Executive	To approve	Enc.	p.44
12.	Safeguarding Annual Report Dr Rob Senior, Medical Director	To approve	Enc.	p.53
13.	Complaints at GIC Ms Amanda Hawke, Complaints Manager	To note	Enc.	p.66

14.	Reference Costing Exercise Mr Terry Noys, Deputy CEO and Finance Director	To approve	Enc.	p.71
15.	Audit Committee Terms of Reference Mr Terry Noys, Deputy CEO and Finance Director	To approve	Enc.	p.82
16.	Outline Business Case for Trust wide Scheduling Mr David Wyndham-Lewis, Director of IM&T	To approve	Enc.	p.90
CLOSE				
17.	Notice of Future Meetings: <ul style="list-style-type: none"> • 25th July, Board of Directors' Meeting, 2.00-5.00pm, Board Room • 12th September, Directors' Conference, 2.00 – 5.00pm, Lecture Theatre • 26th September, Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre • 10th October, Joint Boards Meeting, 2.00 – 5.00pm, Lecture Theatre • 31st October, Board of Directors' Meeting, 2.00 – 5.00pm, Lecture Theatre 			

Board of Directors Meeting Minutes (Part One)
Tuesday 23rd May 2017, 2.00 – 4.00pm

Present:			
Prof. Paul Burstow Trust Chair	Dr Chris Caldwell Nursing Director	Ms Helen Farrow NED	Dr Sally Hodges Director of CYAF
Mr David Holt NED, SID, Audit Chair	Mr Paul Jenkins Chief Executive	Ms Louise Lyon Director of Q&PE	Ms Edna Murphy NED, Deputy Chair
Mr Terry Noys Deputy CEO and FD	Mr Brian Rock Director of E&T/ Dean	Dr Rob Senior Medical Director	Dr Julian Stern, Director of AFS
Attendees:			
Ms Sarah Anderson, Interim Trust Secretary (minutes)	Ms Paula Carmichael, Director GIDS(item 6)	Ms Fiona Hartnett, Dean's Office Manager (item 17)	Mr Craig de Sousa, HR Director (item 16)
Ms Marion Shipman, Associate Director of Quality (item 9c)			
Apologies:			
Prof. Dinesh Bhugra NED	Ms Jane Gizbert NED		

Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to the April minutes	SA	Immd.
2	6	Review the approaches for other providers in training new staff in the gender identity service	SH	
3	6	Update the Board on GIDS waiting times and activity, include a trajectory for when the waiting times will be within the target	SH	
4	9	Undertake an audit of the quality data	LL (Quality Team)	November
5	9	Include in the June Chief Executive's Report an action plan to address issues arising from the Quality Report	PJ/LL	June
6	11	Identify when the planning permission for a temporary building housing the FNP wing needs to be renewed	TN	June
7	12	Provide a schedule of courses on offer and student numbers	BR	June
8	15	Allocation of tasks and priorities to the Non-Executive Directors to include leads for Unexpected deaths and Quality	PB	July
9	16	Confirm when the target for mandatory training with regard to clinical risk will be met.	RS	June

1. Chair's Opening Remarks

Prior to the commencement of the business of the Board Prof. Burstow requested a minute's silence in memory of those affected by the terrorism incident the previous night in Manchester.

Prof. Burstow welcomed the directors to the meeting.

2. Apologies for Absence and declarations of interest

Apologies as above.

No further declarations of interest were made.

3. Minutes of the Previous Meeting

AP1 The minutes were approved with minor amendments

4. Matters Arising

Action points from previous meetings were noted.

5. Patient Story

There was no patient story received at the meeting as the service had been unable to find a young person to attend as it is exam season.

6. Service Line Report: GIDS

Ms Carmichael presented the report and highlighted the challenges experienced by the service around the increase in referrals by 42% in the last year. She noted that, although staff numbers had been increased in response, this had an impact on experienced staff who needed to induct and train new staff, as no specialist training is available.

It is challenging to provide support to young people and their families in Gender Dysphoria where there is diverging evidence of support and treatments available. The Trust is active in research and is a high profile provider nationally.

Ms Carmichael highlighted the impact of a private provider on the service and the challenges in taking on these patients, given that some of their treatment to date has been outside of the protocols in place and the associated safeguarding implications for the young people.

Ms Farrow expressed concern for the mental health of patients who do not need surgery. Ms Carmichael outlined how this is dealt with in the Trust.

Mr Holt queried how young people are managed whilst they are waiting to be seen. Ms Carmichael responded that the Trust is considering group first appointments to see people more quickly.

Ms Murphy queried how the administration is managed given the growth of the service. Ms Carmichael replied that the team is currently at full complement.

Mr Noys asked whether there was any scope for the service to offer a private patient service as this would provide an income stream for the Trust. Ms Hodges and Dr Senior noted the challenges in supervision and that some staff already provide some services privately.

AP2 Ms Caldwell and Mr Rock queried whether training could be provided off the job. Ms Carmichael felt it is a highly specialised area and each case has subtle differences to be

considered therefore all training needed to be on the job. Approaches by other providers will be reviewed. It was noted that GIDS is a popular and attractive work area for nursing staff.

AP3

Prof. Burstow asked when the waiting times would be back within target. Ms Carmichael noted that some patients became eligible for and therefore moved across into the Adult Service whilst waiting and that the Trust ensures that their wait time does not revert to zero. The Board is to receive a review of waiting times and activity.

The Board **noted** the developments that had been achieved in the service in a short time and **noted** the report.

7. Trust Chair's and NEDs' Reports

Prof. Burstow reported that he had had a useful meeting with Lord Richard Layard about child mental health in school and how as a result a visit to a Camden school is being arranged.

Ms Hodges reported a meeting about training with Prof. Tim Kendall, NHS England's National Director for Mental Health.

Ms Farrow had visited Camden's Looked After Children Team, who had reported challenges with working across different IT systems.

Prof. Burstow reported that he had to undertake NED Appointment on that one of the personal objectives for all Non-Executive Directors will be to undertake visits in 2017/18.

The Board **noted** the reports.

8. Chief Executive's Report

Mr Jenkins reported that the Trust had not been affected by the recent cyber-attack. The relevant patches that prohibited the distribution of this attack were deployed to Trust devices immediately following their release by Microsoft in March, therefore the risk of infection of the Trust estate was minimised. In addition the ICT team worked through the weekend actively monitoring the network to ensure no attempted infections were successful.

The Trust had organised a well-attended national stakeholder roundtable on student services and young people.

Mr Jenkins reported that the TV series Kids on the Edge had not won a BAFTA. Ms Murphy reflected that the Trust had been nervous about getting involved in such a project but that it had been a positive experience.

The Board **noted** the report.

9. Annual Report and Accounts

Ms Anderson introduced the Annual Report which had been prepared in line with NHS Improvement guidance. She noted that the Audit Committee had reviewed the draft at its meeting on 16th May and that further formatting and minor amendments had taken place since the Board pack had been distributed. She requested that any further drafting issues be addressed outside of the meeting.

Mr Noys introduced the Annual Accounts which had been subject to audit by Deloitte and reviewed by the Audit Committee on 16 May 2017. He noted that the accounts have been prepared on a going concern basis. He highlighted that the property assets of the Trust were revalued which resulted in a reduction in value of £2.2m, to £17.6m and that the bad debt provision has been slightly reduced to £306k and represents 8.4% of total debt. The result for the year is a surplus of £1,676k, of which £1,309k is STF funding. The Trust, therefore, met both its Budget and Control Total. Excluding STF funding, however, EBITDA declined slightly to £2,150k (compared with £2,345k in 2015/16).

Mr Holt highlighted the borderline nature of the 'adequate' Head of Internal Audit Opinion, and the adverse trajectory since last year. This would require careful engagement and delivery by the management team over the coming year to prevent further slippage.

Deloitte had raised two adjustments which are included in the letter of representation and which were not adjusted for in the accounts. The first is for £50,000 which relates to monies the Trust received to build the 'Oasis'. The Trust had taken these monies to reserves in a prior year, however, in order to ensure that the cost of building the Oasis were properly recognised, a provision had made in the 2016/17 accounts to cover the costs expected to be incurred in 2017/18. The second adjustment was an estimate made by Deloitte of the level of accruals made in 2016/17 which they believed might be excessive- this was for an amount of £217k. Both items, if adjusted for, would have increased the surplus recorded by the Trust.

Ms Shipman presented the Quality Report and outlined how this is prepared. She outlined the difficulty of identifying indicators that can be audited, as electronic records need to be supported by paper input records, for example. Ms Murphy sought clarification on the alterations made to waiting times, which Ms Shipman explained related to clock stops. Mr Holt highlighted some concerns on data quality raised by Internal Audit.

- AP4** Mr Jenkins suggested that the Quality Team undertake an audit of the data in the Autumn to provide some assurance to the Board that the data is being correctly recorded and will not be
- AP5** of concern to the auditors next year. In addition, the June Chief Executive's Report will include an action plan to address issues arising from the Quality Report.

The Board **noted** the draft independent auditor's report.

The Board **approved** the Annual Report, Annual Accounts, Quality Report and Letter of Representation.

10. Annual Self Certifications

Ms Anderson presented the report and noted the change in requirements for this year. She highlighted that she had provided some additional narrative on the license conditions to provide the Board with more assurance prior to confirming the certifications required.

Prof. Burstow confirmed that the Fit and Proper Person Requirements are working as outlined.

The Board **approved** the self-certifications.

11. Finance and Performance Report

Mr Noys presented the report and noted that the Trust is currently ahead of budget.

AP6 Mr Noys noted that the FNP wing only has temporary planning permission and that the Trust needs to apply for a renewal of planning permission on this temporary building.

The Board **noted** the report.

12. Training and Education Report

AP7 Mr Rock presented the report. He highlighted the difficulty in recruiting an Associate Director to lead the National Workforce Skills Development Unit. In addition, courses required by students are being considered along with ways to increase provision of these programmes. Mr Rock offered to bring a schedule of proposed courses to the next Board meeting.

The Board **noted** the report.

13. CQSG Report Q4

Dr Senior took the draft minutes as read and invited comments.

Prof. Burstow queried the serious incident report on the agenda that had been discussed in detail in CQSG. Dr Senior stated that the Trust is trying to get the process of reporting to the Board right making it more transparent whilst preserving the identity and dignity of the individual and their family.

Mr Holt asked whether the trajectory on addressing information governance issues was slipping. Ms Lyon said it was not and noted that recording the item as amber and then stating it was red was an accuracy issue to be corrected at the next CQSG meeting.

Dr Senior suggested that a review of dashboards and reporting should be included in the committee review currently being undertaken.

The Board **noted** the report.

14. CQSG Annual Report 2016/17

Dr Senior introduced the report and noted that the work undertaken at CQSG was evolving and that the contribution from the governors on the Group was invaluable.

Prof. Burstow queried when the report on incidents at Gloucester House was coming to Board. Dr Senior confirmed that this would be September and provided assurance that there had been fewer incidents at the start of the Summer term than previous terms.

Prof. Burstow asked if GIC had its own risk register. Ms Hodges confirmed that it did.

The Board **noted** the report.

15. Serious Incident Report

Dr Senior presented the report which seeks to brief the Board on the issue that had already been considered by the CQSG.

Ms Murphy noted that the roles and responsibilities of people on honorary contracts is sometimes unclear leaving them in a vulnerable position.

AP8 Dr Senior requested the reviews of unexpected deaths and other issues have a designated Non-Executive Director. This requirement has arisen from investigations into issues at Southern

Health NHS Foundation Trust. Prof. Burstow said that this issue would be picked up when Board Committee places and areas were allocated later in the year.

The Board **noted** the report.

16. Staff Survey and HR Organisational Development Annual Report

Mr de Sousa presented the report. The Trust has invested in leadership development in the last year and the first cohort completed their course the previous week. The report also includes the action plan from the staff survey. This and other actions have been included in the People Strategy.

Prof. Burstow asked what is being offered to middle management. Mr de Sousa confirmed that the Trust is developing skills for clinicians moving into management.

Mr Jenkins acknowledged that Mr de Sousa has been in post for a year and made a real impact.

Prof. Burstow queried plans to deliver mandatory training with regard to clinical risk. Dr Senior confirmed that staff receive this at induction and in teams. He will confirm when this target will be met.

AP9

The Board **noted** the report.

17. T&E Complaints Report

This item was taken after item 12.

Ms Hartnett presented the report and highlighted that the Trust is now registered to manage all complaints internally without requiring the support of university partners. Processes have been reviewed and the form completed by students includes the expected outcome. All complaints are considered to be informal unless the issue is serious, as judged by the person receiving the complaint.

Dr Stern asked whether there was any specific course that was the subject of complaints. Ms Hartnett confirmed that there was no pattern.

Mr Jenkins noted that training and education complaints are often more difficult to resolve than clinical complaints as there is an expectation of financial redress as the course has been carefully selected by the student and paid for.

The Board **noted** the report.

18. Any Other Business

The Board noted its future meetings.

Part one of the meeting closed at 4.30pm

Action Point No.	Originating Meeting	Action Required	Director / Manager	Due Date	Progress Update / Comment
1	Jan-17	Develop Race Equality Strategy	Louise Lyon	Apr-17	Due May , revised to June
2	Mar-17	Arrange annual event for interactive discussion of Serious Incident cases to share learning amongst all clinicians	Rob Senior	Sep-17	
3	Mar-17	Audit cases similar to BB to check closure procedures followed.	Sally Hodges/ Rob Senior	Jun-17	
3	Apr-17	Update on complaints at the GIC in June	Amanda Hawke	Jun-17	
4	Apr-17	A report on the increase in incidents at Gloucester House to be provided	Amanda Hawke	Sep-17	
5	Apr-17	An update on the fall in recording of outcome measures to be included in the Chief Executive's report	Paul Jenkins	Jun-17	
6	Apr-17	An update on the delivery of the IM&T Strategy is to be provided to the July Board	David Wyndham-Lewis	Jul-17	
2	May-17	Review the approaches for other providers in training new staff in the gender identity service	Sally Hodges		
3	May-17	Update the Board on GIDS waiting times and activity, include a trajectory for when the waiting times will be within the target	Sally Hodges		
4	May-17	Undertake an audit of the quality data	Louise Lyon	Nov-17	
5	May-17	Include in the June Chief Executive's Report an action plan to address issues arising from the Quality Report	Paul Jenkins/Louise Lyon	Jun-17	
6	May-17	Identify when the planning permission for a temporary building housing the FNP wing needs to be renewed	Terry Noys	Jun-17	
7	May-17	Provide a schedule of courses on offer and student numbers	Brian Rock	Jun-17	
8	May-17	Allocation of tasks and priorities to the Non-Executive Directors to include leads for Unexpected deaths and Quality	Paul Burstow	Jul-17	
9	May-17	Confirm when the target for mandatory training with regard to clinical risk will be met.	Rob Senior	Jun-17	

Board of Directors : June 2017

Item : 06

Title : SLR –Social Care, Leadership & Management Portfolio
Report

Purpose:

The purpose of this report is to provide the Board of Directors with progress on the Social Care, Leadership and Management portfolio within the Directorate of Education and Training (DET); its activity and identified contribution towards DET's 5 Year Ambitions and 2 Year Strategic Objectives.

This report has been reviewed by the following Committees:

- Executive Management Committee

For : Discussion

From : Paul Dugmore, Portfolio Manager, Social Care, Leadership and Management

Update
Department of Education and Training
Executive Summary

1. Introduction

- 1.1 This is the second report for the Board, following the last report in March 2016.
- 1.2 The Social Care, Leadership and Management Portfolio delivers a number of postgraduate courses which were successfully validated by the University of Essex in the previous academic year and one Master's programme jointly delivered in partnership with the University of East London. Additionally, the portfolio delivers an expanding range of more than 20 CPD courses, events/conferences as well as bespoke courses for commissioning/provider organisations. In addition to the portfolio manager, there are four Course Leads, five other permanent members of staff and over 40 visiting lecturers. Part of the portfolio includes staff from Tavistock Consulting.

2. Areas of Risk and Concern

- 2.1 As HEE continues to exercise scrutiny of the Trust's use of the national training contract, work to align courses to HEE priorities and demonstrate value to health professionals is in progress, such as creating a webpage for the MA in Consulting and Leading in Organisations specifically for health staff. The portfolio needs to continue to engage more widely and effectively with the social work and social care sector. The continued financial squeeze on local government and its direct impact on training and development budgets means that less prospective students are able to access employer contributions to fees and in some cases, agreed time

- away from employment to undertake training. To mitigate this we have redesigned some long course provision so it is more accessible. There is an extended meeting of the portfolio staff team in July where we will be thinking further about how to address the issue of reduced employer support of social work staff attending long courses, including establishing better links with the social work team at the University of Essex and developing more trainings for bespoke delivery.
- 2.2 There is an ongoing discussion with UEL regarding the contribution of fees for the shared programme, which will be the subject of a review of the input of Trust resources into this programme and more widely into the future of the partnership and potential opportunities for growth.
- 2.3 One of the challenges within the portfolio is the issue of capacity to deliver existing provision whilst being able to respond to tenders, often at short notice and lead new developments.

Main Report

3. Overview of the Portfolio

- 3.1 Over the past 12 months, the Portfolio's academic programmes have all received successful validation from the University of Essex. Currently this includes:

PGCert/Dip/MA in Consulting and Leading in Organisations: psychodynamic and systemic approaches;
Professional Doctorate in Consultation and the Organisation;
Professional Doctorate in Social Work and Social Care;
MA in Safeguarding, Risk and Relational Practice in Social Work and Integrated Care.

It also includes UEL validated courses on teach out:

PG Cert/Dip/MA in Social Work and Emotional Wellbeing (D60M)

PG Cert/Dip/MA in Social Care and Emotional Wellbeing (D50M)

Professional Doctorate in Social Work and Emotional Wellbeing (D60)

Professional Doctorate in Social Care and Emotional Wellbeing (D50M)

PG Dip/MA in Leadership and Management (M26)

MA in Social Work (M23) – a UEL/Tavistock joint programme which continues to recruit and run.

3.2 The qualifying MA in Social Work (M23) and the new Best Interests Assessor course are regulated and approved/accredited by the Health and Care Professions Council and the Department of Health respectively. Most courses are delivered across London and the South East either at the Tavistock Centre or in employer locations. We continue to explore the viability of delivery in other geographical regions in our Associate and Alternative Delivery sites, such as the Northern School of Child & Adolescent Psychotherapy (NSCAP) and Gloucester.

3.3 The portfolio has been subject to the changes brought about by changes to the HEE national training contract. The review has involved all courses to reduce costs by better balancing the mix of staff and visiting lecturer input, ensuring the size of student classes is the maximum they can be without adversely affecting the quality of the student experience and by introducing a reduced offer to doctoral supervision. The impact of this change is causing some anxiety, as employed teaching staff have to take on increased workload to manage the reduction in visiting lecturers.

- 3.4 Significant work is being undertaken with the course lead of the MA in Consulting and Leading in Organisations to ensure that all possibilities for growth in relation to this successful course can be realised. This includes consideration of delivery in the north of England at an associate centre such as the Northern School; developing a shorter version of the MA for health specific staff; developing an online/blended version of the MA and more focused marketing and recruitment to sector specific professionals.
- 3.5 Earlier this academic year the Portfolio recruited to the vacant post of Senior Clinical Lecturer to teach on the newly validated social work and social care doctorate, which has now been integrated with three other doctoral programmes. This has enabled better use of teaching resources with all students taught together for research methods modules and we have been able to market the multi-disciplinary nature of the doctorate. Across the two doctorates in the Social Care, Leadership and Management portfolio, recruitment to the doctoral programmes exceeded twenty students in the current academic year. Proposed research of doctoral students includes:
- Research into underlying stories that account for variable doctoral completion rates;*
- Research into how reflective practice works;*
- Taken on Trust? How can a systems psychodynamic intervention support and develop people working in a Foundation Trust in the English National Health Service;*
- A systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery.*

The doctoral team is also looking at providing dedicated support for BAME doctoral researchers given the profile of students on the course.

3.6 Staff within the portfolio continue to adjust to the significant change within DET compounded by the departure of the Course Administrator and the appointment of a new person to this role. The Student Information Management System (MyTap) has been introduced for recruitment and I am pleased with how staff have engaged with this.

4 Overall vision and strategy

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

- Increase intake of Y1 student numbers to 700 for 2017/8 Academic Year

Last year, the portfolio contributed to this objective by exceeding course targets in relation to Y1 student numbers across all validated programmes within the portfolio with the exception of the MA in Safeguarding and Risk, which was only validated just before the summer:

MA Social Work (qualifying) recruitment has increased from 27 last year to 42 (+55%).

MA Leading and Consulting in Organisations has increased from 27 to 36 (+33%).

Professional Doctorate in Social Work and Social Care has increased from 7 to 13 (+86%).

Professional Doctorate in Consultation and the Organisation has increased from 3 to 6 (+100%) with a further 6 undertaking the professional component of the doctorate with the option of continuing with the research on completion.

- 4.2 The current recruitment pipeline suggests that we are on track to meet targets for the Social Work qualifying MA with over 50 offers made. There have been 4 applications for the Social Work and Social Care Doctorate and there is no reason to suggest we will not meet the target compared to applications this time last year. There have been 2 applications for the Consultation and the Organisation Doctorate with significant prospective interest which should equate to the target being met. The MA in Consulting and Leading in Organisations has received 25 applications to date with a further open day and interviews planned for later in June. The only course which is vulnerable to not meeting the target is the MA in Safeguarding, Risk and Relational Practice. To mitigate this risk, the course is now being advertised as a postgraduate certificate being delivered over half a day for two terms. There have been two applications to date and targeted marketing is being undertaken with the hope of reaching the target by September.
- 4.3 We have developed a new Best Interests Assessor course for professionals who wish to qualify under the Deprivation of Liberty Safeguards within the Mental Capacity Act. Having been approved by the Department of Health this has successfully recruited two cohorts of students with a third planned for early next year.
- Diversification of impact and income streams
- 4.4 We have further broadened our reach to a wider section of the social care workforce with a range of short CPD courses running in relation to mental capacity and adult safeguarding. Over the past year the sector skills council, Skills for Care, has endorsed

7

the Trust as a training provider. We have been exploring options for the Trust to become a training provider for apprenticeships in health and social care and have sought entry onto the Register of Providers should we decide this is an area we wish to develop. We are in discussion with a range of statutory, voluntary and private sector organisations to establish need and where we might be able to develop and deliver relevant apprenticeship training as well as with FE colleges with whom we may wish to partner.

Over the course of the academic year, there have been over 50 short courses within the portfolio with a projected income of £171,000.

4.5 Over the past year there has been significant increased activity in the portfolio around bid developments as outlined in section 6.

- Increase the national reach of our training and education offer through greater regional presence.

As mentioned, we have met with the Director of NSCAP with a view to extending our Leadership and Management programmes to the North. We are currently engaged with Yorkshire and the Humber NHS Education and Training Leads Network to establish viability for such development.

5. **Progress to date and current position**

In this academic year there are 205 students enrolled on validated Trust-based courses within the portfolio.

Feedback from last year's student survey on courses across the portfolio showed:

Staff are enthusiastic about what they are teaching: 100%
I am happy with the support for my learning I receive from (teaching) staff on my course: 89%
Teaching staff are good at explaining things: 96%
There is sufficient contact time to support my learning: 92%
The course is intellectually stimulating: 95%
The course has enhanced my academic ability: 93%
The learning materials provided on my course are useful: 96%
I have been able to apply my learning on the course to my job: 90%
Attending the course has improved my approach to my job: 95%
As a result of the course I feel better prepared for my future career: 88%

In terms of the doctoral programmes feedback included:

My academic supervisor/s have the skills and subject knowledge to support my research: 87%
I have regular contact with my academic supervisor/s, which is appropriate for my needs: 84%
My academic supervisor/s provide feedback that helps me to direct my research activities: 94%
My academic supervisor/s help me to identify my training and development needs as a researcher: 89%
I am aware of my academic supervisor/s responsibilities towards me as a research degree student: 91%
Other than my academic supervisor/s, I know who to approach if I am concerned about any aspect of my degree course: 70%

These are significant improvements across all rated dimensions compared with last year's data and is a testament to the hard work of course teams.

6. Portfolio developments

6.1 Since the last Board report in 2016 the following developments have taken place:

Bid activity

There has been much activity in relation to writing bids for funding over the past year, which has placed considerable strain on staff time. In all, nine bids have been submitted:

- 1 won (Frontline)

- 2 are still active (CPD for Social Workers Delivery and What Works Centre for Children and Families)
- 3 awaiting outcome (VIPP, Northants Systemic Coaching and Tower Hamlets Systemic Practice)
- 3 lost (Kings Org Development Framework, Health Foundation (VIPP) and Medway Systems Leadership)

Details of a couple of these bids are outlined below:

Video-feedback Intervention to Promote Positive Parenting

Following the end of the DfE grant in March, the Trust submitted a bid to the Health Foundation to continue to deliver this evidenced-based intervention to adoptive families and deliver training to four further cohorts of staff in London and the South East. The Trust was shortlisted to the second round and interviewed, however, the bid was not successful due to the longer-term sustainability of the project. A further bid to the Health Foundation's Scaling Up grant programme was submitted in May.

Frontline

Frontline, the fast-track social work training provider is seeking a University or an equivalent academic research institution to act as a Research Partner to assist in delivering a research programme, called 'Practice Insights'. We have recently been notified that we are the preferred bidder for the research partner for the Practice Insights project. The programme will consist of three elements:

Professional Doctorate Programme

Support to develop small research projects

Developing Research Mindedness

This will award the Trust just under £50,000 to deliver this programme over the next two years and potentially bring a range of other benefits including contributing to recruitment to our social work doctoral programme.

6.2 Course development

Various new courses, training programmes & events have been proposed or commissioned:

Camden Children's Services have further commissioned the Trust to continue to deliver systemic training to all of their children's social work service over the next year. Following the intensive programme which began in October 2015, all staff have had some training and further training is being designed to embed the systemic model of practice in teams, developing champions in the workforce and ensuring new staff also receive training.

Motivational Interviewing This course was initially ran in January 2016. It is now a regular feature of the CPD calendar and we have been approached by Bexley Council to train 90 social workers.

Mental Capacity Act (aimed at levels 1–5)

Safeguarding Adults (aimed at levels 1–5)

Best Interests Assessor

6.3 Other developments

For the past year, the Trust has been involved with the Independent Inquiry into Child Sexual Abuse. Professor Andrew Cooper has been appointed as clinical and organisational consultant to the Truth Project within the Inquiry, providing training to those who facilitate the Truth sessions and individual consultancy to the judge who leads this project.

More recently, a collaboration between the portfolio and Tavistock Consulting involves the Trust offering consultation to the Football Association's Inquiry into Sexual Abuse.

A further attempt to encourage greater collaboration between TC and the Social Care and Systemic portfolios involved a joint visit to Hertfordshire Adult Social Care Directorate with a view to undertaking a programme of organisational change and development.

The portfolio has been piloting a 'teaching the teachers' programme in Cork, Ireland, using the early infant development: an observation module.

There has been significant professional development activity of staff including membership on the board of editors of the Journal of Social Work Practice, active membership of Centre for Social Work Practice; editing and authoring books and journal articles.

7. Conclusion

It has been a challenging but successful year as the portfolio has been able to grow in relation to student numbers across most courses and in terms of developing new short course provision. Staff within the portfolio have been proactive in thinking about areas in which we are able to grow further through being involved in writing bids, developing new courses and in taking on additional work to enable a reduction in visiting lecturers. The portfolio is well-placed to continue to innovate and enable growth in new areas and there are promising opportunities such as a Trust presence in social care apprenticeship training.

Paul Dugmore
Portfolio manager
June 2017

Part 2 – Financial position: Social Care, Leadership & Management Portfolio Report

Academic year 2016-17								
Enrolled students	Y1	Y2	Y4	Y5	Y6	Grand Total		
D10		3				3		
D10_E	36	22				58		
D10C	4	1				5		
D10D			5		6	11		
D10D_E	6	3				9		
D50			1	4		5		
D55	1					1		
D55_E	11					11		
D60		1	9	3	11	24		
D60M_E		3				3		
M26			2			2		
M23	42	31				73		
Total	100	64	17	7	17	205		
Academic year 2017-18 - planned student numbers								
	Y1	Y2	Y4	Y5	Y6	Grand Total		
D10*	44	34				78		
D10C	6					6		
D10D	6	5	3	0	9	23		
D55	8	11	0	0	9	28		
M55	8	0				8		
M26	0					0		
M23	40	40				80		
Total	112	90	3	0	18	223		
* Year 1 target for D10 subsequently reduced to 40.								

SOCIAL CARE, LEADERSHIP AND MANAGEMENT PORTFOLIO

Long Courses - incl. HEFCE income	FY16/17 Budget	FY16/17 Actual	FY16/17 Variance	FY17/18 Budget
INCOME	£690,395	£725,138	£34,743	£839,648
PAY	-£283,700	-£308,639	-£24,939	-£325,662
NON-PAY	-£235,587	-£170,037	£65,550	-£152,990
Total Expenditure	-£519,287	-£478,676	£40,611	-£478,652
Gross profit (£)	£171,108	£246,462	£75,354	£360,996
Gross profit (%)	25%	34%		43%

Short Courses	FY16/17 Actual	FY17/18 Plan **
Income - cpd	£153,811	£119,420
Income - bespoke	£117,870	£28,900
	£271,681	£148,320
Expenditure - cpd	-£121,935	-£55,957
Expenditure - bespoke	-£89,886	-£20,298
	-£211,821	-£76,255
Gross profit (£)*	£59,861	£72,065
Gross profit (%)*	22%	49%

* Short courses gross profit levels not comparable 16/17 v 17/18 as former includes indirect costs of CEDU. This does however give assurance of satisfactory contribution post these costs.

** The FY17/18 is not populated with the full pipeline of CPD courses or those which ran last year which may repeat again. It is estimated this would increase income from the CPD (excluding bespoke) to approx £170k. A further update will be provided at the Board.

Board of Directors : June 2017

Item : 8

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. NHS Confederation Conference

1.1 Paul Burstow and I attended the NHS Confederation Annual Conference in Liverpool on 14th and 15th June.

1.2 There were plenary presentations from national leaders including Jeremy Hunt, Simon Stevens and Jim Mackey. Key messages included:

- A recognition of the considerable improvement in overall NHS finances at the end of 2016/7 but the need to continue this effort in the next 2 years where funding per head of population served falls.
- Continuation of the priorities set out in the March refresh of the 5 Year Forward view.
- Strong support for the concept of Accountable Care Systems with an announcement of the first 8 pilots. At the same time there was recognition of the unlikelihood of any legislative changes to support their development.

1.3 There was a strong focus at the Conference on workforce issues and I had the opportunity to speak at fringe meetings on the project on the future of the mental health workforce which I have co-chaired for the Mental Health Network and at a wider workshop on staff engagement and productivity.

2. Quality Performance

2.1 At the last Board meeting the decline in outcome measures performance was noted in the Annual Quality Report. There were also concerns to provide further assurance on data quality in the light of the issues raised by External Audit in their audit of the Quality report indicators.

2.2 This is a complex issue and there are a number of actions being taken. These issues and actions will be actively monitored through the Clinical

Data Quality Review group. This group reports directly to the Executive Management team. Foremost is a focus on ensuring the quality of data that informs our decision making and reporting. Robust validation processes in both the Quality Team and more recently administration teams continue. Other actions being undertaken include:

- 'reducing the burden' : a project being led by the AFS and CYAF clinical governance leads, aiming to identify and focus on essential Carenotes items and individual responsibilities of clinicians and administration staff to streamline processes. This is part of the overall Quality Improvement programme.
- Review of the range of outcome measures in use to include only those for the patient benefit. This information will also inform the 'reducing the burden' project and is being led by the Associate Medical Director and Director Quality and Patient Experience.
- 'Embedding meaningful use of data'. This is a Trust quality priority and also links to the 'reducing the burden' project. It is also led by the Trust clinical governance leads.

2.3 As agreed at the last Board meeting we will undertake an audit exercise in the autumn to give us assurance of the quality of data across a range of key performance measures.

3. Accommodation

3.1 We face a challenge of accommodating 15 or so staff associated with new projects (eg the Syrian project and the Workforce Skills Development Unit).

3.2 There are very limited options in the existing building and we have been looking at alternatives such as renting external space or developing a modular building which can be placed on the roof.

3.3 I attach a short briefing note on this at **Annex A**. Following a review of the capital and revenue costs and a structural survey our preferred option

would be the development of a modular building. We would aim to bring a business case for Board approval at the July meeting.

4. Race Equality

- 4.1 Dinesh Bhugra, Paul Burstow and I held a further meeting with BAME staff about the development of the Race Equality Strategy. It was very well attended. The group reviewed a draft of the strategy and provided some very helpful feedback on how it could be strengthened.
- 4.2 A key challenge was how we could ensure the strategy is fully owned across the organisation, including specifically by white managers and other leaders.
- 4.3 I have discussed the issue with the EMT and the Professional Clinical Advisory Group and agreed that the strategy will be discussed across all our key discipline and managerial group. We are proposing that the Board considers the strategy at the July Board but should sign it off finally in September to take account of the results of this wider process of consultation. We are also planning a wider leadership engagement event around the strategy for September.

5. Julia Smith

Julia Smith, our Commercial Director, leaves the Trust at the end of this month. Julia has worked in a number of roles at the Tavistock and Portman for nearly twenty years. She has made a considerable contribution to the growth of the organisation, in particular with her work on securing the FNP National Unit and the TAP service. She has also been responsible for a number of important improvements in our systems, including, recently, the development of performance dashboards.

Paul Jenkins
Chief Executive

19th June 2017

Annex A

The Tavistock and Portman NHS Foundation Trust

Project Title/Code:	Estate Sustainability – Additional Interim Space
Date:	19/06/2017
Document:	Trust Board Briefing Document
Document Version:	V4

1. 1.0 Introduction

An activity and space analysis report has been produced by Essentia to identify the space required for the relocation of the Tavistock and Portman NHS Foundation Trust to a new site in spring 2021. The report provides an indication of the room and space requirements and recommends the Trust considers a range of opportunities to achieve space efficiencies and reduce overall area and building costs.

Within the existing Trust buildings and with the recent expansion of Trust services, there is also an immediate requirement to provide additional space as well as plan for future growth within the next 3 years prior to the relocation to the new site.

The purpose of the Estate Sustainability programme is to expand our existing space and to trial new models of flexible workspace allocation to better understand our requirements for the new building and assure the Trust that we will be ready for relocation.

3.0 Objectives

To create new working environments that offer a variety of office spaces, quiet, collaborative and meeting space options.

To achieve stakeholder confidence, paving the way for the cultural and behavioural change through the trial of new spaces and ways of working.

To achieve greater efficiency and availability of physical office space available to staff.

To trial, develop and define the office design brief for the new site.

4.0 Scope of Project

Generate additional space to accommodate circa 50 additional work spaces via acquisition of additional external office accommodation within a 1 mile radius of The Tavistock building or further development of the Tavistock Centre Site.

To refurbish circa 2000–3000 sqft of space within the Tavistock building to an agreed schedule of accommodation and specification.

To provide additional space for the trial of intelligent scheduling and to support the assessment of the success of the proof of concept and the potential value of deploying across all office spaces at the new site. This will be run as a separate project, “Trustwide Scheduling”, though with clear and understood interdependencies.

To assess and consider the value of a Phase 2 at the Tavistock building providing further pilot space for additional groups.

5.0 Proposal

Following discussion at both Executive and Wider Management Teams the options to construct additional modular buildings on level 5 has been selected as the preferred option.

A decision has yet to be reached as to whether this is best fit out as clinical space, and so relieving tension elsewhere in the building, or as office space with downstream decant and refurbishment generating new clinical and education space.

6.0 Procurement and indicative costs for capital refurbishment works at the Tavistock Centre

Below are indicative costs for the construction of a modular building, similar to that constructed behind the Tavistock Centre for housing of the Family Nursing Partnership in 2015, to be located on the vacant roof space on level 5 of the Tavistock Centre.

The proposal would be to construct a simple timber framed and clad structure onto the existing flat roof of circa 4800 sqft (442m²). The accommodation would be accessed from the existing 5th floor lobby. An additional stair for fire escape

will be required on the east side and would be an extension of the existing escape stair which lands next to the Library.

This scheme would be subject to planning approval. The previous modular building received planning for a fixed period only due for renewal in 2018. This could again be deemed as acceptable to the Trust if the time period granted was until 2021 or more.

Programme

- A structural feasibility report has been undertaken to investigate if the existing building is of adequate structure to support a modular building at roof level. There was no record information available and following this initial feasibility full testing of the existing structure will be required. The initial feasibility report is underway and early indications from the Surveyor are positive.
- Advice has been received from Ansell and Bailey, experienced Architects with both the Trust and Camden, to make a pre application submission for Planning. A full application would be prepared and submitted with the earliest decision date estimated to be the end of September 2017.
- In parallel to the planning application the detailed design would be undertaken followed by a tender period to select the appropriate contractor to undertake the construction works.
- On receiving planning the Contractor would be appointed and commence off site construction and on site enabling works for a period of circa 16 weeks. On site works would then commence for a further circa 16 weeks. Based on this programme the earliest opportunity to occupy would be estimated to be April 2018.

Risks

- Ansell and Bailey have advised a planning pre application with Camden. The pre application report will aim to significantly reduce the risk by detailing what is required for a full application and provide the Trust with vital information on whether or not Camden will support the proposal. A&B further advised the Trust will need to use some political pressure where possible.

- There is an opportunity to accelerate the programme if a 2 stage procurement approach was adopted saving on a tender period. The Trust could also consider appointing a contractor at risk to commence works on the strength of early positive planning advice if received from Camden. This could potentially provide an 8 week advantage on programme with the earliest opportunity to then occupy in February 2018.

Option B-Provision of additional modular building.	
	£
Capital Costs	
Modular or Timber Building	£750,000
Furniture	£30,000
Technology	TBC
Total	£780,000
Professional Fees	
Structural Surveyor	10,000
Planning Consultant	8,000
Architects specification	15,000
MEP	15,000
Interiors and F&F specifying (in house)	2000
Cost Consultant	10,000
Contract Administration	8000
Total	68,000
* Source - Estimate based on 2015 costs to create modular building at Tavistock.	

Board of Directors : June 2017

Item: 9

Title: Finance And Performance Report for the period
ended May 2017

Summary: The Board are asked to note the contents of the report

For : Noting / Discussion

From : Terry Noys, Director of Finance
16 June 2017

MONTHLY FINANCE AND PERFORMANCE REPORT

Period 2

31 May 2017

Section

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

Issued to EMT on

17-May-17

By

Terry Noys
Director of Finance

FINANCE AND PERFORMANCE REPORT

SUMMARY I&E

Period 2

31 May 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	3,988	4,000	4,015	12	16
Staff costs	(2,656)	(3,003)	(3,145)	(347)	(142)
Non-staff costs	(894)	(923)	(744)	(30)	165
Operational costs	(3,550)	(3,927)	(3,889)	(377)	23
EBITDA	438	74	126	(364)	39
- Margin	11%	2%	3%		
Interest receivable	1	1	1	(1)	(0)
Interest payable	0	0	0	0	0
Depreciation / amortisation	(61)	(54)	(65)	7	11
Public Dividend Capital	(57)	(45)	(48)	12	4
Restructuring costs	(57)	0	0	57	0
Other			0	0	0
Net surplus	265	(25)	13	(289)	53
- Margin	7%	(1)%	0%		

	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	7,821	7,966	8,223	8,223	145	(258)	(3)%
Staff costs	(5,166)	(5,960)	(6,290)	(6,290)	(794)	330	(5)%
Non-staff costs	(1,858)	(1,673)	(1,599)	(1,599)	185	(66)	4%
Operational costs	(7,024)	(7,634)	(7,889)	(7,889)	(610)	264	
EBITDA	797	332	333	333	(464)	6	0
- Margin	10%	4%	4%		0%		
Interest receivable	2	1	1	1	(1)	0	(0)
Interest payable	0	0	0	0	0	0	0
Depreciation / amortisation	(122)	(129)	(130)	(130)	(7)	0	1
Public Dividend Capital	(97)	(89)	(97)	(97)	7	0	7
Restructuring costs	(61)	0	0	0	61	0	0
Other		0	0	0	0	0	0
Net surplus	519	113	108	108	(405)	6	8
- Margin	7%	1%	1%				

COMMENTARY

As at 31st May actual net surplus of £113k is £6k ahead of the Budget but £36k behind the NHSI Month 2 target of £149k.

This reflects the NHSI template requirement that I&E amounts are profiled in equal twelfths

The surplus is expected to be above the NHSI target in Month 3

Income is £258k below budget but this is offset by operational costs £264k below budget.

Staff costs are £330k below Budget, whilst non-pay costs are £66k worse than budget (primarily in Education and Training)

There are shortfalls in Education and Training income across a range of activities, in particular Portfolios and Short Course income

Whilst YTD income is only slightly higher than last year, staff costs are significantly higher due to the expansion of GIDS / GIC. This growth in costs is matched by higher

CYAF income, the issue (YoY) being a shortfall in Education and Training income exacerbated by E&T costs also being higher (YoY)

FINANCE AND PERFORMANCE REPORT

Period 2

31 May 2017

HIGHLIGHTS

RATINGS

Year To Date

Full Year Forecast

Net surplus

GREEN

GREEN

Cash flow

GREEN

GREEN

Agency spend

GREEN

GREEN

SOF rating for finance and resources

GREEN

GREEN

Supplier payments

AMBER

GREEN

STAFF NUMBERS (WTE)

YTD Budget

YTD Actual

663.87

629.68

PROVISIONS / ACCRUALS

31-Mar-17

31-May-17

Holiday pay accrual

305

305

Bad debt provision

305

305

Restructuring

179

179

Adult GIC Employee Claim

15

15

Other staff related

65

65

Camden Shed'

50

50

CREDITORS / BETTER PAYMENT PRACTICE CODE

YTD

Target

Actual

Number of invoices

95%

89%

Value of invoices

95%

93%

FINANCE AND PERFORMANCE REPORT

Period 2

31 May 2017

BALANCE SHEET

	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
Intangible assets	191	188	199										
Land and buildings	18,381	18,432	18,673										
IT equipment	1,329	1,345	1,311										
Other	0	0	0										
Property, Plant & Equipment	19,709	19,777	19,984	0	0	0	0	0	0	0	0	0	0
Total non-current assets	19,900	19,964	20,183	0	0	0	0	0	0	0	0	0	0
Trade and other receivables	5,518	3,740	2,979										
Accrued Income and prepayments	2,098	3,614	4,701										
Cash / equivalents	2,152	5,279	3,224										
Total current assets	9,768	12,634	10,905	0	0	0	0	0	0	0	0	0	0
Trade and other payables	(2,272)	(2,456)	(2,374)										
Accruals	(3,289)	(3,221)	(2,921)										
Deferred income	(3,010)	(5,684)	(4,583)										
Provisions	(254)	(254)	(254)										
Total current liabilities	(8,824)	(11,616)	(10,132)	0	0	0	0	0	0	0	0	0	0
Total assets less current liabilities	20,844	20,982	20,955	0	0	0	0	0	0	0	0	0	0
Non-current provisions	(82)	(84)	(81)										
Total assets employed	20,761	20,898	20,875	0	0	0	0	0	0	0	0	0	0
Public dividend capital	3,474	3,474	3,474										
Revaluation reserve	12,263	12,263	12,263										
I&E reserve	5,024	5,162	5,138										
Total taxpayers equity	20,761	20,899	20,875	0	0	0	0	0	0	0	0	0	0

FINANCE AND PERFORMANCE REPORT

Period 2

31 May 2017

FUNDS FLOW

	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)											113
Depreciation / amortisation	75	54											129
PDC dividend paid	45	45											89
(Increase) / Decrease in receivables	261	(326)											(65)
Increase / (Decrease) in liabilities	2,792	(1,484)											1,308
Increase / (Decrease) in provisions	2	(3)											(2)
Net operating cash flow	3,312	(1,739)	0	0	0	0	0	0	0	0	0	0	1,574
Interest received	0	1											1
Interest paid	0	0											0
PDC dividend paid	(45)	(45)											(89)
Cash flow available for investment	3,268	(44)	0	0	0	0	0	0	0	0	0	0	(88)
Purchase of intangible assets	3	(11)											(8)
Purchase of property, plant & equipment	(142)	(262)											(404)
Net cash flow before financing	3,128	(2,056)	0	0	0	0	0	0	0	0	0	0	1,073
Drawdown of debt facilities	0	0											0
Repayment of debt facilities	0	0											0
Net increase / (decrease) in cash	3,128	(2,056)	0	0	0	0	0	0	0	0	0	0	1,073
Opening Cash	2,152	5,279											2,152
Closing cash	5,279	3,224	0	0	0	0	0	0	0	0	0	0	3,224

Board of Directors : June 2017

Item : 10

Title : Directorate of Education and Training Board Report

Purpose:

To update on issues in the Education & Training Directorate.
To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 12th June 2017.

This report focuses on the following areas:

- Quality
- Risk
- Finance
- Communications

For : Noting

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

Directorate of Education and Training Board Report

1. Introduction

- 1.1 This report provides an update on the issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 12th June 2017

2. SITS and MyTap Contingency Paper

- 2.1 Brian Rock advised the programme board of developments regarding SITS.

- 2.2 The project is progressing well however there are outstanding issues regarding functionality for CPD courses and we are reviewing a proposal from Tribal as to how these may be resolved. The next release of the project is on track to be delivered to schedule. Work is continuing to recruit to the currently vacant operational support roles for MyTAP within the Informatics team. Concerns have been noted in the wider DET team that these posts have not yet been filled. The project team is therefore looking at interim resourcing arrangements alongside the permanent recruitment being undertaken by the Head of Informatics. The Director of Technology and Transformation has been clear, now that educational and clinical system support has been merged into a single team, DET can expect the Informatics team to provide all necessary support to deliver upcoming operational requirements, such as the HESA return.

- 2.3 Karen Tanner, Deputy Director of Education and Training and Associate Dean for Learning and Teaching, presented a paper on contingency planning that has been prepared ahead of this year's assessment period. A rapid response group was established last year to address operational issues arising from the professional support restructure and has continued to meet regularly through the year; it will meet daily during the assessment period. There have also been workshops held with both faculty and support staff to better understand roles and responsibilities.

- 2.4 MyTap will go live for assessment this week, the group have been planning for any problems in this area. The migration of data has facilitated bringing all assessment data into one master Excel list and this is now held externally should there be an issue with the system.
- 2.5 The group discussed the issues that may arise in relation to marking and the difficulties staff and visiting lectures have experienced using the system. KT advised that even with planning we could not guarantee the absence of any problems would not occur but there is a greater vigilance and engagement around potential areas.
- 2.6 A further update will be brought to the July programme board.

3. Finance Report

- 3.1 Bhavna Tailor, Finance Manager, presented the finance report for this month.
- 3.2 The group reviewed the data and discussed what information it would be helpful to include and where there may be areas in need of clarification.
- 3.3 There is a gap of £200k to address the productivity target and this is currently being actively reviewed. .
- 3.4 BT explained that the next report will have more information on fee income and its impact. An update will be brought to the July programme board.

4. Student Recruitment and Marketing Update

- 4.1 Laure Thomas, Director of Marketing and Communications, presented a paper on this item.
- 4.2 An update on the latest recruitment figures can be found in Appendix A

- 4.3 The group discussed recruitment across the various courses and portfolios. The key issues identified were:
 - 4.3.1 Low recruitment to the social work masters course likely due to most already having a masters
 - 4.3.2 Low recruitment across the forensic portfolio
 - 4.3.3 High numbers of applications and students in the pipeline for M7, EC1 and D58
- 4.4 Work will be taken forward looking at how we can manage courses that over recruit in terms of ensuring adequate teaching staff and space for delivery.
- 4.5 Consideration will also be given to the redeployment of staff teaching on courses that may not run as they are failing to recruit.

5. International Update

- 5.1 BR presented a number of papers on this item.
- 5.2 It was explained that the Directorate intends to engage a consultancy to undertake further work in scoping the potential for running programmes internationally.
- 5.3 Further an MBA student will be undertaking a research project looking at e-learning for international delivery.
- 5.4 Further updates will be brought to the programme board as this work progresses.

6. Library Presentation

- 6.1 Angela Douglas, Head of the library and Aurelie Grandour, Information Systems Trainer attended to deliver a presentation on developments within the library.

- 6.2 This was very well received by the programme board and it was recommended that this was brought to the Board of Directors in due course.

7. T&P Academy

- 7.1 Craig de Sousa, Director of Human Resources, attended the meeting for this item and presented a paper with Karen Tanner.
- 7.2 The academy will allow staff to develop in their teaching role and links to the Trust people strategy.
- 7.3 BR suggested that this was a particular opportunity to identify students particularly on the later stages of our qualifying courses. Discussion was also had about supporting staff at an earlier stage of their career development to develop in future. A programme could be developed to nurture this group. KT agreed and explained that there would be ways of identifying staff that could benefit from the academy. The group agreed that there should be a range of people looking to identify these people.
- 7.4 Rob Senior, Medical Director, emphasised the importance of research and including this in the development of staff.

8. Review of Meetings

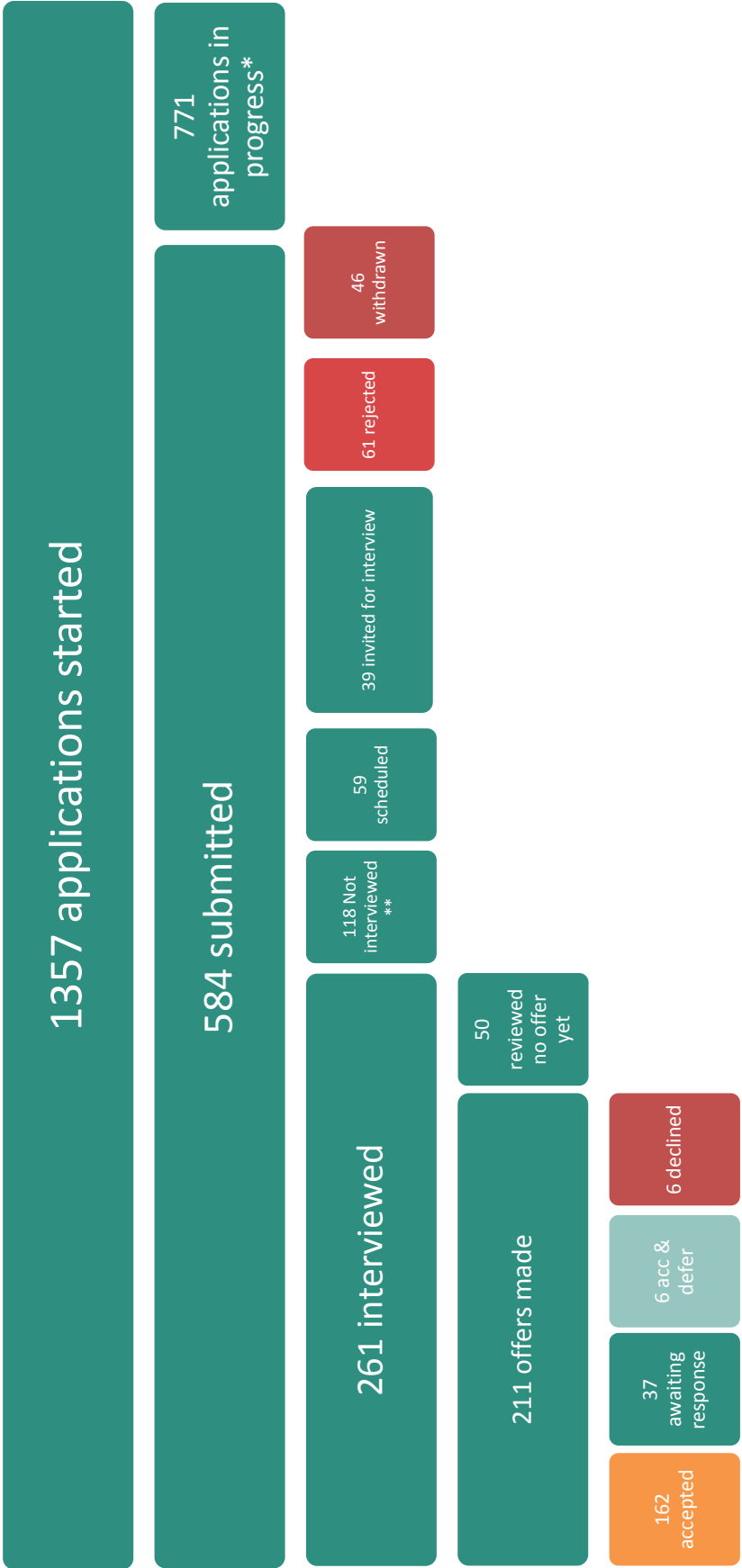
- 8.1 PJ explained that the board was considering the frequency of the various Trust committees.
- 8.2 The group discussed this and agreed they would welcome a move away from monthly meetings and would be happy to consider bi-monthly or 8 meetings a year.

Brian Rock

Director of Education and Training/Dean of Postgraduate Studies

15th June 2017

Appendix A
June Recruitment Figures



Adding non-SITS courses: offers accepted



Board of Directors : June 2017

Item : 11

Title : Board of Directors Objectives 2017/18

Purpose:

This paper sets out the proposed objectives for the Board of Directors for 2017/18.

These objectives have come out of the work being done on the 2 year strategic plan.

The Board is asked to consider and approve these objectives, which will form the basis of individual objectives to be agreed at a later date.

For : Approval

From : Trust Chair

Tavistock and Portman NHS Foundation Trust

Board objectives July 2017 – June 2018

Area	Aim	Objectives
Strategy	Ensure the Trust plays an active role in the development of mental health care in North Central London and nationally	<p>Support the delivery and development of STP plans for mental health including making the case for additional investment, championing the wider contribution of mental health to the delivery of the STP and promoting models of effective collaboration between mental health organisations.</p> <p>Promote the Trust's work on the development of evidence based new models of care such as Thrive, FDAC, FNP and primary care mental health.</p> <p>Over the securing of a sustainable new model of funding for FDAC based on social investment.</p>

Area	Aim	Objective
Strategy	Give leadership to the programme to transform the Trust's training and education work in the light of changes to the National Training Contract.	Oversee delivery of key milestones for the National Training Contract in 2017/8 including establishment and development of the Workforce Skills Development Unit and the Mental Health Workforce Collaborative.
Strategy	Deliver a step change in ambition in relation to new income generation	<p>Promote a more ambitious approach across the organisation to new income generation.</p> <p>Oversee delivery of at least £1m additional baseline contribution from new income by March 2018.</p> <p>Ensure clear progress in "new" areas of income development: schools, corporate support, gender identity, transnational education.</p>

Area	Aim	Objective
Strategy	Ensure Trust strategy and risk management frameworks remain up-to-date and effective	Agree in autumn 2017 an updated Trust Medium Term Strategy and Board Assurance Framework including a strategy for medium term financial sustainability.
Strategy	Oversee an expansion in the Trust's role in research	Agree a Research Strategy by autumn 2017 with focus on the delivery of existing programmes and the securing of at least one new major research grant.

Area	Aim	Objectives
Performance	Ensure Trust maintains strong operational and financial performance	<p>Use dashboards and other approaches to strengthen the performance culture within the organisation. Ensure that steps are being taken to improve the Trusts recording and reporting of data and seek the necessary assurance and actions to improve data hygiene and the reliability of information presented to the Board</p> <p>Oversee delivery of financial control total for 2017/8 and other required financial duties.</p> <p>Oversee the Trust maintaining a rating of 1 in against the Single Oversight Framework.</p> <p>Oversee delivery of targets for student recruitment.</p> <p>Oversee improvements in waiting time performance in GIDS and other priority areas.</p>

Performance	<p>Make tangible progress in improving the Trusts' performance on race equality.</p>	<p>Agree a Race Equality Strategy to the Board by September 2017</p> <p>Oversee improvements in the Trust's performance against WRES indicators.</p> <p>Promote organisational engagement with this agenda and its reflection in team and individual objectives across the organisation.</p>
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Area	Aim	Objective
Quality	Champion the quality of the Trust's activities and our aspiration to move from "good" to "outstanding".	<p>Oversee delivery of the Trust's clinical quality strategy including the adoption of a range of quality improvement methodologies and embedded quality improvement initiatives in all clinical teams.</p> <p>Oversee the further development of patient, carers and student engagement and their involvement in the development of the Trust's work.</p>

Area	Aim	Objective
Enablers	Ensure the Trust has the necessary plans and capacity to deliver its strategic objectives.	<p>Agree a Public Affairs strategy by Summer 2017.</p> <p>Develop opportunities to support the Strategy and promote the profile of the Trust.</p>
		<p>Oversee the development of the Trust IM&T strategy including a clear vision for its digital ambitions.</p>
		<p>Oversee delivery of the Trust's People Strategy including a specific focus on staff wellbeing.</p> <p>Ensure targeted action to address areas of concern in 2016 staff survey.</p>
		<p>Oversee the next stages of work on relocation leading to the agreement of a Full Business Case for a new site by March 2018. Oversee the engagement of staff, patients, carers, students and staff in developing a design which enables the Trust's mission, values and ambitions.</p>

Area	Aim	Objective
Governance	Support effective Governance in the organisation.	Agree in July 2017 the outcome of an internal Governance review including reviewing the modus operandi of Board Committees, their function and relationship to the Board. Oversee delivery of recommendations.
		Ensure ongoing effective engagement with the Council of Governors.

Board of Directors : June 2017

Item : 12

Title: Annual Safeguarding Report 2017

Purpose:

This paper provides an update for the Board of Directors about safeguarding of children, young people and adults at risk in the Tavistock & Portman NHS Foundation Trust in the context of local and national developments.

This report includes information about both safeguarding children and adults at risk.

This report focuses on the following areas:

- Patient / User Experience
- Risk
- Quality

For: Discussion and noting

From: Rob Senior, Medical Director, Sarah Helps, safeguarding adults at risk lead, Sonia Appleby, named professional for child protection.

Introduction

Child protection and safeguarding adults at risk continue to be high up the list of national and local policy and regulatory concerns. The CQC inspection of the Trust last year was positive about our performance and we are expecting an imminent Ofsted-led inspection of Camden services for children which will focus on multi-agency arrangements to safeguard children.

As indicated in this report, the Prevent agenda is facing scrutiny following the recent harrowing events in Manchester and London and we can anticipate increased expectations on the contribution of Health to keeping the public safe. We continue to take a thoughtful approach to radicalisation and link it to our thinking about individuals' vulnerability to exploitation and malign influence more generally.

The Trust remains committed to providing help and support to children and adults who have experienced severe adversity and maltreatment as evidenced by the commissioning of the Returning Families Team and the Child Sexual Abuse Hubs in North Central London which will evolve into the pilot Child House for CSA in Camden in 2018.

As Board colleagues will be aware, resources in the current climate tend not to match expectations. Despite this the safeguarding team continue to deliver high quality safeguarding training, supervision and support for staff and for the families with whom they work.

Rob Senior, Medical Director

Safeguarding Children Report

1. Overview

- 1.1 This report pertains to safeguarding children activity within Qs1-4 2016-2017, and seeks to provide assurance regarding the Trust's legal obligations by dint of section 11 of the Children Act 2004, to provide service updates and advise the Board of extant or potential risks in the delivery of clinical services to children and young people.

2. Corporate Responsibilities

- 2.1 The Children Act 2004 (s.11) imposes a statutory responsibility on key people and agencies to ensure arrangements to safeguard and promote the welfare of children are embedded within their organisational structures. The aforementioned act requires a 'root and branch' approach to safeguarding children to ensure the right procedures, policies and cultural beliefs and values are evident within all NHS Trusts, NHS foundation Trusts and CCGs.

3. Multi-Agency Work and the Children's Workforce

- 3.1 The Tavistock and Portman works within the context of safeguarding children via its own procedural practices and by ensuring vulnerable children and young people and their families have access to timely interventions from agencies who provide services to support and address developmental needs and those whose services have statutory powers of intervention to address risk and harm.

- 3.2 The statutory responsibility for the co-ordination of local agencies to safeguard children is held by the Local Safeguarding Children Boards. The Trust works closely with other agencies under the aegis of the Camden Safeguarding Children Board.

4. Governance

- 4.1 Safeguarding children governance within the Trust is monitored via the Adult and Children Safeguarding Committee; the Patient Safety and Risk Work Stream of the CQSG Committee; the Clinical Quality and Review Group (CQRG) and the Camden Safeguarding Children Board. Additional governance is provided during the inspection processes of the Care Quality Commission (CQC) and Joint Inspections, which include Ofsted and other inspectorates.

5. Serious Case Reviews

- 5.1 The Trust was advised in late 2016 of a Barnet case, which is currently to sub-judice. The matter relates to a widely reported case involving the deaths of two children. One child ingested a tiny, toy battery and sadly died. In the course of the subsequent serious case review regarding the child's death, it became apparent there was a child missing from the family; the child's remains were found later.
- 5.2 The Trust was previously involved with the family some six years' ago. The case was closed the following year. The referred child, who is not deceased is a sibling to the children as cited above.

6. Adult and Children Safeguarding Committee

- 6.1 The above Committee convenes at least three times a year and has a wide membership representing the salient areas of the Trust service delivery and governance assurance. The work in 2016-2017 has included the following
- (a) reviewing Lampard Recommendations;
 - (b) discussing the efficacy of CareNotes, particularly reported concerns regarding connectivity beyond the Trust's main building;
 - (c) safer recruitment and DBS checks;
 - (d) safeguarding training;
 - (e) domestic abuse;
 - (f) safeguarding supervision
 - (g) serious incidents and serious case reviews;
 - (h) the work of Camden Safeguarding Children Board.
- 6.2 Finally, the Adult and Children Safeguarding Committee provides a useful forum to consider operational issues and experiences of staff in delivering services within the context of safeguarding and child protection.
- 6.3 The Patient Safety Work Stream provides oversight of the functions of the Adult and Children Safeguarding Committee.
- 6.4 The Adult and Children Safeguarding Committee is supported by the operational safeguarding sub-committee.

7. PREVENT

- 7.1 The Counter-Terrorism and Security Act 2015 which came into force in July 2015, places a duty on specified authorities to 'have due regard' to the need to prevent people from being drawn into terrorism. This places a duty on all Trusts, known as a Prevent Duty, to inform the local Channel Panel of persons who are known or suspected of being vulnerable to radicalisation.
- 7.2 The profile of the Prevent agenda has been highlighted following the increase in terror attacks in Europe and specifically in the UK and the Trust Prevent lead has drafted a Prevent strategy, which includes the criteria for external referrals to Channel, the local multi-agency panel, which is due to be discussed and ratified at the Safeguarding Children and Adults at Risk Committee in the autumn of 2017.
- 7.3 Staff seeking consultations in relation to Prevent concerns have increased and the Prevent lead now keeps an internal database detailing all consultations and outcomes. During 2016/17 the Trust has not made any direct external referrals but we have been involved as third parties and have been able to offer advice as appropriate to support our partnership working with these individuals. The Prevent lead has also requested a place on the Channel Panel which will enable deeper engagement in the referral process.
- 7.4 Training for Prevent is on the Trusts' mandatory training programme and level one awareness training is provided to all staff at INSET and Inductions. For all clinical staff who undertake level three safeguarding training, a further Workshop to Raise the Awareness of Prevent (WRAP) is required to be attended every three years. The Prevent lead is also working closely with our commissioners and NHS England on the WRAP Evaluation Panel to review how best we can get staff to engage with the WRAP training and ensure it is as useful as possible.
- 7.5 In 2016-2017, three cases were referred to the Trust's PREVENT lead but none were escalated to the Channel Panel as they did not fully meet the criteria for onward referral.

8. Female Genital Mutilation (FGM)

- 8.1 The Serious Crime Act (SCA) 2015 amended the Female Genital Mutilation Act 2003 and under section 74 of the SCA requires all persons working within a regulated professional (health and education in England and social work in Wales) to directly report to the police any actual or direct disclosures of FGM in girls below the age of majority. Within the context of mental health, the Trust advised all staff about the SCA 2015, the requirement for mandatory reporting and the consequences of withholding disclosures.
- 8.2 In addition, the Trust is required to Report FGM to NHS Digital, and within 2016-2017 there were no definitive disclosures of FGM within the context of SCA 2015. Risks are associated with country of origin; ethnicity and religion. In 2016-2017,

36 cases were indicated to have some risks of FGM but no concerns were escalated to the Named Professional regarding a risk of, or disclosure of FGM.

9. Safer Recruitment

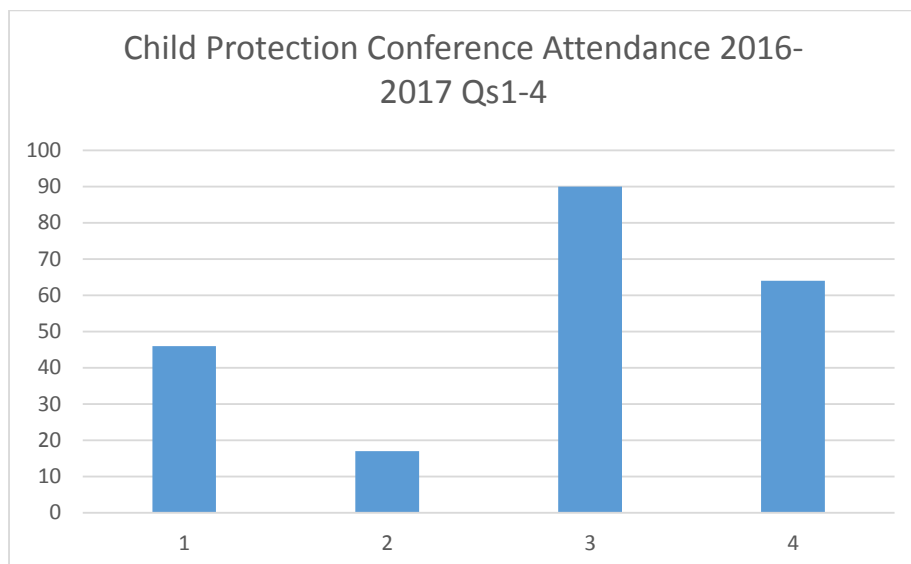
- 9.1 Human Resources has established a model of delivering safer recruitment training to appropriate Trust staff.
- 9.2 Maintaining robust practice in regards to safer recruitment is a crucial process in deterring unsuitable individuals from seeking employment or access to patients within the Trust. Human Resources plan to roll out management training for staff to include safer recruitment as previous methods of safer recruitment training were inconsistent.

10. Disclosure and Barring Service (DBS)

- 10.1 All staff with responsibilities requiring unsupervised contact with patients and service users are required to have the relevant enhanced DBS check. The Adult and Children Safeguarding Committee received reports that DBS checks were not being undertaken in a timely manner and this was having an impact on a limited number of staff and their ability to undertake their clinical duties. The matter was formally raised with the Human Resources Director on 8th May 2017.

11. Camden and North Central London Safeguarding Metrics

- 11.1 The Trust is required to submit on a quarterly basis metrics regarding mandatory safeguarding training; attendance at child protection conferences and supervision, which for the purposes of children and young people subject to child protection plans, must be safeguarding supervision.
- 11.2 From Quarter 3, 2016-2017, safeguarding data was directly sourced from CareNotes. This is a very positive step forward in terms of less reliance on self-reported clinical outcomes and enabling information to be sourced from electronic reports. Conversely, this has, in some domains, negatively, affected data outcomes.
- 11.3 Case conference attendance for children and young people subject to child protection plans is a necessity for those within professional networks and those providing direct services. The Camden Safeguarding Children Board and the Camden Clinical Commission Group have been encouraging and monitoring professional attendance for some time. Trust staff are widely perceived to be reasonably compliant regarding conference attendance although this is undermined by last minute invitations and cases new to Trust services when conferences are co-terminus with the referral date.
- 11.4 Child Protection Conference attendance was variable in 2016-2017. A specific focus on supervision will increase attendance rates and will ensure consistency. (The y axis represents the percentage rate as calculated by the numerator/denominator, and the x axis the Quarter 2016-2017).



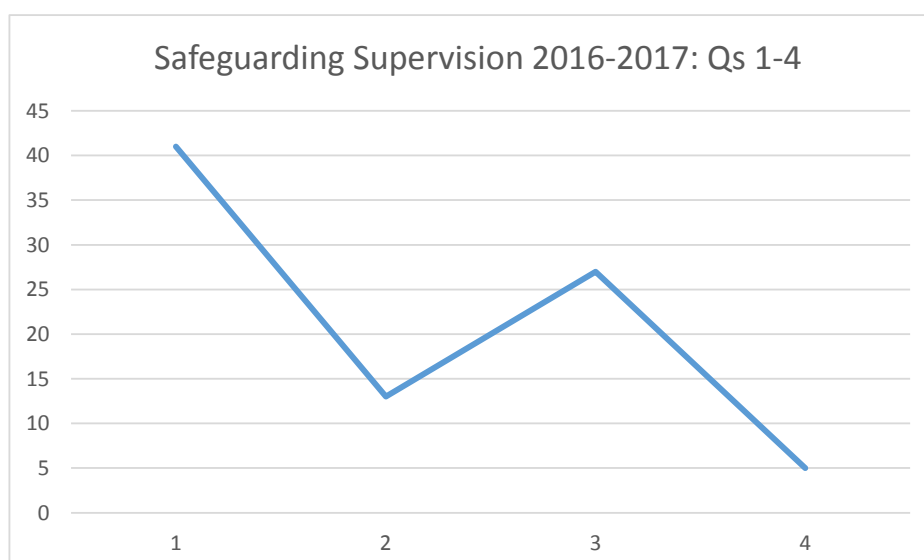
11.5 Safeguarding Supervision

11.5.1 The model of self-report outcomes and the shift to reports being based on recorded information has illuminated a fundamental challenge within the child and young people cohort with regards to evidencing supervision events.

11.5.2 Best practice in safeguarding and child protection work requires quality-based supervision, which in part is performance related but should also provide the clinician with an opportunity to reflect upon the impact of complex and, on many occasions, disturbing dynamics of managing dysfunctional families and complicated professional systems. The body of knowledge accumulated as a consequence of serious case reviews requires the children and young people workforce to be subject to competent supervisory oversight.

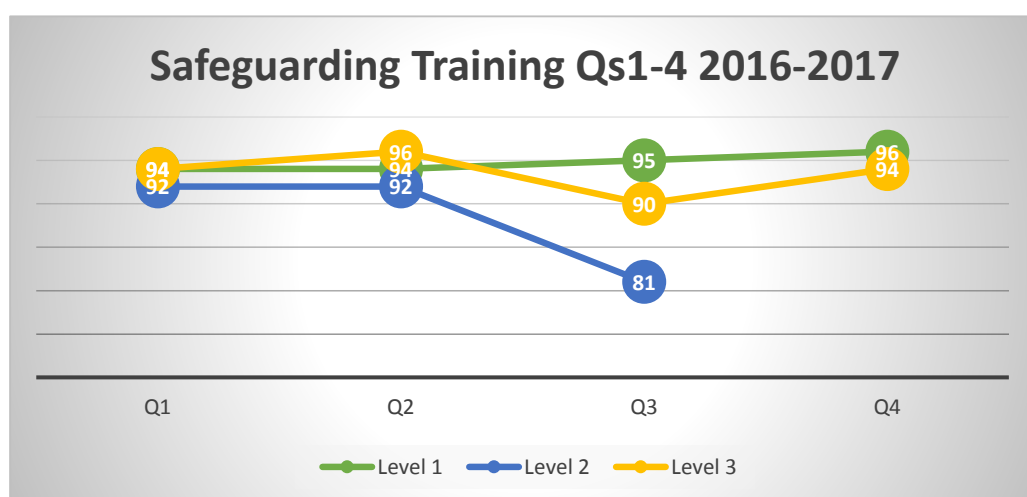
11.5.3 The data output for the supervision of child protection cases is cause for concern and this has been escalated via the Patient Safety Work Stream and is on the Trust Risk Register. In Q4, 2016-2017 this dropped to 5% of cases. (The y axis represents the percentage rate as calculated by the numerator/denominator, and the x axis the Quarters for 2016-2017).

11.5.4 The Director for Children, Young People and Families endorsed a plan to improve supervision outcomes on the 18th April 2017. The Named Professional, the Named Doctor and the Patient Safety Officer under the aegis of Clinical Governance are expediting an improvement plan.



11.6 Safeguarding Children Training

- 11.6.1 Safeguarding Children training for the Trust's workforce was undertaken using the three levels as defined by the Intercollegiate Document 2014, which determines the knowledge, skills and competencies for the health workforce.
- 11.6.2 At the outset of Q4, 2016-2017 Level 2 training was subsumed into the Level 3 training, this was partly to create more efficiency in the planning and delivery of safeguarding training; taking into account the relatively small number of staff eligible for Level 2 training within the Trust and it was noted the quality of the training improved when both adult and child practitioners trained together.
- 11.6.3 Training across all levels (y axis as a percentage rate and the x axis is the level of training 1-3) has been consistently high with a dip in Level 2 training, which is accounted for by staff migrating to Level 3 training.

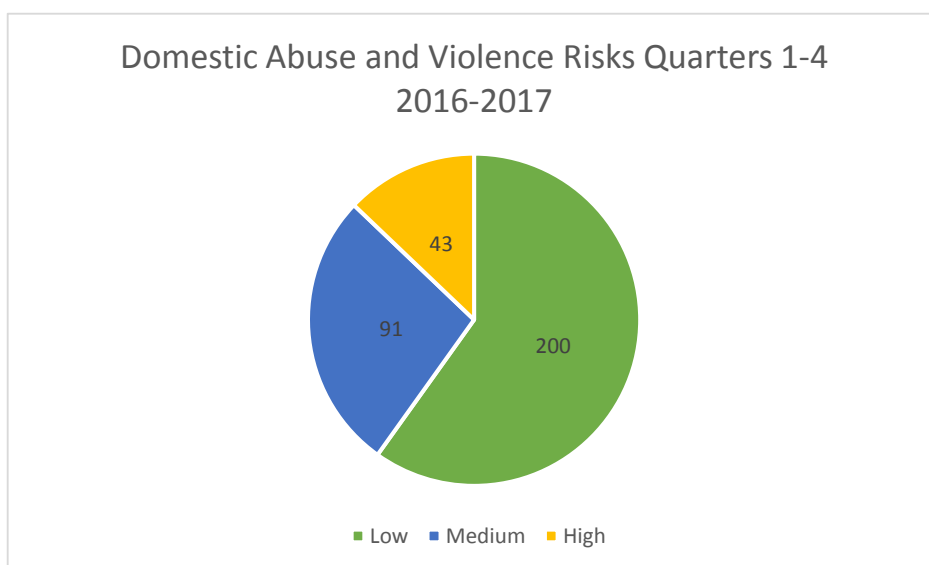
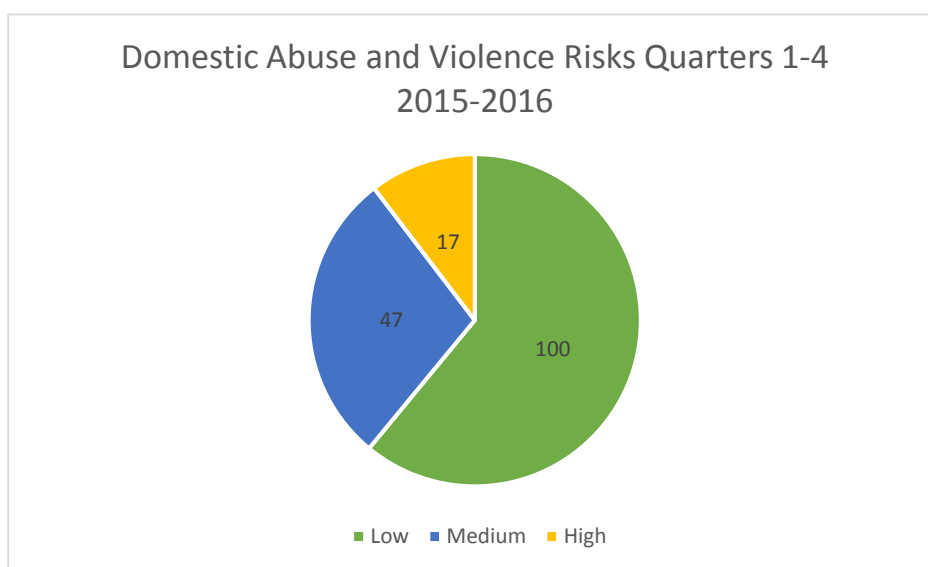


12. CQUIN: Domestic Abuse

- 12.1 The 2016-2017 CQUIN for safeguarding related to domestic abuse and violence. Research informs practitioners that detection and assessment of domestic abuse is relatively low. This is partly caused by services failing to understand the presentations of domestic abuse, which are diversified beyond physical abuse; both victims and perpetrators denying experiences of abuse and the impact of the coercive and controlling behaviours, which is, now, a criminal offence under the Serious Crime Act 2015.
- 12.2 In addition, the National Institute of Clinical Excellence (NICE) issued guidance about domestic abuse in 2016 to provide a specific focus on identifying, assessing and referral to specialist domestic abuse agencies.
- 12.3 Level 3 safeguarding children training provides research-led information to support improved recognition and referral of domestic abuse cases. In addition, Team Managers, and some service leads were invited to attend additional training in 2016-2017 using the DASH (Domestic Abuse, Stalking and Harassment) tool to further improve detection and assessment of patients who are either at risk of

domestic abuse or have made a disclosure. 96% of the required managers attended the training.

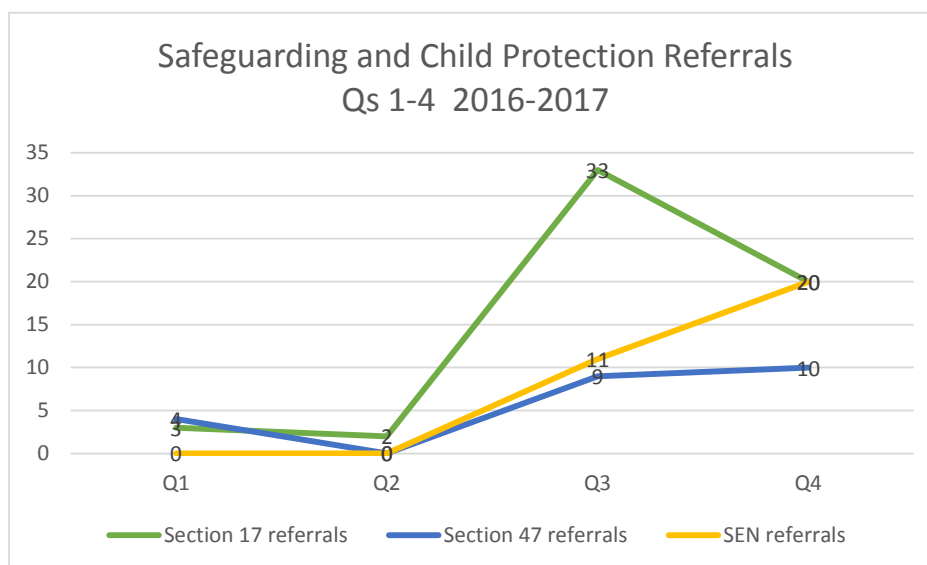
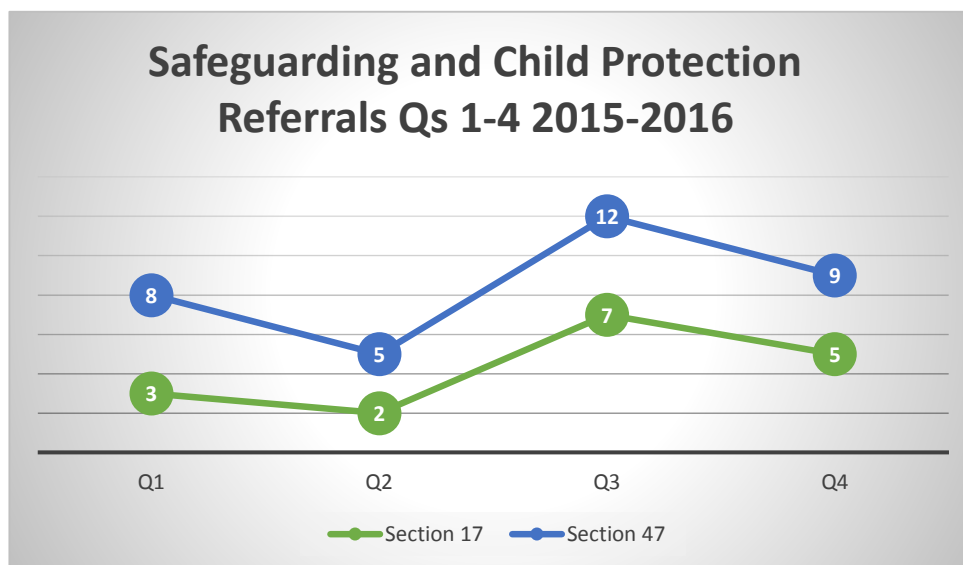
- 12.4 The detection of domestic abuse rose steeply between 2015-2016 and 2016-2017 data. (See below).
- 12.5 The audits regarding those patients at medium (n=91) – high (n=43) risk in 2016-2017 has shown, clinicians are appropriately referring cases to statutory agencies when there are children under 18 within households or where there is proximity to persons over 16 who are perpetrating or who are affected by abuse.
- 12.6 Low risk cases generally relate to historical concerns about domestic abuse but where there are no current risks associated with this concern.



13. Safeguarding Children Referrals

13.1 The positive impact of collecting data directly from the electronic record is again highlighted. This report has cited the migration from data collection from self-report tools to being wholly reliant on data extraction from 1st October 2016 and this is evident in the rise in referrals from Q2 onwards but this is not the only causal factor regarding safeguarding children referrals.

13.2 The charts below shows an increase in referrals from 2015-2016 and 2016-2017, which highlights that staff are appropriate referring cases.



- 13.3 The other causal factor is thought to be seasonal. The data trend (2015-2017) indicates a drop or zero activity between Q1 and Q2 followed by a sharp rise is likely to be attributable to school holidays and professionals being on leave.
- 14. Patient Safety Officer**
- 14.1 This new post and the post-holder appointed in September 2016 has ably assisted the Safeguarding and Clinical Governance Team.
- 15. Safeguarding Priorities**
- 15.1 IT and CareNotes**
- 15.1.1 Many staff working beyond the main building report connectivity problems, which are disruptive to timely record-keeping. Informatics, Clinical Governance and the Safeguarding Team continue to provide support.
- 15.2 Supervision**
- 15.2.1 Ensuring safeguarding supervision events are consistently recorded regarding those children who are subject to child protection plans (CPPs) and child patients who are vulnerable and subject to increased risk: self-harm; suicidality; Looked After Children (LAC); Children in Need (CIN) and those with Special Educational Needs (SEN). This safeguarding and child protection priorities relates to CPPs and those who are at risk of serious self-harm and suicide.
- 15.3 Preparing for the Joint Targeted Area Inspection (JTAI)**
- 15.3.1 Ofsted published guidance for the next series of joint inspections in April 2017. The JTAI will be current from May – December 2017 and will focus on children living with neglect. However, it can be expected inspectors will also consider the wider context of child protection practice.
- 15.3.2 Preparation will ensure a sample of children and young people cases living with neglect will be subject to audit processes; the outcomes and learning will be disseminated to Associate Directors and Team Managers.
- 15.3.3 Furthermore, the Ofsted (JTAI) document will be sent to Associate Directors to circulate to their services.
- 15.4 Mandatory Reporting**
- 15.4.1 The Trust took part in a consultation process in Quarter 3, 2016-2017 to consider whether it would be more efficacious to mandatorily report child abuse or whether the accent should be on a 'duty to act'. There has not yet been a government determination. Notwithstanding the hiatus, the import of safeguarding children must be central to our clinical activity and this involves reporting and responding appropriately.
- 15.5 Safeguarding Procedures**
- 15.5.1 The safeguarding Children Procedures (last reviewed March 2016) will need to be updated to include further guidance regarding domestic abuse and violence; FGM and Body Maps. Gloucester House is completing amendments to its safeguarding procedures to be more closely aligned with the Department for Education Guidance: Keeping Children Safe in Schools and Colleges, 2016.

15.6 Multi-Agency Work and the Local Safeguarding Children Board

15.6.1 The Named Doctor and the Named Professional attend relevant meetings and training events supporting multi-agency colleagues and the strategic work of the Camden Safeguarding Children Board.

15.7 Signs of Safety

15.7.1 The Trust will be building on its CQUIN delivery to further consolidate the improvements in domestic abuse. The Barnardo's model of assessing children will be delivered as a separate training to team representatives and will be delivered during 2017-2018.

Sonia Appleby
Named Professional for Safeguarding Children
June 2017

Adult Safeguarding Report

1 Introduction

1.1 Safeguarding adults within the trust continues to be seen as everybody's business. The safeguarding work of the trust is underpinned by the safeguarding principles set out in the statutory guidance accompanying the Care Act 2014. The principles apply to all sectors and settings including care and support services. The principles inform the ways in which we work with adults.

Empowerment –supporting person-led decisions and informed consent.

Prevention - taking action before harm occurs, including access to information on how to prevent or stop abuse, neglect and concerns about care quality or dignity.

Proportionality – taking a proportionate and least intrusive response appropriate to the risk presented.

Protection – providing support and representation for those in greatest need, including identifying and protecting people who are unable to take their own decisions, or to protect themselves or their assets through mechanisms such as the Mental Capacity Act.

Partnership – finding local solutions through services working with their communities.

Accountability – ensuring accountability and transparency in delivering safeguarding, with agencies recognising that it may be necessary to share confidential information, but that any disclosure should be compliant with relevant legislation.

For a safeguarding response to be required under the Care Act 2014, it has to meet three criteria: having care and support needs, experiencing (or being at risk of) abuse or neglect and being unable to protect themselves because of those needs.

There are ten main categories of abuse. These frequently overlap:

- discriminatory
- psychological
- financial or material
- organisational
- neglect and acts of omission
- physical
- sexual
- domestic
- modern slavery
- self-neglect

2. Work involving our patients

2.1 Adult safeguarding consultations and referrals

Over the past year, I have provided on average two consultations a month to staff who are concerned about adult safeguarding issues. These often involve the boundary between mental health and safeguarding and often involve staff concerns about both adult patients and those in the close familial network around the named patient.

The number of formal adult safeguarding referrals to the local authority has remained static and low over the past year. This reflects the needs of the patients that we see. Across the trust, based on recent data gathered from CareNotes, we currently see very few patients who have an identified learning disability or who have care and support needs and who are unable to protect themselves. However, as the nature of trust services changes, the nature of adult safeguarding within the trust and the adult safeguarding issues faced by staff will continue to evolve. None of our patients have been involved in any serious care reviews.

3. Work to support staff

3.1 Trust developments in recording adult safeguarding issues

The new trust adult safeguarding policy was launched in January 2016, to take account of the changes within the Care Act.

As part of this a new form was added to Care Notes to enable capture of data regarding adult safeguarding data, in a way that can be easily gathered for the purposes of internal and external reporting. The use of this is gradually becoming embedded into routine practice. This forms is part of the broader work to ensure that safeguarding work is documented and supervised across the trust.

3.2 Adult safeguarding training within the trust

Level 1 training is delivered at INSET and Induction. The draft intercollegiate adult safeguarding training competencies have yet to be finalised. We have been working to the draft criteria.

Two teams have received additional training over the past year. Work with HR is ongoing to identify the number of staff who require level 2 and 3 adult safeguarding training and to set out a framework toward delivering of this training. Staff can also access specialist training, regarding for example self-neglect or financial and material abuse via Camden TDS.

4. Priorities for 2016-2017

The following priorities are identified:

- Continue to deliver and develop bespoke trainings to targeted services across the trust and develop ways of evaluating these, for example GIC.
- Involve service-users in discussions about adult safeguarding policy and procedures
 - this remains a key priority in line with the Making Safeguarding Personal Agenda
- Explore the costs and benefit of delivering level 1 safeguarding training via e-learning in order to free staff time to deliver more bespoke and sophisticated trainings.
- Formalise support from HR to support adult safeguarding training above level 1

Sarah Helps
Safeguarding Adults at Risk Lead
June 2017

Board of Directors : June 2017

Item : 13

Title : Gender Identity Clinic, Charing Cross, Interim
Complaints Report 2016–17

Purpose:

The purpose of this report is to provide a summary of the formal complaints received by the Gender Identity Clinic since 1st April 2017 when the service was taken on by the Trust.

This report has been reviewed by the following:

- Executive Management Team

This report focuses on the following areas:

- Patient / User Experience

For : Discussion

From : Chief Executive and Complaints Manager

Gender Identity Clinic Interim Complaints Report

1. Introduction

The Trust took over the running of the Gender Identity Clinic at Charing Cross on 1st April 2017. It was clear at this time that the number of complaints received by this service was high and was likely to more than double the number of complaints the Trust receive as a whole over the year. This report is to review the situation after the first quarter of operation.

2. Formal complaints received

To date we have received 27 formal complaints from the Gender Identity Clinic at Charing Cross, by comparison we have received 3 complaints in total from all the other services in the Trust.

The table below is a summary of the current position.

Acknowledged with 3 days	Acknowledged after 3 days	Response within 25 days	Response after 25 days	Open	Upheld/ Upheld in part	Not Upheld
22	5	7	2	18	9	0

Most complaints are acknowledged within 3 days. Five complaints were acknowledged after 3 days including 4 which had been passed to us by West London Mental Health Trust. To date all complaints have been upheld.

All complaints received are investigated by the GIC staff and a report written. This report is reviewed by Frances Endres, Service Manager, and then passed to me to draft a response which is then signed by Paul Jenkins.

3. Topics of Complaints

The topics of the complaints are mostly very similar, and on the whole relate to waiting times and communication. The table below is a summary of the core topics of the complaints received.

Delays
Delay in sending out referral letter has led to delay in date for surgery being set.
Referral letter for surgery was not sent promptly
Delays in sending out letters leading to delays in treatment.
Delays in appointments, no clear plan for treatment, Clinician was rude and dismissive
Delay in letter being sent to GP to receive hormones.
Delay in sending referral letters, staff were rude when patient contacted them about this.
Delays in sending letters leading to delays in treatment
Delays in sending details for hormone treatment so this has not yet been started
Communication
Medical records not sent to Leeds as requested. Poor communication with patient
Poor communication from GIC Charing Cross. Referral letter not received by hospital
Waiting times for counselling and telephone messages not being responded to.
Information sent to wrong address on 2 occasions delaying treatment
No response from clinic following urgent request for an appointment. Phone not answered and messages not returned.
Wrongly discharged, unreasonable wait time following re-referral, unable to get through on the phone, messages not responded to.
Letter not received for prescription of hormones and phone calls not answered
Delays/Communications
Delay in sending clinical letters, poor communication, wrong name used.
Poor communication and delays in arranging appointments
Other

Discharged against their will, left with no support, wrong name used, staff were deliberately offensive.
Unhappy with attitude of therapist
Did not refer for both types of surgery required
False information in patient record, felt they were the subject of gossip and ridicule by GIC staff
Discharged halfway through gender reassignment treatment
Receptionist was rude and dismissive

4. Summary

As a result of taking on the Gender Identity Service at Charing Cross the number of complaints received by the Trust has greatly increased as expected. If the trend continues we estimate that we will receive in excess of 100 complaints for the year 2017/18. This compares to 39 received for 2016/17.

This has had an impact on the staff dealing with this area of work including the Complaints Manager and the PALS Officer. As many of the complaints are to do with communication and administration if steps to address these difficulties are implemented we should expect the number of complaints received by the Gender Identity Service, Charing Cross to reduce.

We are becoming increasingly more aware of the difficulties that the GIC faces. The very large patient base (5500+ patients) is supported by 19 clinicians (17.6 WTE) and 27 administrators. The long waiting times are an ongoing issue, although the Charing Cross GIC has the shortest waiting times of any other GIC at present. The sheer number of incoming requests leaves the GIC in a reactive position at present.

The current communications of the clinic are poor, and the root of most of the complaints. We are working to improve these.

A new phone system goes live on the 12 June which should improve patients incoming call experience, although currently not able to answer any more phone calls. A new administration structure is also being devised which should enable patients to have better access to administrators which will improve communication.

We have published information on the website regarding waiting times and realistic time frames for appointments, letters and blood results.

The waiting times will continue to be a problem until there is a more robust staffing structure, although a variety of groups and workshops are being devised to help patients have some access to the clinic even before proper treatment begins. As well, a Triaging clinic has been tested and is under review. All of these options should help support a very anxious patient base.

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

Board of Directors : June 2017

Item: 14

Title: Reference Costing Exercise

Summary: The Board are asked to note the contents of the report and to make the approvals noted in section 5

For : Approval

From : Terry Noys, Director of Finance
16 June 2017

2016/17 Integrated Reference Costs Collection Exercise

1. Introduction

1.1. Overview

NHS Trusts are required to make an annual Reference Cost Submission to the Department of Health to inform the Department's understanding of the costs of providing healthcare to NHS patients across the country (clinical service costs), education and training costs and the overall impact of one on the other.

Whereas in the past two returns were made, for 2016/17 these are now combined into one.

1.2. What are Reference Costs?

Reference Costs are the average unit costs across the NHS of providing defined services in a given financial year. These are collected yearly from all trusts at healthcare resource group (HRG) point-of-delivery level. For mental health services this equates to the average unit cost per patient cluster for adults (mandated from April 2012) and attendances for children (under 18 years).

Reference costs are used to set prices for NHS-funded services in England. They also support commitment to data transparency for the benefit of patients and the public.

NHS Improvement is accountable for reference costs collection, with the Department continuing to collect reference costs on its behalf. NHSI's strategy for costing and cost collection to inform price setting is set out in their Approved Costing Guidance.

The main uses of the Reference Cost are to:

- Support the development of price setting;
- Develop the scope and design of currencies;
- Inform Payment by Results tariffs nationally; and
- Enable trusts to benchmark their unit costs against the national average, and against other Trusts of similar size and settings.

1.3 Reference Costs Information

The information is presented in three ways:

- National schedules of Reference Costs: these show the national average unit costs derived from the unit costs of NHS providers
- NHSI's / Monitor's database of source data: this allows a more detailed analysis of organisation level costs.
- Reference Cost Index (RCI): a measure of the relative efficiency of NHS providers

1.4 The Reference Cost Index (RCI) & the Market Forces Factor (MFF)

The RCI enables a comparison of costs at the aggregate level for each NHS provider. The RCI shows the actual cost of an organisation's case mix compared with the same case mix delivered at national average cost.

An organisation with costs equal to the national average will score 100, with higher cost organisations scoring above 100 and lower cost organisations scoring below 100. For example, a score of 110 means that the costs are 10% above the average whilst a score of 90 shows costs are 10% below the average. The RCI is therefore a measure of relative efficiency.

Market forces factor (MFF) - this is an estimate of unavoidable cost differences between health care providers based on their geographical location. This is factored in when payments are made to NHS providers on an activity basis.

Tavistock and Portman Trust's published Reference Cost Index over the last 5 years can be summarised as follows:

Year	2011/12	2012/13	2013/14	2014/15	2015/16
Published RCI - MFF adjusted	105	63	77	87	93
Published RCI - non MFF adjusted	119	71	87	98	104
MFF	1.1404	1.2383	1.1405	1.1399	1.1393

2. Board approval and sign off

This year's submission is due by the 31st of July 2017. In accordance with the issued guidance the Board (or its audit committee or other appropriate sub-committee), is required to confirm (or provide details of non-compliance) that: The finance director and education lead are responsible for the accurate completion of the combined costs collection return. The submission should be subjected to the same scrutiny and diligence as any other financial returns submitted by the provider.

The board of (or its audit committee or other appropriate sub-committee), is also required to confirm the following in relation to the reference cost return (or provide details of non-compliance):

- the board or its appropriate sub-committee has approved the costing process ahead of the collection
- the finance director and education lead have, on behalf of the board, approved the final combined costs collection return before submission
- the return has been prepared in accordance with the approved costing guidance, which includes the combined costs collection guidance
- information, data and systems underpinning the combined costs collection return are reliable and accurate
- there are proper internal controls over the collection and reporting of the information included in the combined costs collection, and these controls are subject to review to confirm that they are working effectively in practice

- Costing and Education & Training teams are appropriately resourced to complete the combined costs collection return, including the self-assessment quality checklist and validations, accurately within the timescales set out in the guidance.

3. The Trust's Approach

The Trust's costing process is governed by the principles that costs are:

- Calculated on a full absorption basis in order to establish the full cost of services delivered
- Allocated and apportioned accurately by maximizing direct charging, and where this is not possible, using standard methods of apportionment
- Matched to the services that generate them to avoid cross subsidization

And following the approved costing process;

- Define the patient care to be costed
- Identify the activities
- Identify the relevant costs
- Classify costs
- Assign costs
- Validate the outputs

Our detailed approach is illustrated in **Appendix 1**. A detailed work plan, **Appendix 2** has been prepared to support the delivery of the submission and the completion of the quality checklist. The plan has been prepared and agreed to jointly by finance and the informatics team.

Our draft response to the board requirements and quality checklist is attached **Appendix 3 and 4** and **Appendix 5** is the final sign off template for the Finance Director and the Education Lead.

This will be reviewed and finalised ready for submission in Mid July 2017.

4. Key Milestones

February 2017	Combined costs collection guidance for 2016/17 published
April 2017	Release of HRG4+ 2016/17 Reference Costs Grouper and documentation
April 2017	Release of Unify2 compliant draft workbook
May 2017	Release of Unify2 compliant final workbook
19 June 2017	Cost collection window opens
31st July 2017	Collection deadline for London Trusts
04 August 2017	Reference costs collection window closes for non-CTP (Costing transformation program) patient level.

5. Requested Action

The Board is asked to confirm that:

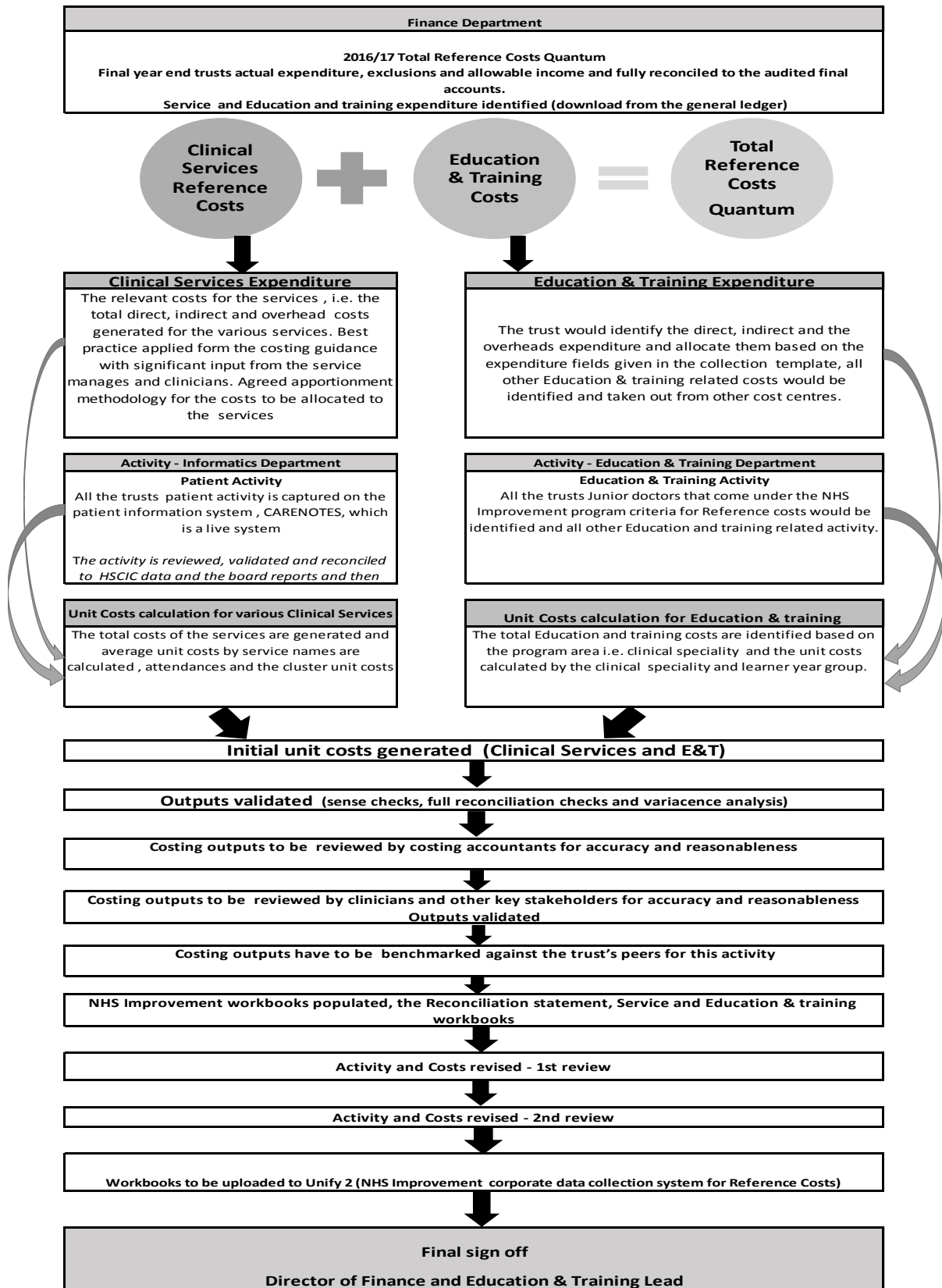
- Costs will be prepared with due regard to the principals and the standards set out in Monitor's approved Costing Guidance;
- Appropriate costing and information systems are in operation;
- Costing teams are appropriately resourced to complete the reference costs return within the timescale set out in the reference cost guidance;
- Procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference cost return; and
- the Trust will submit its return in accordance with the guidance.

An update in relation to the submission will be provided to the Board in due course.

Terry Noys
Finance Director
16TH June 2017

Appendix 1

2016/17 Integrated Reference Costs Process Map



Appendix 2 – Work Plan

Project Name: Integrated Reference Cost Collection 2016/17

Team	
Terry Noys - (TN)	Finance - Director of Finance
Carl Doherty - (CD)	Finance - Deputy Director of Finance
Udey Chowdhury (UD)	Finance - Assistant Director of Finance
Moranti Falade - (MF)	Finance - Cost Accountant
Darren Flanagan - (DF)	Finance - Finance Manager
Kryss Katsiavriades - (KK)	Informatics - Lead Information Analyst
Brian Rock - (BR)	Education & Training - Director of Education and Training

Total Timescale		
Start Date	End date	Weeks
11/05/2017	31/07/2017	11.6

Order	Rank	Task	Start date	Finish Date	No. of working days	Parent Task?	Complete?	Revised Finish date	Owner
1	1	Reference Cost Submission	11/05/2017	31/07/2017	58				MF
2	2	Overall Preparation	11/05/2017	11/05/2017	1	Y	Y		MF
2.1	3	Download Integrated Reference Cost Guidance 2016-17	11/05/2017	11/05/2017	1	Y	Y		MF
2.2	4	Download NHS Improvement MH Clinical Costing & Technical guidance	11/05/2017	11/05/2017	1	Y	Y		MF
2.3	5	Download HFMA MH Clinical Costing Guidance	12/05/2017	12/05/2017	1	Y	Y		MF
2.3	5	Establish main changes in 2016-17 ref cost guidance	12/05/2017	15/05/2017	2	Y	Y		MF
2.4	7	Prepare and agree timetable	16/05/2017	17/05/2017	2	Y	Y		MF
2.6	8	Agree frequency of meetings (working group)	17/05/2017	17/05/2017	1	Y	Y		MF
2.7	9	Finalise Work plan -Work breakdown structure based on new guidance	17/05/2017	23/05/2017	5	Y	Y		MF / CD
2.8	10	Prepare Board Assurance paper / Costing assurance review	01/06/2017	14/06/2017	10	Y	Y		MF / CD
3	11	Information Requirements (IR)							
		IR1: Collecting information for costing purposes							
		IR2: Management of information for costing							
3.1	12	Arrange first meeting with Information team	18/05/2017	19/05/2017	2	Y	Y		MF
3.2	13	Request and obtain all data as per activity requirements	18/05/2017	19/05/2017	2	Y	Y		MF
3.3	14	Arrange first meeting with Education & Training Lead	25/05/2017	25/05/2017	1	Y	Y		MF
3.4	15	Arrange first meeting with Financial Controller	25/05/2017	25/05/2017	1	Y	Y		MF
3.5	16	Activity Data Collection & Data Validation	08/06/2017	14/06/2017	5	Y	N		MF
3.6	17	IT review and sign-off of all activity	08/06/2017	15/06/2017	6	N	N		MF / KK / CD
3.7	18	Send activity data to all service managers to review and sense check	15/06/2017	16/06/2017	2	N	N		MF / DF
4	19	Costing Process (CP)							
		CP1: Role of the general ledger in costing							
		CP2: Clearly identifiable costs							
		CP3: Appropriate cost allocation methods							
		CP4: Matching costed activities to patients							
		CP5: Reconciliation							
4.1	20	Obtain copy of final accounts	22/05/2017	23/05/2017	2	Y	Y		MF
4.2	21	Obtain final trial balance at detailed account code level	22/05/2017	23/05/2017	2	Y	Y		MF
4.3	22	Identify the Reference cost expenditure	24/05/2017	25/05/2017	2	Y	Y		MF
4.4	23	Allocate lines on trial balance to reconciliation worksheet	19/06/2017	23/06/2017	5	N	N		MF
4.5	34	Identify the services to be excluded from the Reference costs	19/06/2017	23/06/2017	5	N	N		MF
4.6	35	Establish Reference Cost Quantum	19/06/2017	23/06/2017	5	N	N		MF / CD
4.7	36	Review /ensure costing methodology is in line with approved costing guidance	19/06/2017	23/06/2017	5	N	N		MF
4.8	37	Review and update cost centre analysis	19/06/2017	23/06/2017	5	N	N		MF
4.9	38	Review and update account code analysis	19/06/2017	23/06/2017	5	N	N		MF
4.10	20	Revise/update Cost pools	19/06/2017	23/06/2017	5	N	N		MF
4.11	22	Revise/update Apportionment methods	19/06/2017	23/06/2017	5	N	N		MF
4.12	23	Integrate the Clinical Costing process	19/06/2017	23/06/2017	5	N	N		MF
4.13	24	Check the final figures obtained in the step above agree to final audited accounts i.e. to FTC's	26/06/2017	26/06/2017	1	N	N		MF
4.14	25	Complete the reconciliation worksheet to the Total costs line 26 and ensure this agrees to trial balance download	26/06/2017	26/06/2017	1	N	N		MF
4.15	26	Check the quantum against last years to identify any material or unexpected variations and investigate	26/06/2017	26/06/2017	1	N	N		MF
4.16	27	Identify the costs of non-NHS patients and excluded services from output of the costing model and add to appropriate lines in reconciliation statement	26/06/2017	26/06/2017	1	N	N		MF
4.17	28	Build a Costing model	27/06/2017	27/06/2017	1	N	N		MF
4.18	29	Ensure the total reference cost quantum in ref cost workbook agree to the total ref cost submission line 26 on the reconciliation worksheet	27/06/2017	27/06/2017	1	N	N		MF
4.19	30	Import the quantum into the costing model	27/06/2017	28/06/2017	2	N	N		MF
5	39	Costing Methodology (CM)							
		CM1: Admitted Patient care - Clusters and attendances							
		CM2: Additional staff activities							
		CM3: Group activities							
		CM4: The income ledger							
5.1	40	Integrate the Clinical Costing process	03/07/2017	06/07/2017	4	N	N		MF
5.2	41	Work out clustered unit costs (CAMHS)	03/07/2017	06/07/2017	4	N	N		MF
5.4	42	Work out unclustered unit costs (CAMHS)	03/07/2017	06/07/2017	4	N	N		MF
5.4	42	Review and revise data as needed	03/07/2017	06/07/2017	4	N	N		MF
6	44	Education and Training (E&T)							
6.1	45	Set-up process to identify and analyse the relevant E&T expenditure and Income	07/07/2017	11/07/2017	3	N	N		MF
6.2	46	Education & Training Activity - collect and revise	07/07/2017	11/07/2017	3	N	N		MF
6.3	47	Review E &T activity and expenditure with the finance managers	07/07/2017	11/07/2017	3	N	N		MF
6.4	48	Arrange second meeting with Education & Training Lead	07/07/2017	11/07/2017	3	N	N		MF
7	49	Governance & Assurance							
7.1	50	Obtain Board approval of reference costing process and methodology (Internal)	26/06/2017	26/06/2017	1	N	N		TN / CD
7.2	51	Final check of the reconciliation to statement against last years to identify any material or unexpected variations	27/06/2017	27/06/2017	1	N	N		MF
7.3	52	Review and revise data as needed	10/07/2017	14/07/2017	5	N	N		MF
7.4	53	Populate ref cost workbooks	10/07/2017	14/07/2017	5	N	N		MF
7.6	54	Complete Survey and Self-assessment checklist	10/07/2017	14/07/2017	5	N	N		MF
8	55	1st Progress Review / Sense checking/Benchmarking							
8.1	56	Review outliers			0	N	N		MF
8.2	57	Review Non-mandatory validations			0	N	N		MF
8.3	58	Benchmarking - Internal year on year comparison			0	N	N		MF
8.4	59	Benchmarking - National comparison			0	N	N		MF
8.5	60	Review benchmarking results with FM's and clinicians best placed to validate costs			0	N	N		MF / DF
8.6	61	Variance analysis and explanation			0	N	N		MF / DF
9	62	2nd Progress Review							
10	63	Submission & Final reviews							MF / UC
10.1	64	Populate template	18/07/2017	26/07/2017	7	N	N		MF
10.2	65	Adjust for any changes required	18/07/2017	26/07/2017	7	N	N		MF
10.3	66	2nd Review	18/07/2017	26/07/2017	7	N	N		MF
10.4	67	Final changes if any	18/07/2017	26/07/2017	7	N	N		MF / UC
10.5	68	Submit workbooks on Unify 2 (Mandatory REFC submission deadline)	27/07/2017	28/07/2017	2	N	N		MF
10.6	69	Director of Finance and Director of Education sign-off	28/07/2017	31/07/2017	2	N	N		TN / BR
		Reference Cost Collection window closes	04/08/2017	04/08/2017					
		Post Submission Business Continuity Review							

Appendix 3 – Draft Response to Board Requirements

	Requirement	Assurance
1	The board or its appropriate sub-committee has approved the costing process ahead of the collection	The costing process is governed by the principle that costs are calculated on a full absorption basis as prescribed by the principles and standards set out in Monitors Approved Costing Guidance. with the costing principles, standards, and guidance for reference costs incorporated in Monitor's formal guidance issued February 2017
2	The finance director and education lead have, on behalf of the board, approved the final combined costs collection return before submission.	The finance director and education lead have, on behalf of the board, have approved the methodology and will approve the final combined costs collection return before submission.
3	The return has been prepared in accordance with the Approved costing guidance, which includes the combined costs collection guidance	The return are currently being prepared in accordance with the Approved costing guidance, which includes the combined costs collection guidance
4	Information, data and systems underpinning the combined costs collection return are reliable and accurate	Costs are developed using financial information from both the ledger (Oracle) and together with appropriate data extracts from the Patient Information system (Care Notes)
5	There are proper internal controls over the collection and reporting of the information included in the combined costs collection, and these controls are subject to review to confirm that they are working effectively in practice	The reference costs submission is coordinated through the finance team with support from the Information team and there are proper internal controls over the collection and reporting of the information. A dedicated team is working against a detailed project plan.
6	Costing and E&T teams are appropriately resourced to complete the combined costs collection return, including the self-assessment quality checklist and validations, accurately within the timescales set out in the guidance	A working group is in place with a dedicated Cost Accountant, headed up by the Deputy Director of Finance. A project plan is in place which identifies resources required to deliver all the tasks required.

Appendix 4 Draft Response to Self-Assessment Checklist

2016/17 Integrated collection workbook

Self-assessment quality checklist

	Check	Trusts Draft Response	Assurance
QC1	Total costs: The reference costs quanta have been fully reconciled to the signed annual accounts through completion of the reconciliation statement workbook in line with guidance	Fully reconciled to within +/- 1% of the signed annual accounts	This is part of the checking process and will be signed off by Deputy Director of Finance.
QC2	Total activity: The activity information used in the reference costs submissions to report admitted patient care, outpatient attendances and A&E attendances has been fully reconciled to provisional Hospital Episode Statistics and documented	Fully reconciled and documented	We are not required to report activity to HES. In place of HES, activity data is reported to Health & Social Care Information centre (HSCIC) as part of the Information dept.'s routine process, and is reviewed in-house prior to submission.
QC3	Sense check: All relevant reference costs unit costs under £5 have been reviewed and are justifiable	All relevant unit costs under £5 reviewed and justified [state reason]	This is part of the checking process and will be signed off by Deputy Director of Finance.
QC4	Sense check: All relevant reference costs unit costs over £50,000 have been reviewed and are justified	n/a – no relevant costs over £50,000 within the submission	This is part of the checking process and will be signed off by Deputy Director of Finance.
QC5	Sense check: All BAU reference costs unit cost outliers (defined as unit costs less than one-tenth or more than ten times the previous year's national mean average unit cost) have been reviewed and are justifiable	n/a – no unit cost outliers within the submission	This is part of the checking process and will be signed off by Deputy Director of Finance.
QC6	Benchmarking: Data has been benchmarked where possible against national data for individual unit costs and for activity volumes	Some but not all cost an activity data within the submission has been benchmarked using another benchmarking process [state]	We will undertake a review of previous year compared to this year, and any variances understood.
QC7	Data quality: Assurance is obtained over the quality of data for 2016-17	Internal management checks have provided assurance over data quality	Internal checks have been carried out by the Information team. This provides assurance on data quality which we use for out costings
QC8	Data quality: Assurance is obtained over the reliability of costing and information systems for 2016-17	Internal management checks have provided assurance over costing and information system reliability	We will undertake internal management checks to provide assurance over costing and information systems
QC9	Data quality: Where issues have been identified in the work performed on the 2015-16 data and systems, these issues have been resolved to mitigate the risk of inaccuracy in the 2016-17 combined costs collection submission	Some exceptions have been resolved but not all	The work plan includes specific responsibilities for the identification and resolution of data quality issues.
QC10	Data quality: All other non-mandatory validations as specified in the guidance and workbooks have been considered and any necessary revisions made	All non-mandatory validations have been considered and necessary revisions made	The work plan includes specific responsibilities for the resolution of all validations. Sign off by Deputy Finance Director

Appendix 5

Statement of directors' responsibilities for the 2016/17 combined costs collection

In producing the annual combined costs collection return the provider must include a statement of the finance director and education leads responsibilities.
This should be kept on site and made available if external auditors request it, in the following form of words:

[NHS foundation trusts/NHS trusts] are required in accordance with the [NHS Provider Licence/Accountability Framework] [delete as appropriate] to comply with NHS Improvement's Approved costing guidance in the completion of the combined costs collection. In preparing the combined costs collection return the board or relevant sub-committee is required to take steps to satisfy themselves that:

- the cost return has been prepared in accordance with the Approved costing guidance, which includes the combined costs collection guidance
- the information, data and system underpinning the return are reliable and accurate
- there are proper internal controls over the collection and reporting of the information included in the combined costs collection, and these controls are subject to review to confirm that they are working effectively in practice
- costing and E&T teams are appropriately resourced to complete the return, including the self-assessment quality checklist and validations, accurately within the timescales set out in the reference costs guidance
- The content of the return is not inconsistent with internal and external sources of information.

The finance director and education lead confirm to the best of their knowledge and belief the board has discharged its responsibilities above and the trust has complied with these requirements in preparing the combined costs collection return.

By order of the board

NB: sign and date in any colour ink except black

.....Date.....Finance Director

.....Date.....Education lead

Board : June 2017

Item : 15

Title : Audit Committee Terms of Reference

Summary:

The Board is asked to approve the updated Audit Committee Terms of Reference which were reviewed and agreed by the Audit Committee at its meeting on 16 May 2017.

The ToR have been amended from the previous version, as follows:

- Some re-formatting
- Removal of duplicate paragraphs

For : Approval

From : Terry Noys, Director of Finance

Audit Committee Terms of Reference

Ratified by:	Board of Directors
Date ratified:	27 June 2017
Name of originator/author:	David Holt, Committee Chair
Name of responsible committee/individual:	Audit Committee / Committee Chair
Date issued:	28 June 2017
Review date:	May 2018

AUDIT COMMITTEE TERMS OF REFERENCE

CONSTITUTION

1. The Board of Directors hereby resolves to establish a committee to be known as the Audit Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

MEMBERSHIP

2. The Committee will be appointed by the Board of Directors.
3. All members of the Committee should be independent Non-Executive Directors of the Trust. For the avoidance of doubt, the Trust Chair shall not be a member of the Committee.
4. The Committee shall consist of at least three members.
5. The Board should appoint the Chair of the Audit Committee from amongst its independent Non-Executive Directors.
6. At least one member of the Audit Committee should have recent and relevant financial experience.

ATTENDANCE

7. The Director of Finance and appropriate External and Internal Audit representatives shall normally attend meetings.
8. At least once a year the External and Internal Auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.
9. The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report.
10. The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.
11. The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.

QUORUM

12. This shall be at least two members.

SECRETARY

13. A Secretary shall be appointed for the Committee.

FREQUENCY OF MEETINGS

14. The Committee shall meet at least four times per year.
15. The external or internal auditor may request a meeting whenever they consider it necessary.

AGENDA & PAPERS

16. Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
17. Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

MINUTES OF THE MEETING

18. The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.
19. Approved minutes will be forwarded to the Board of Directors for noting.
20. In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.

AUTHORITY

21. The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.
22. The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

DUTIES

Governance, Risk Management and Internal Control

23. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives
24. In particular, the Committee will review the adequacy of:
 - 24.1 all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission's *Judgement Framework*), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors
 - 24.2 the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
 - 24.3 the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Clinical Quality, Safety, and Governance Committee
 - 24.4 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect
 - 24.5 the financial systems
 - 24.6 the Internal and External Audit services, and counter fraud services
 - 24.7 compliance with *Board of Directors' Standing Orders* (BDSOs) and *Standing Financial Instructions* (SFIs)
25. The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following:
 - 25.1 the process for the completion and up-dating of the Assurance Framework;
 - 25.2 the relevance and quality of the assurances received
 - 25.3 whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and
 - 25.4 Whether the Assurance Framework remains relevant and effective for the organisation.
26. The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

27. In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, the Local Counter-Fraud Service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.
28. The Committee shall review at each meeting a schedule of debtors balances, with material debtors more than six months requiring explanations/action plans.
29. The Committee shall review at each meeting a report of tenders and tender waivers since the previous meeting.

INTERNAL AUDIT

30. The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by:
 - 30.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
 - 30.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
 - 30.3 consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources
 - 30.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
 - 30.5 monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework
 - 30.6 ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation

EXTERNAL AUDIT

31. The Committee shall review the work and findings of the External Auditor appointed by the Board of Governors, and consider the implications and management's responses to their work. This will be achieved by:
 - 31.1 approval of the remuneration to be paid to the External Auditor in respect of the audit services provided
 - 31.2 consideration of recommendations to the Board of Governors relating to the appointment and performance of the External Auditor

- 31.3 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy
- 31.4 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- 31.5 review all External Audit reports and any work carried out outside the annual audit plan, together with the appropriateness of management responses

OTHER ASSURANCE FUNCTIONS

- 32. The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust
- 33. These will include, but will not be limited to, any reviews by NHSi, Department of Health arm's length bodies or regulators / inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)
- 34. In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Clinical Quality, Safety, and Governance Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed.
- 35. In reviewing the work of the Clinical Quality, Safety, and Governance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.
- 36. The Audit Committee should incorporate within its schedule a review of the underlying processes for the Information Governance Toolkit and the Quality Accounts production to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced.

MANAGEMENT

- 37. The Committee shall request and review reports and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control
- 38. They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements

FINANCIAL REPORTING

- 39. The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:
 - 39.1 the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
 - 39.2 changes in, and compliance with, accounting policies and practices

39.3 unadjusted mis-statements in the financial statements

39.4 major judgemental areas

39.5 significant adjustments resulting from the audit

40. The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors

APPOINTMENT, REAPPOINTMENT, AND REMOVAL OF EXTERNAL AUDITORS

41. The Committee shall make recommendations to the Council of Governors, in relation to the appointment, reappointment, and removal of the External Auditors, providing the Council of Governors with information on the performance of the External Auditor
42. The Committee shall approve the remuneration and terms of engagement of the External Auditors

OTHER MATTERS

43. At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.
44. The Committee should consider holding a discussion at the end of some meetings with regards to the effectiveness of the committee, considering those areas highlighted within this paper.

SOURCES OF INFORMATION

45. The Committee will receive and consider minutes from the Clinical Quality, Safety, and Governance Committee. The Committee will receive and consider other sources of information from the Director of Finance.

REPORTING

46. The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Board of Directors to any issues in the minutes that require disclosure or executive action.
47. The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement, specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements, and the appropriateness of the self-assessment against the Care Quality Commission's *Judgement Framework*.
48. The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

Board of Directors : June 2017

Item : 16

Title : Outline Business Case for Trust Wide Scheduling

Summary:

The Business Case for implementation of Trust-wide Scheduling will describe in outline what the project is attempting to achieve and the business justification for doing so. This document collates the information previously provided in the project brief and supplements this information adequately to provide an adequate base for decision making regarding project approval and a strong foundation for the initiation of the project, should permission to proceed be given. The Business Case will define:

What the project aims to achieve,

Why it is important to achieve it, and

When indicative duration of the project and expected delivery of benefits

For : Approval

From : David Wyndham-Lewis, Director of IM&T

PROJECT DOCUMENTATION**IM&T DIRECTORATE****Trustwide Scheduling
Outline Business Case**

Identity:

Project Name	Trustwide Scheduling
Service Desk Request Number	N/A
Document Name	Trustwide Scheduling – Outline Business Case
Release	DRAFT
Date	5 th June 2017
Version Number	1.0
Author	David Wyndham Lewis / Niall Tesic-O'Dwyer
Project Sponsor	Terry Noys

1 Document Control

1.1 Document Location

- 11.1 Find the source of the document and any subsequent versions at:
P:_New Folder Structure\20 PPM\20 Projects\TVPIMT-P114 - Trustwide Scheduling\

1.2 Revision History

Version	Revision Date	Summary of Changes	Revised by
0.1	15/05/2017	First Draft	David Wyndham Lewis
0.2	26/05/2017	Draft – Additional Information	Niall Tesic-O’Dwyer
0.3	02/05/2017	Draft - Additional Information	Niall Tesic-O’Dwyer
0.4	05/06/2017	Draft – Feedback updates and Additional Information	Niall Tesic-O’Dwyer
1.0	20/06/2017	Release for Trust Board	David Wyndham Lewis

1.3 Approvals

This document requires the following approvals:

Name	Title	Issue Date
Terry Noys	Deputy Chief Executive and Director of Finance	
Terry Noys	Finance	
David Wyndham Lewis	Director of Technology and Transformation	
David Wyndham Lewis	Information Governance	
Irene Henderson	Clinical Governance	
N/A	IMT Steering Committee	
N/A	Management Team	
N/A	Trust Board	

1.4 Distribution

Issued version of this document sent to:

Name	Title	Issue Date
Terry Noys	Deputy Chief Executive and Director of Finance	
David Wyndham Lewis	Director of Technology and Transformation	
Irene Henderson	Clinical Governance	

David Wyndham Lewis	Information Governance	
TBC	Finance	
Sally Hodges	Director of CYAF	
Julian Stern	Director of AFS	
Brian Rock	Dean and Director of Education and Training	

1.5 Related documents

These materials are background reference:

Ref No	Document Ref	Title	Version
TS001	Essentia Report	Tavistock and Portman NHS FT Relocation - Activity and space analysis - March 2017	11.0

1.6 Glossary of Terms

Acronym	Definition
WTE	Whole Time Equivalent
FY	Financial Year
EPR	Electronic Patient Record
SIMS	Student Management Information System
CCS	Crown Commercial Service

Contents

1	Document Control	2
1.1	Document Location	2
1.2	Revision History	2
1.3	Approvals	2
1.4	Distribution	2
1.5	Related documents	3
1.6	Glossary of Terms	3
2	Document Purpose	5
3	Executive Summary	6
4	Project Definition	7
4.1	Background	7
4.2	Strategic Context	7
4.3	Objectives	8
4.4	Constraints	10
5	Options	13
5.1	Options Appraisal	13
5.2	Recommended Option	16
5.3	High-Level Strategic and Operational Benefits	17
6	Assessment of Benefits	18
6.1	Cash Releasing Benefits	18
6.2	Non - Cash Releasing Benefits	19
6.3	Disbenefits	20
7	Analysis of Recommended Option	21
7.1	Timescales	21
7.2	Risks	21
7.3	Interfaces	23
8	Financial Information	24
8.1	Cost	24
8.2	Funding	25
9	Appendix A - Essentia Report	26

2 Document Purpose

- 2.1 The Business Case for implementation of Trust-wide Scheduling will describe in outline what the project is attempting to achieve and the business justification for doing so. This document collates the information previously provided in the project brief and supplements this information adequately to provide an adequate base for decision making regarding project approval and a strong foundation for the initiation of the project, should permission to proceed be given. The Business Case will define:

What the project aims to achieve
Why it is important to achieve it
When indicative duration of the project and expected delivery of benefits

- 2.2 Given the scale of this project, it is not necessary to develop a full five case model business case for this project.

3 Executive Summary

- 3.1 As part of preparatory works for the Relocation programme, the Trust commissioned a third party, Essentia, to analyse the data current available on the profile of our activity over time and how this will guide space requirements for our new site. This exercise highlighted substantial peaks and troughs in our activity over the working week and across the academic year.
- 3.2 The Relocation Programme Board has previously noted that some levelling of these peaks and troughs will be necessary and in advance of Relocation. Also, the Estate Sustainability work stream has highlighted:
- The benefit of undertaking this levelling of activity within the current estate as a means of ensuring space sustainability in the run up to Relocation; and
 - The opportunity of embedding the organisational and cultural changes necessary for activity levelling before Relocation thus allowing for trial and refinement of the scheduling model to fit our services.
- 3.3 Trust-wide Scheduling, while it will incorporate the implementation of an enabling IT scheduling tool, is not fundamentally an IMT project. The Trust services will need to own the bulk of the work required to deliver the expected benefits, recognising that this project will need to draw significantly on the clinical, education and administrative expertise already present in the directorates to develop a scheduling model that works across the Trust.
- 3.4 An important note is this project retains significant interdependencies with other proposed changes to the Trust over the coming four years. These interdependent projects include:
- Relocation
 - Electronic Referrals
 - Patient Check In and Patient Flow
 - Integration Platform
 - Student Information Management System (MyTAP)
 - Patient Engagement (including Remote Patient Therapy / Consultation)
- 3.5 The case will recommend 'Option 4', to create a central scheduling project team to deliver the necessary changes to the Trust-wide schedule, to procure and implement both a scheduling tool and integrated room booking system and to utilise these tools in the development of a future scheduling model and a phased roadmap for its implementation.
- 3.6 The project team will vary in size during its lifecycle peaking at 9.5 WTE between late 2017 and mid-2018. The peak costs of the project are in 2017/18 FY.

Expenditure Type	2017/18	2018/19	2019/20	3-Year Total	Annual Revenue Consequence
Initial Capital Expenditure	£118,000	£30,000	£30,000	£179,000	£30,000
One-off Capital Costs	£58,000	£200,000	£	£258,000	£
On-going Revenue Costs	£	£4,000	£4,000	£8,000	£4,000
GRAND TOTAL	£176,000	£234,000	£34,000	£444,000	£34,000

4 Project Definition

4.1 Background

- 4.1.1 The Essentia Report (provided as Appendix A to this Business Case) sets out in detail the activity profile as measured in 2015/16.
- 4.1.2 The Trust-wide Scheduling project will seek to develop an aspirational model for efficient scheduling of all services and set out, between now and the date of Relocation (February 2021), iterative changes to the existing schedule of activity to move towards the aspirational model. The project will implement an IMT toolkit to provide visibility of real activity, space utilisation and intelligent scheduling recommendations to advise day-to-day planning.
- 4.1.3 In so doing the project will achieve an actual profile of activity “on the ground” in advance of Relocation that assures the Trust of its ability to operate within the space available within the new building. Also, the project will achieve an improved efficiency of space utilisation that will provide cost avoidance both now and in the future with the commissioning of new or expanded services from the Trust.
- 4.1.4 This Business Case will set out the options available to achieve these goals, assess these options and make a recommendation to the Trust to best achieve the required benefits.

4.2 Strategic Context

- 4.2.1 This project will support the delivery of the Trust objectives in the following areas:

Strategic Objective	Related Project Aims
Aim 2 – Maintaining and developing the quality and reach of our clinical services	<p>The project will seek to support the planning and scheduling of clinical activity so as to:</p> <ul style="list-style-type: none"> • Work in close collaboration with CYAF, ASF, DET and other departments. • Help ensure the provision of existing services is resilient from both staffing and space perspectives. • Help simulate both new and changes to existing clinical activities to understand staffing and space requirements. • Trial and embed the new services before the relocation to ensure the cultural and process changes needed are integrated.
Aim 3 – Growing and developing our training and education and delivering a remodelled National Training Contract	<p>The project will seek to support the planning and scheduling of education activity so as to:</p> <ul style="list-style-type: none"> • Help ensure the provision of existing services is resilient from both staffing and space perspectives. • Help simulate both new and changes to existing education activities to understand staffing and space requirements.

	<ul style="list-style-type: none"> • Ensure that the cultural and process changes needed before Relocation are trialled and embedded before the services move. • Develop training for the administrators, users and support staff to ensure knowledge of the new services are embedded.
Aim 4 – Supporting the wellbeing and engagement of our staff	<p>The project will seek to:</p> <ul style="list-style-type: none"> • Ensure allocation of suitable space to staff based on their activity. • Provide all appropriate bookable space for staff provided as and when required. • Through efficient and proactive allocation of space allow for the development of a pleasant, calming, containing and consistent workspace.
Aim 5 – Delivering a sustainable financial future for the Trust	<p>The project will seek to:</p> <ul style="list-style-type: none"> • Ensure maximisation of space utilisation. • Provide maintenance and efficiency of space utilisation through changes to service configuration as part of continuous service operation. • Identify mechanisms for more efficient use of existing space and limit additional costs to the Trust from the lease of any additional space, capital costs for reconfiguration of existing estate or provision of excessive space within the new building.
Aim 7 - Develop our infrastructure to support our work	<p>The project will seek to:</p> <ul style="list-style-type: none"> • Provide a scheduling platform that is integrable to both the EPR, CareNotes, and the SIMS, MyTAP. • Provide scheduling data in an electronic form to be used as part of the management of Patient Check In and Flow and Electronic Referrals. • Design, document and implement the future policy, process and procedures of the new Trust-wide scheduling services to embed the change and supported by a new role of a Scheduling Manager.

4.3 Objectives

Project Objectives	Measurable Targets
1. Level overarching activity across all service lines to meet the 80% utilisation baseline for	1.1 Reschedule CYAF activity to ensure it utilises less than 25 concurrent rooms, inclusive of supervision activity, based on current service

Project Objectives	Measurable Targets																							
room utilisation within the new building design.	volumes. Iteratively implemented and complete by September 2020.																							
	1.2 Reschedule AFS activity to ensure it utilises less than 10 concurrent rooms, inclusive of supervision activity, based on current service volumes. Iteratively implemented and complete by September 2020.																							
	1.2 Reschedule DET activity to ensure it utilises less than the concurrent rooms by room type set out in the Essentia report below, based on current service volumes. Iteratively implemented and complete by September 2019. For this to be achieved the dates must be published in the 2019 Prospectus.																							
	<p>Source: Essentia Report</p> <table><tr><th>Room Types</th><th>Capacity (no. people)</th><th>Area (sqm)</th></tr><tr><td>Lecture Theatre</td><td>138</td><td>165</td></tr><tr><td>Small Lecture</td><td>40</td><td>60</td></tr><tr><td>Large Seminar</td><td>20</td><td>36</td></tr><tr><td>Medium Seminar</td><td>12</td><td>18</td></tr><tr><td>Small Seminar</td><td>6</td><td>12</td></tr><tr><td>Tutorial room</td><td>4</td><td>12</td></tr><tr><td>Small Tutorial</td><td>2</td><td>8</td></tr></table>	Room Types	Capacity (no. people)	Area (sqm)	Lecture Theatre	138	165	Small Lecture	40	60	Large Seminar	20	36	Medium Seminar	12	18	Small Seminar	6	12	Tutorial room	4	12	Small Tutorial	2
Room Types	Capacity (no. people)	Area (sqm)																						
Lecture Theatre	138	165																						
Small Lecture	40	60																						
Large Seminar	20	36																						
Medium Seminar	12	18																						
Small Seminar	6	12																						
Tutorial room	4	12																						
Small Tutorial	2	8																						
2. Increase room scheduling frequency for existing bookable rooms	2.1 Increase room scheduled frequency to greater than 80% for all bookable rooms within the current estate. Complete by September 2019. Processes put in place to validate the maintained efficiency of room utilisation termly.																							
	2.2 Assess the success of location specific ownership versus open ownership in maintaining booking frequency above 80% over a 6 month period. Complete by September 2019. Processes put in place to validate the maintained efficiency of room utilisation termly.																							
3. Increase room occupancy for existing bookable rooms	3.1 Increase average room occupancy to greater than 60% for all bookable rooms within the current estate. Complete by September 2018.																							
	3.2 Maintain physical occupancy measurement for two periods of 3 months, 6 months apart, across a minimum of 50% of the bookable estate. Complete by December 2018.																							
4. Confirm model for consistent room scheduling for	4.1 Utilising scheduled therapy rooms simulate scheduling of activity where the patient's group requires the same therapy room for each visit to																							

Project Objectives	Measurable Targets
individual patients within required patient cohorts	the Trust. Simulated with actual patient volumes and complete by September 2018.
	4.2 Schedule 60% of existing patients within the in scope clinical service lines using the new consistent scheduled therapy rooms over a minimum of a twelve-month period. Complete by September 2019.
	4.3 Schedule more than 95% of existing patients within the in scope clinical service lines using the new consistent scheduled therapy rooms over a minimum of a twelve-month period. Complete by September 2020.
5. Demonstrate the utility of wayfinding and student notification in enabling educational activity to be relocated within the estate	5.1 Utilising a combination of scheduled and bookable seminar and lecture facilities simulate scheduling of concurrent educational activity for a minimum of 50% of current courses to identify any benefits of variable room allocation. Complete by May 2018.

4.4 Constraints

Constraints	Measures to address constraints
Opportunities to significantly refine the broad schedule are limited to annual academic boundaries and require confirmation adequately in advance of the year for publication in the prospectus.	<p>Plan for iterative changes in the 2018/19 and 2019/2020 annual boundaries only.</p> <p>Simulation of changes in the toolkit will allow for an understanding of opportunities for minor refinement in the year and at the 2017/18 boundaries working within the constraints of the published 2017/18 prospectus.</p> <p>The focus of the “in year” project activity will be on clinical scheduling aspects of the project.</p>
The system and processes must operate within the constraints of the National Electronic Referrals system.	<p>The project must take the requirements of the national ERS into account. It is important that the direct integration to ERS is provided via CareNotes and not the new scheduling system.</p> <p>A separate project is planned for the 17/18 FY to undertake the integration of eReferrals to CareNotes.</p>

Constraints	Measures to address constraints
Many Trust staff work within both the clinical and education streams of the Trust business. Scheduling must accommodate consolidated resource planning across both streams.	<p>The project must include operational representatives from each of AFS, CYAF and DET.</p> <p>This additional complexity will be made clear in the specification provided to potential system suppliers.</p>
Many Trust staff work part time and may well work elsewhere in private practice or other organisations. Changes to our schedule must take into account the time necessary to accommodate this issue.	<p>HR and senior management engagement from the start of the project to consider and address this issue.</p> <p>Please note consideration has been given to Job Planning systems. This has not been deemed valuable at this time and can again be considered following completion of this project.</p>
The existing room booking system(s) is of older design and has limited user-facing functionality.	<p>The existing room booking system will be replaced as part of the scope of this project.</p> <p>All bookings present on the existing system will be migrated to the new platform as part of the project.</p>
While accepting that technology has a significant role to play in the delivery of the project; the project recognises the key challenges for the project are the requirement for changes in attitudes and culture within and across the Trust towards the process (and associated issues) to do with timetabling, clinic bookings and space allocation.	The project will work with the Communications team to build a project communications plan will include Intranet updates, emails, face-to-face meetings, surveys and so on. The project will work through the assigned department representatives to ensure the maintenance of consensus during the project delivery.
The project requires much data gathering before any detailed design work can take place. The project will need to fully understand the current process flows and put forward recommendations for future improvements.	The project will start to work in close collaboration with the departments involved or impacted by scheduling to understand how the system works today, the current issues and limitations, and capture all future requirements for the new service.
The project will work with current scheduling staff and so will take an increasing level of involvement on the schedule part of their current roles. These are backfilled to a level	The project will work in close collaboration mainly with the AFS, DET and CYAF departments and will work closely with all other project connected departments to help ensure the correct and timely implementation of any changes. Will plan to ensure levels of activity are

Constraints	Measures to address constraints
that may not be enough during certain periods of the delivery of the project	as evenly spread as possible throughout their time on the project so not to interfere with their other non-scheduling activities.
It will be important to ensure that the project is correctly scoped and planned with the delivery of some services in advance of any final solution delivery.	The procurement process will design the further solution and ensure it is better understood. The outcome of the acquisition process will update the Final detailed business case with the detail of the project delivery allowing the project proceed.

5 Options

5.1 Options Appraisal

Option Number/ Description	Shortlisted (S) or Rejected (R)	Option Review
1. Do nothing	R	<p>This option is the current state and is used as a baseline to compare all other appraisal options.</p> <p>The work is decentralised, completed manually and with no centralised electronic method used. The current scheduling of activity is known to create excessive peaks and troughs in activity over the working week and year.</p> <p>The Statement of Accommodation for the new building and with increased demand for space, it is clear that we cannot contain these peaks of activity within the available footprint of the new facility.</p> <p>Selection of the “Do nothing” option would present a very high risk to the Relocation programme and see the continuation of the currently blockers to service growth.</p>
2. Continue manual rescheduling of clinical and education activity, but now utilising a central scheduling team and improve the current processes.	R	<p>While this mechanism could potentially achieve the desired benefits the level of additional administrative resource to create a shared, central team required would be excessive.</p> <p>Works have already commenced in this area, albeit within the silos of each team. While this work has progressed the challenges of scheduling across department boundaries, have become more apparent and demonstrate that, without a combination of technology support and additional resource, the changes are not achievable within the specified timelines.</p> <p>This option would require the capture and documentation of the whole process, and enforcement of any new</p>

Option Number/ Description	Shortlisted (S) or Rejected (R)	Option Review
		<p>and recommended Policies, Processes, and Procedural changes.</p> <p>Areas for improvement is in information duplication and sharing, which could help improve the speed of the whole process. Also, requiring the introduction of new standardised policies and procedures to improve the existing system and processes.</p>
<p>3. Procure and implement an IMT system to support the scheduling project only.</p> <p>Undertake simulated rescheduling and then implement the chosen scheduling model across all Trust activity. Then integrate to the existing room booking system.</p>	S	<p>While this option could deliver the expected benefits in full, continued use of the current booking system and methods is likely to create challenges with the implementation of new processes. A modern system would provide functionality, set out below in option 4, which would address this and other issues.</p>
<p>4. Procure and implement both an IMT system to support the scheduling project and a modern room booking system, and then integrate these into the scheduling toolkit.</p> <p>Undertake simulated rescheduling and then implement the chosen scheduling model across all Trust activities.</p>	S	<p>The preferred option and most likely to deliver the benefits in full. In addition to the scheduling system a more modern booking system would allow for:</p> <ul style="list-style-type: none"> • Integrated wayfinding for rooms and desks • Ensure only one centralised booking and timetable system and require the possible integration of other related systems. • Desk booking and scheduling in addition to room booking and scheduling • A broader range of devices for both booking and timetable viewing, including smartphones • Active room monitoring and release if meetings do not start to schedule • Meeting/lecture/seminar attendance monitoring and review of integration into MyTAP • Provide a centralised Timetable service

Option Number/ Description	Shortlisted (S) or Rejected (R)	Option Review
		<ul style="list-style-type: none">• Allows gathering of the accurate utilisation details that will help the Trust in its future strategic planning.• Develop and document the future policy, process and procedures to maintain the new scheduling service.

5.2 Recommended Option

5.2.1 The recommendation for the Trust is progress option 4:

- Procure and implement an IMT system to support the scheduling project.
- Procure and implement a modern room booking system and integrate to the scheduling toolkit.
- Undertake simulated rescheduling and then implement the chosen scheduling model across all Trust activity.

5.2.2 This option provides the greatest assurance of the delivery of all project benefits and objectives within the required timelines.

5.2.3 Following discussions with the department heads of CYAF, AFS and DET, they agreed to provide a total of 5½ WTE staff from bands 6 and 7, for a duration of 10 months and starting in autumn 2017 seconded from existing posts and back filled. Appropriately skilled staff will be provided for backfill, funded by this project. The Project Staff will also include a full-time Project Manager and Business Analyst (shorter period) and for a shorter term activity of 3 to 6 months IMT staff who provide skills in CareNote application changes and training.

5.2.4 Given the scale of the procurements required for option 4, it is recommended the Trust sources and engages procurement support for the project. Based on an initial review the reasonable procurement approach is set out below and subject to review and comment from the selected acquisition partner.

- A single specification covers the requirements for scheduling, booking, wayfinding and all required hardware to be drafted by the Trust.
- The above procured via a suitable procurement framework, such as CCS Technology Products 2 (RM3733 - <https://ccs-agreements.cabinetoffice.gov.uk/contracts/rm3733>). As part of this acquisition, the project expects that multiple suppliers may wish to partner to provide the solution in full (i.e. one vendor providing scheduling and another providing booking and wayfinding). Where this is the case, the Trust should consider the inherent risk of this approach and should ensure the appointment of a lead partner with responsibility for the end-to-end solution and any technical integrations between systems.
- Given the length of the change project that follows technical system implementation, the expected contract value and the inherent recommended need to integrate to both CareNotes and MyTap that the Trust seek an initial contract term of 5 years for the systems and hardware with options to extend (ideally 5+2+2+1). The contract should include equipment and technology refresh at years 3, 6 and 9.
- Project support for this project will be critical to successful delivery and should include project management and change management as a minimum. There is also a possible requirement for specialist technical skills related to best practice for clinic modelling, similar to work undertaken in many Trusts regarding Referral To Treatment (RTT). Given these requirements, the recommendation is these requirements be converged and contracted as a service from specialist suppliers.

- It may be necessary given the tight timescales to separate contract of project management (PM) and business analyst (BA), which will be required immediately (the PM) and late in 2017 (the BA) following project approval, from other project support. The options available are considered at project initiation.

5.3 High-Level Strategic and Operational Benefits.

5.3.1 These linked benefits to the primary objectives of the project and arranged into categories. The benefits marked as Financial (tangible) or Non-financial (intangible). The project's benefits categories are:

- Management
- Productivity
- Efficiency
- Resilience

Category	Financial / Non-Financial	Benefit
Management	Non-financial	End-User Satisfaction
		Ensures compliance with legal and Trust best practice and provides a full audit trail to meet legal compliance
		Utilisation information delivered within a timely manner
		When the schedule or booking changes, real-time calendar updates are provided
Productivity	Non-financial	Time to change of Timetables reduced considerably
		Improved staff efficiency owing to greater management of information and training
		Reduction in time to complete previous paper-based activities. Improved documentation on the whole booking policy, process and procedures
Efficiency	Financial	Reduction in time to complete tasks, i.e. via the web can immediately change reservations rather submit requests or updating via paper, email or another spreadsheet-based system
		Financial savings in any reactive planning to enable greater spend on proactive planning
		Reduction in use manual documentation, Outlook calendar management and request handling
		Booking continues when key personnel are absent. So there will be a reduction in manual intervention on ad-hoc judgements
Resilience	Non-Financial	Technical uptime is measurable at 99.999% of a high availability design

6 Assessment of Benefits

6.1 Outline

- 6.1.1 An important point, at the time of this outline business case the benefits of the project have not been worked up in full.
- 6.1.2 Assuming agreement in principal to progress is received the project will then work to define these benefits in detail. The benefits schedule and its acceptance and ownership by the relevant Directors of each service line must be signed off before the project progresses through any significant milestone, for example, commencement of system procurement.
- 6.1.3 Benefits may be cash releasing or non-cash releasing and may, therefore, focus on improvements to quality either directly delivered by this project or enabled delivery as part of future strategically aligned projects. However, this does not discount the need for benefits to be S.M.A.R.T:
- Specific – identify specific areas of the Trust’s business that will be involved in realising the benefit
 - Measurable – identify mechanisms for quantitative assessment of the benefits and a baseline
 - Achievable – it needs to be realistic given the environment in which the project operates
 - Responsible – who will own the delivery of the benefits after the completion of the project
 - Time-related – specify when the benefits realisation will start and the profile for realisation over time
- 6.1.4 In particular, it is important to note that each benefit will require a business owner responsible for the continued realisation of the benefit and reporting of this realisation after project closure.
- 6.1.5 Provided post procurement is the benefits realisation plan and at the time of approval of the full business case and will then be reviewed and maintained throughout the lifecycle of the project.

6.2 Cash Releasing Benefits

Description	Expected Total Value	Realisation Timeframe
Return on Investment (ROI) when compared to Cost Avoidance from moving to a new centralised platform against not implementing this	Cost of extra 400m ² space and Option Appraisal 1 selected <ul style="list-style-type: none">- £629,000 – 1 year- £956,000– 2 years- £1,333,000 – 3 years	18 Months

change and requiring an extra 400m ² of space to rent.	£735,000 – Total Business Case Costs (Year 1 and 2) See Appenedix B for calculations	
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6.3 Non - Cash Releasing Benefits

Description	Measurement Metric	Baseline Measurement	Realisation Timeframe
<p>The Reputation of the Trusts' is damaged by incorrect or late to the implementation of this new scheduling service. The project may be late and over budget. As a result, the Trust is hindered from further or increased revenue from NHS referrals and reduction in Teaching.</p> <p>Consideration of the Quality Assurance assessment did not provide any reference to any scheduling or timetabling, so not added to this section.</p>	Student Satisfaction Survey Question 15b (ORG:H31b)	2016/17 Student Satisfaction Survey Results	1 to 2 Years
<p>Equity (The quality of being fair and impartial)</p> <p>Ensuring that the new scheduling service that will merge all current methods is equitable and unbiased with agreed process, procedures and policies to provide Equity of the services to all its users.</p>	Internal Survey in June or July 2019	New Internal Survey in July or September 2017	2 years
<p>Enhanced utilisation of the existing building available to the Trust for teaching and learning, Clinic Appointments, meetings and other purposes</p>	Analysis of future room/ space utilisation finalised in July-2019 from new Scheduling service reports	Analysis of current room/ space utilisation concluded in July-2017 from current systems	2 years

6.4 Disbenefits

Description	Measurement Metric	Baseline Measurement	Realisation Timeframe
An expected drop in productivity in Trust-wide scheduling in the first few months of the service in use. There could be some new stress both in the staff implementing the solution and those that need to use the outcomes of the solution. Enhancement of this disbenefit arrives with the combination of the use of the new scheduling tools and in parallel the implementation of the new process, procedures and policies against the current cultural norms.	<p>Improved returns to scale, i.e. unit cost of scheduling.</p> <p>Improved level of use and ease of reporting of both inputs and outputs of room and other space bookings</p> <p>These are measured every three months starting in September 2018</p>	<p>Current returns to scale, i.e. unit cost of scheduling</p> <p>Current level of use and ease of reporting of both inputs and outputs of room and other space bookings</p>	July 2019

7 Analysis of Recommended Option

7.1 Timescales

- 7.1.1 The below sets out high-level milestones for the project. They will be used to inform the project plan produced during the initiation of the project.

Main milestones and dates	Proposed Start	Proposed End
Communication Plan - Develop and Update	June 2017	On-Going
Procurement Requirements Gathering	June 2017	July 2017
Procurement Design	July 2017	September 2017
Procurement Bid Period	September 2017	October 2017
Procurement Award	October 2017	October 2017
Technology Implementation	November 2017	December 2017
DET - Schedule Development	October 2017	July 2018
CYAF - Schedule Development	October 2017	July 2018
AFS - Schedule Development	October 2017	July 2018
Schedule Proof of Concept/ Simulation	March 2018	April 2018
Schedule Implementation	May 2018	July 2018
Project Completed	July 2018	July 2018
Project Closed (Post Benefit Review)	July 2019	July 2019

7.2 Risks

- 7.2.1 The below sets out high level identified risks for the project. They will be used to inform the risk register for the projects produced during the initiation of the project.

Risk	Implication	Imp	Prob	Rating	Owner
The project is delivered late or does not provide the expected practical benefits that could impact the Reputational view of this Trust at both the Clinical and Education areas.	The Trust may develop a reputation of disorganised in both its educational and clinical delivery. Then the Trust would remain at risk of not able to provide the required robust Clinical Timetable, Teaching Timetable and room booking services in the space available in the current and new building.	H	L	M	
Ability to improve or adapt to legislative changes around eReferrals.	Potential impact to clinical service income where the Trust cannot efficiently or adequately respond to	H	L	M	

Risk	Implication	Imp	Prob	Rating	Owner
	electronic referrals issued from the national eReferrals service.				
Insufficient training and understanding of the new systems and the changes of practice required in CareNotes.	Without the correct training at the correct time and correct level, the investment in the project and its benefits not fully realised as the best use of the service may not be fully discovered or utilised correctly.	M	L	L	
Inadequate communication for new annual Teaching schedules and semester updated schedule changes.	Impacting the overall student experience, lower the current score on the student survey that covers scheduling.	L	L	L	
A process to manage conflicting priorities from difference departments in the Trust and not to utilise the bookable locations to their fullest extent.	Without analysis of the current process and followed by great improvements the reduction or elimination of conflicting priorities will persist and may increase costs to the Trust where extra space is required.	L	L	L	
There would be continued inability to free-up or maximise critical resources in both Clinics, Timetabling and Room Booking.	The project delivery would be delayed with delays of the backfilled staff starting on the project.	M	L	L	
The project will be merging the clinical and education department bookings. Some departments are managing the own space within their office space.	The perceived concern in some areas is the impact of the loss of scheduling management on their current controlled areas.	M	M	M	
Overall Risk (H/M/L)		M	L	M	

7.3 Interfaces

7.3.1 [UPDATE – links to other projects]

8 Financial Information

8.1 Cost (Preferred Option 4)

	2017/18	2018/19	2019/20	3-Year Total	Annual Revenue Consequence
1: Initial Capital Expenditure					
Scheduling and Room Booking					
Software Licences	£ 11,000	£ 11,000	£ 11,000	£ 34,000	£ 11,000
Hardware servers or Cloud Hosting Service	£ 15,000	£ 15,000	£ 15,000	£ 45,000	£ 15,000
Supplier implementation services, configuration and changes required for go-live	£ 34,000	£ -	£ -	£ 34,000	
Total Scheduling and Room Booking	£ 60,000	£ 26,000	£ 26,000	£ 113,000	£ 26,000
Wayfinding					
Wayfinding Room Screen Implementation, Hardware, Licences and Software	£ 58,000	£ 4,000	£ 4,000	£ 66,000	£ 4,000
Total Wayfinding	£ 58,000	£ 4,000	£ 4,000	£ 66,000	£ 4,000
Total Initial Capital Expenditure	£ 118,000	£ 30,000	£ 30,000	£ 179,000	£ 30,000
2: One-off Capital costs					
Procurement-Contract negotiation services	£ 21,000				
Project Staff (PM, BA, In-House Training, Care Notes APP Specialist, Backfill)	£ 330,000	£ 200,000	£ -	£ 530,000	
Training (Train the Trainer)	£ 7,000			£ 7,000	
Total One-Off Capital Expenditure	£ 358,000	£ 200,000	£ -	£ 537,000	£ -
3: On-going Revenue Costs					
Scheduling Manager (Band 7)	£ -	£ 54,000	£ 54,000	£ 108,000	£ 54,000
Total One-Off Capital Expenditure	£ -	£ 54,000	£ 54,000	£ 108,000	£ 54,000
GRAND TOTAL	£ 476,000	£ 284,000	£ 84,000	£ 824,000	£ 84,000

8.2 Cost (Option 3 – Alternative)

	2017/18	2018/19	2019/20	3-Year Total	Annual Revenue Consequence
1: Initial Capital Expenditure					
Scheduling and Room Booking					
Software Licences	£1,000	£1,000	£1,000	£4,000	£1,000
Hardware Servers and Cloud Hosting Service	£5,000	£5,000	£5,000	£15,000	£5,000
Supplier Implementation Services, configuration and changes required for go-live	£4,000			£4,000	
Total Scheduling and Room Booking	£10,000	£6,000	£6,000	£22,000	£6,000
Total Initial Capital Expenditure	£10,000	£6,000	£6,000	£22,000	£6,000
2: One-off Capital Costs					
Procurement-Contract negotiation services	£1,000				
Project Staff (PM, BA, In-House Training, Care Notes APP Specialist, Backfill)	£330,000	£200,000		£530,000	
Training (Train the Trainer)	£7,000			£7,000	
Total One-Off Capital Expenditure	£338,000	£200,000		£538,000	
3: On-going Revenue Costs					
Scheduling Manager (Band 7)		£4,000	£4,000	£8,000	£4,000
Total One-Off Capital Expenditure		£4,000	£4,000	£8,000	£4,000
GRAND TOTAL	£348,000	£204,000	£10,000	£562,000	£10,000

8.3 Funding

8.2.1 The funding for this project will be from internal (cash) resources.

Tavistock and Portman NHSFT Relocation

Activity and space analysis V 11.0

March 2017



Attached as separate file.

10 Appendix B – Cost Avoidance

No Change: Cost Avoidance						
Space Required (SQ. M)	Space Required (SQ. FT)	Description	Cost Per FT SQ. per Annum	Year 1	Year 2	Year 3
400	4305.6	Fitting out	£ 70.00	£ 301,392	£ -	£ -
		Rent	£ 50.00	£ 215,280	£ 215,280	£ 215,280
		Service Charge	£ 6.00	£ 25,834	£ 25,834	£ 25,834
		Business Rate	£ 20.00	£ 86,112	£ 86,112	£ 86,112
		Dilapidations				£ 50,000
			Total	£ 628,618	£ 327,226	£ 377,226
			Total Cumulative	£ 628,618	£ 955,843	£ 1,333,069

Tavistock and Portman NHSFT Relocation

Activity and space analysis V 11.0

March 2017

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Table of Contents

Glossary of terms1

1 | Introduction2

2 | Methodology.....3

3 | Clinical activity4

4 | Education activity.....10

5 | Workspace Allocation13

6 | Schedule of Accommodation15

7 | Conclusions and Recommendations15

Appendix A: Indicative schedule of accommodation17

Glossary of terms

Actual Peak

The highest number of appointments seen during the stated year at any one hour.

Average Requirements

The average number of appointments at any one hour over the stated working year.

Frequency

The number of hours a room is in use as a proportion of total availability.

Occupancy

The average group size as a proportion of total capacity for the hours a room is in use.

Utilisation

A measure of how rooms and spaces are being used – both in terms of how often rooms are used and, when they are in use, how many people are in them – (% frequency x % occupancy) / 100

Workspace Allocation Ratio

Ratio of workspaces to users.

1 | Introduction

This document summarises the analyses undertaken by Essentia Trading Limited during January 2016 – March 2017 to identify the space required for the relocation of the Tavistock and Portman NHS Foundation Trust headquarters building.

Types of spaces required

It is intended that the different space allocations will be organised as shown in Figure 1. The analyses carried out looked at three different space groupings:

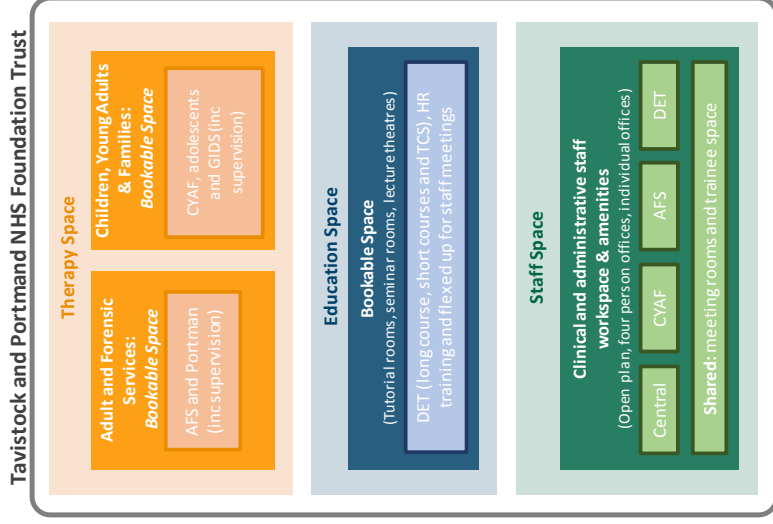
- Therapy space
- Education space
- Staff space

All therapy rooms will be provided in bookable space. They will be identified as Adult and Forensic Services (AFS) to include Adult Complex Needs and Portman services and Children's, Young Adults and Families (CYAF) to include Child and Adolescent Mental Health Services (CAMHS), Adolescents Service and Gender Identity Development Service (GIDS).

Department of Education and Training (DET) space will also be provided in bookable rooms. It is intended that these rooms will be available to other users, particularly outside of teaching weeks. It is anticipated that a system of priority booking will be introduced to manage the appropriate use of the space.

Staff space will be attributable to AFS, CYAF, DET, Central Directorates as well as some shared space for trainees and meetings. Workstation access will be provided for all staff which will include a mixture of single person offices, larger offices and open workspace

Figure 1. Space groupings

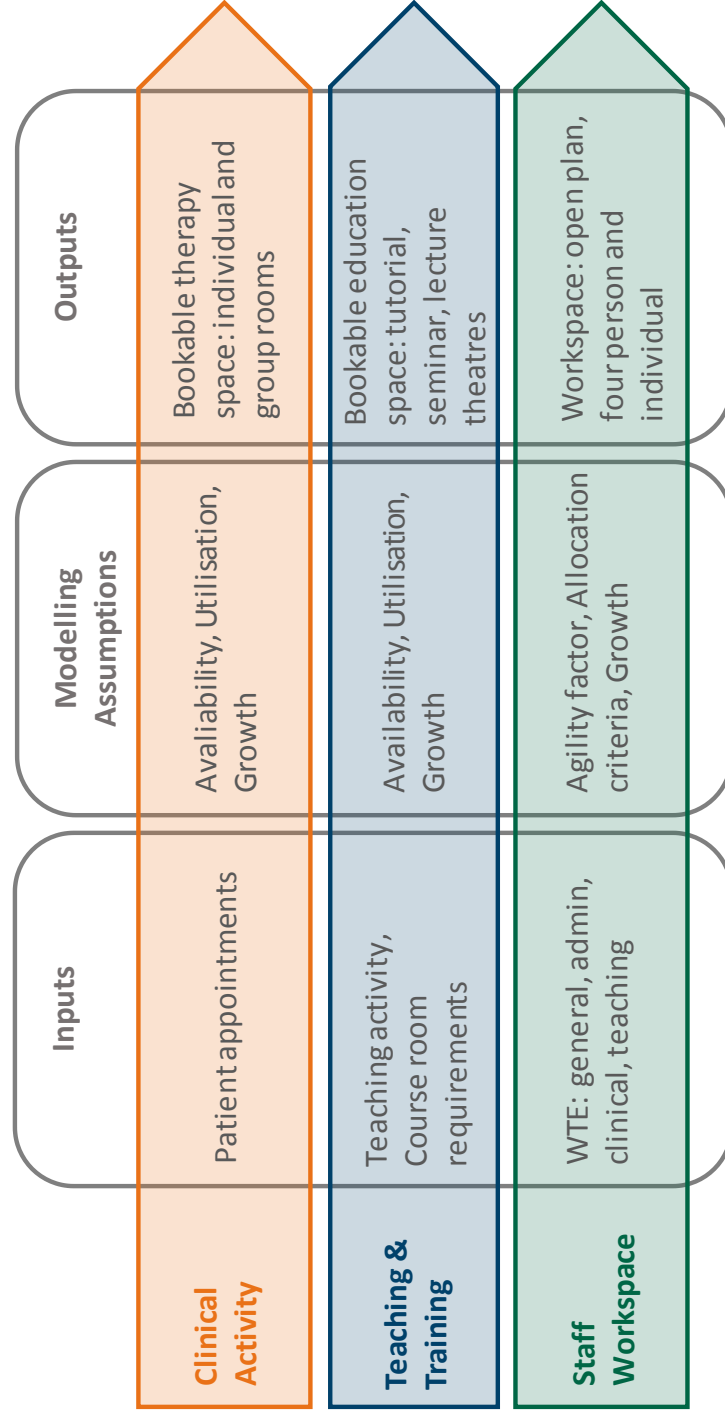


2| Methodology

Tavistock and Portman NHS Foundation Trust have provided a range of data sources for each space grouping. Relevant data for each group were analysed and run through activity models using assumptions outlined in Figure 2.

This generated the number of rooms required for the identified activity. Further details of how each data input was manipulated and the assumptions around the modelling are discussed below under the relevant headings.

Figure 2. Data analysis methodology



3 | Clinical activity

Data Source

The first iteration of the clinical activity analysis (January to April 2016) was based on patient appointment data from April 2014 to March 2015, provided by the Trust. The analysis identified trends in the clinical activity and the number and sizes of therapy rooms that would be required.

Since the initial analysis, the Trust provided the patient appointment data from April 2015 to March 2016. Overall there was a 5% increase in the number of individual appointments between 14/15 and 15/16 data. To account for this difference, the percentage increase in each service line for individual appointments was applied to both the 14/15 individual and group appointments.

Validation

To validate the appointment numbers, in August 2016 the Trust's Informatics Department provided the number of appointments during 15/16. They identified 41,048 appointments listed as individual appointments, and 924 appointments listed as group appointments (excluding GIDS patient group days and assuming a working year of 48 weeks for CYAF and 44 weeks for AFS). This totalled to 41,972 appointments, only 59 appointments less than the 42,031 appointments accounted for in the model after the 15/16 growth was applied. This marginal difference validates the number of appointments accounted for in the model.

Growth

The Trust provided forecast growth of 15% for CYAF activity which has been applied to the model. All other service lines were expected to remain constant with any growth occurring in offsite locations.

The Trust confirmed that all the activity provided within the patient appointment data will continue to be provided on the Tavistock and Portman site, with the exception of 5% of Camden CAMHS to account for a minor number of community appointments based at the Tavistock Centre.

Data manipulation

Each appointment was allocated a group size depending on the number of attendees. Both individual and group appointments could have one or more attendees.

All patients attending group appointments in the clinical activity data were listed independently, giving all group appointments an attendance of one. To establish the actual number of group appointments, all those flagged as 'group appointments' within one hour of each other with the same invited clinician were grouped to become one appointment with the relevant number of attendees.

The Trust's Informatics Department identified the maximum number of attendees for group appointments as ten, excluding GIDS patient group days. This agrees with the analysis which showed that very few appointments have eight or more attendees.

GIDS runs a number of large patient group days which were not included in the modelling. They include the London Young Person Group and London Parents Group which run on eight days over the summer, one day at Easter and one day at Christmas as well as a family day, which runs on one day over the summer. Once the overall space requirements have been confirmed, the Trust should review these group days to ensure that these seasonal events can be accommodated through timetabling. They run outside the standard 28 week working year for DET, where there would be space available that is large enough for the big group sizes to be accommodated.

Room allocation

All therapy rooms will be allocated to the following two service lines:

- CYAF (Adolescent, GIDS, Camden CAMHS and Other CAMHS)
- AFS (Adult Complex Needs and Portman)

The majority of appointments have three or less attendances and are recommended to all be held in standard therapy rooms. Due to the small number of group appointments, all appointments with four or more attendees were grouped and are recommended to all be held in rooms with a capacity of twelve people. Should these be ring-fenced for each service the utilisation will be low.

Consistent Room Use

Service leads identified the importance, in many cases, of consistent therapy room use for each patient. To ensure that this is achievable will

require appropriate booking rules within the scheduling system which should be trialled ahead of the new facility.

Clinical activity model

To identify the number of therapy rooms required the total number of appointments were separated by group size and service and run through the clinical activity model shown in Figure 3.

The following modelling assumptions have been established in conjunction with the Trust and follow best practice where applicable:

- Inclusion of appointments that displayed as 'Attended', 'Carer Attended' or 'Did not Attend'
- Proportional % increase in individual and group appointments between 14/15 and 15/16
- 15% growth in CYAF appointments from 15/16
- 95% of Camden CAMHS will be provided on site
- 20% of TAP appointments will be provided on site
- Average consult time of 60 and 90 minutes for single and group appointments respectively
- Working year: 48 week for CYAF, 46 week for AFS
- Working week: 40 hour
- 80% utilisation (frequency) of therapy room use

The model identified a requirement for 31 standard therapy rooms and two group therapy rooms. In addition to patient activity, clinical supervision for both CYAF and AFS were run through the model. This identified a requirement for an additional 5 standard therapy rooms and 2 group therapy rooms which should be available across the relevant service line to accommodate peaks in appointment demand (see section on peaks in clinical activity, page 8).

Figure 3. Clinical activity model

Tavistock and Portman NHSFT Clinical Activity Model													
Service	No. appointments by group size (14/15)			15/16 growth	Projected growth	% on site	Projected number of appointments	Av 1-3 consult (hrs)	Av 4+ consult (hrs)	Availability			No. rooms required by group size & service
	1-3	4+								weeks pa	hours/week	% frequency	
Gender Identity	CYAF	4151	1	2.3%	15%	100%	4884	1	1.5	40	40	80%	
Adolescent	CYAF	5464	42	2.4%	15%	100%	6485	1	1.5	48	40	80%	
Camden CAMHS	CYAF	10280	34	4.4%	15%	95%	11763	1	1.5	48	40	80%	22
Other CAMHS	CYAF	7970	180	4.5%	15%	100%	9795	1	1.5	48	40	80%	1
Adults Complex Needs	AFS	8806	324	4.2%	0%	100%	9512	1	1.5	46	40	80%	
Portman	AFS	2629	365	15.0%	0%	100%	3443	1	1.5	46	40	80%	9
TAP	AFS	4440			0%	20%	888	1	1.5	46	40	80%	
Total no. appointments		40246		42126	46502	45883	45883	Total rooms req:					
													31
Supervision	CYAF	5280	0	0.0%	0%	100%	5280	1	1.5	48	40	80%	4
Supervision	AFS	1564	1380	0.0%	0%	100%	1564	1	1.5	46	40	80%	1
Total no. appointments		48470						Total rooms req inc supervision:					
													36
													4

Peaks in clinical activity

The model above assumes that clinical activity is spread evenly across the year, week and time of day. Analysis of the 14/15 data, however, showed that there were peaks in clinical activity, with the patterns varying between service line, as shown in Figure 4.

The current peaks seen in the clinical activity will be due to a combination of both:

- **Demand** where in some cases, peaks will be unavoidable due to patients needing to be seen at particular times such as out of school hours.
- **Capacity** where the current space and staff models allow a high number of appointments to be held in parallel, leaving space underutilised at other times during the week.

The model sets a utilisation (frequency of use target) of 80% (but due to rounding up the number of rooms, the actual frequency is likely to be lower and headroom greater) which enables some of the peaks to be accommodated within the modelled capacity.

By sharing the therapy space with that for clinical supervision, further clinical peaks can be accommodated, provided that supervision is held outside of peak times.

Figure 4 shows that the combined space could accommodate the average activity patterns in AFS, but not CYAF. One additional therapy room would be required to accommodate the two hours per week on average that the room requirements within CYAF are expected to exceed the proposed

number. This has been included in the schedule of accommodation in addition to modelled capacity as a contingency. Should rescheduling reduce the Thursday peak, this additional room may not be required.

Figure 4 identifies actual demand and therefore does not include DNA appointments, these are however accounted for within the capacity model. It therefore assumes, better management of DNA appointments going forward, particularly around peak times.

It is recommended that the Trust, where possible, redistributes appointments to reduce peak demand exceeding capacity, where in all cases there is capacity in the hours either side of the peaks. Some peaks will be unavoidable due to demand preferences. Others, however, may be easier to control via timetabling or job plans.

While the interrelationship between clinical activity, education and training and supervision makes rescheduling more complicated, the impact, for example, of shifting of only one AFS training event in from Wednesday to Friday would make a significant contribution to smoothing demand for space.

Daily variation, in particular, is likely to be a function of supply side constraints (perceived or actual). The Trust provided information on staff working days where AFS staff most commonly work on Wednesdays and Thursdays, while CYAF staff most commonly work on Tuesday to Thursday. This pattern limits clinical (and education) activity at the start and end of the week and increases the activity peaks in the middle.

To understand the magnitude of the peaking beyond the average, the expected number of appointments (based on 14/15 activity) that would exceed the proposed capacity is outlined in Table 1. It identifies only 1.2% of appointments needing to be rescheduled under the scheduled room numbers. This analysis does not include DNA appointments or projected growth and therefore also assumes management of DNAs and growth to avoid peak times.

Figure 4. Average demand for therapy rooms over the week by service

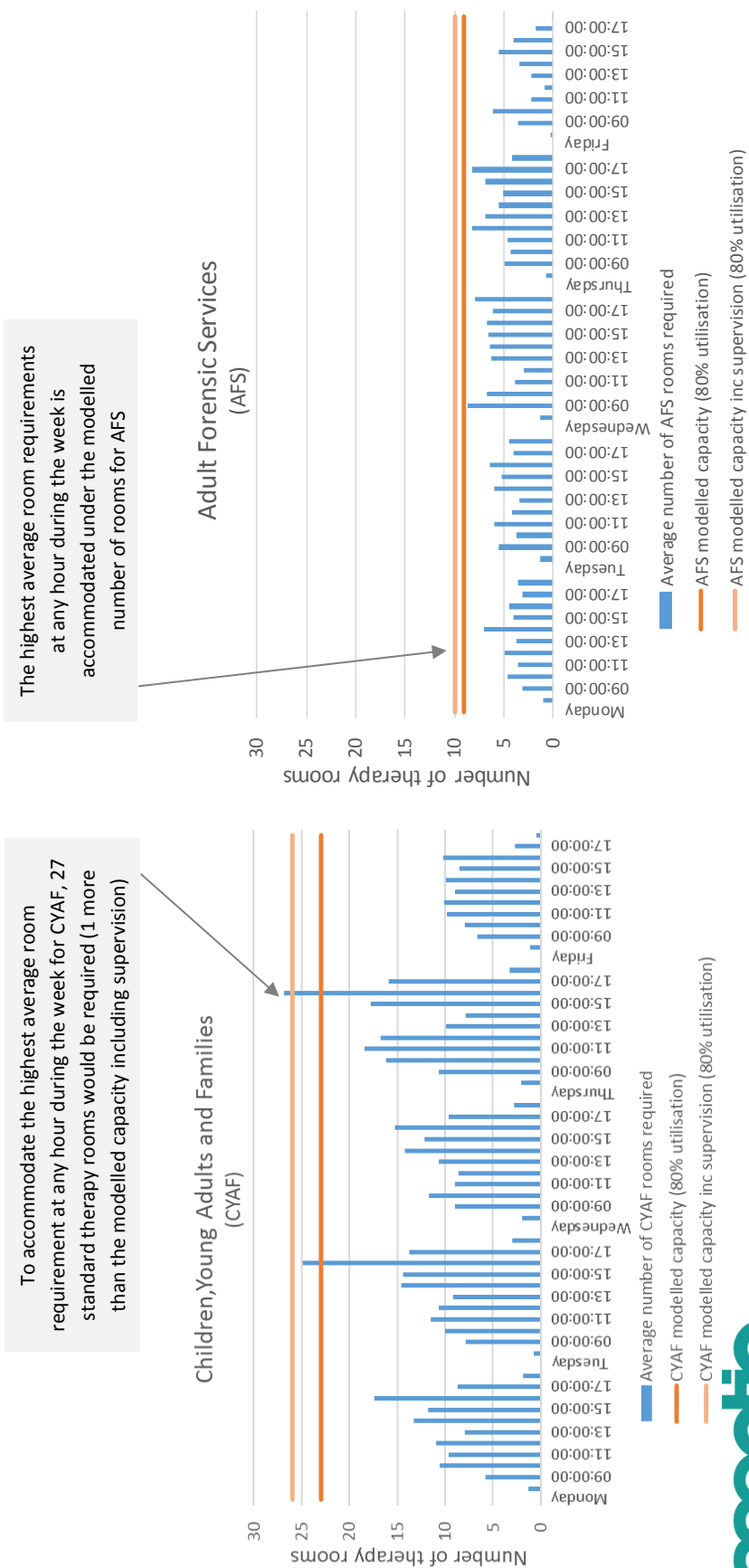


Table 1. Number of appointments that would have exceeded proposed capacity based on 14/15 appointment data

	CYAF (modelled)	CYAF (scheduled)	AFS (scheduled)	Total (scheduled)
No. appointments needing redistribution	463	172	264	436
% total	1.8%	0.7%	2.5%	1.2%
<div><div>- Growth is not included as it is assumed that this will be accommodated outside peak times</div><div>- DNA appointments are not included</div><div>- Group appointments are not included</div><div>- AFS scheduled is the same as that modelled</div></div>				

4 | Education activity

The Trust provided information on DET course components for long courses, short courses (Continuing Professional Development and conferences) and Tavistock Consultancy. In addition, HR training and DET supervision were included in the education activity analysis. It is expected that the space will be able to be flexed up and down as required, particularly outside of usual term times. Clinical supervision indicated within the staff meeting data was modelled with clinical activity.

Data Manipulation

There were a number of gaps in the course component data regarding the number of attendees, duration, number of groups, annual frequency and time of day. In order to obtain the total hours per annum of each course component the missing data were accounted for using assumptions outlined in Table 2.

Table 2. Assumptions applied to missing education data

Data category	Applied assumption to unknown fields
Room type: Average number of attendees	In line with frequency distribution within each service
Duration	Increased total hours by 17% (missing data) for each room type
Number of groups per course component	Average across services
Numerical annual frequency	Average for each service
Day / Evening	Day 2:1 Eve (random)



Room capacity

Room capacities were determined as in Table 3, to provide the best fit for the demand. Each course component was allocated a room type according to the number of attendees. Some target room areas shown in Table 3 have been adjusted to reflect space efficiency which the Trust's architects have advised will be achievable in design development. Further to the rooms modelled, support space including computer room and resource centre are included in the schedule of accommodation.

Table 3. Education room categorisation

Room Types	Capacity (no. people)	Area (sqm)
Lecture Theatre	138	165
Small Lecture	40	60
Large Seminar	20	36
Medium Seminar	12	18
Small Seminar	6	12
Tutorial room	4	12
Small Tutorial	2	8

Future room provision

The duration, number of groups and annual frequency were multiplied to give the total hours per annum for each course component. This was then used to calculate the total annual **day** time hours for each room type.

The model assumes an even spread of activity across the available hours and therefore timetabling constraints should be considered (see section on peak demand below).

The total annual hours were run through the education activity model shown in Figure 5 with the following assumptions:

- Education activity spread across of 28 weeks for DET and TCS courses and 48 weeks for all other education activity
- 40 hours of day time education activity per week
- 70% frequency of teaching room use (HEFCE and SMG good practice target¹)
- 45% growth for long courses, 45% growth for short courses and CPD, a notional 15% growth for meetings to accommodate additional ad hoc meetings, 0% for TCS and HR training
- 100% of the activity will remain on site

Figure 5. Education activity model

Tavistock and Portman NHSFT Education Activity Model																						
Service	Total hours per annum	Day time ours per annum					% growth	% on site	Total projected day hours per annum	Availability		Rooms by groupsize										
		Tutorial		Sml sem		Lrg sem				Sml lec	Lecture	weeks pa	hours/week	% frequency	Sml tut	Tutorial	Sml sem	Med sem	Lrg sem	Sml lec	Lecture	
		Sml tut	Tutorial	Sml sem	Med sem	Lrg sem																Sml lec
DET activity																						
Long Courses	24373	10345	2118	2458	4987	2055	2259	152	45%	100%	35341	28	40	70%	19.13	3.92	4.55	9.22	3.80	4.18	0.28	
Short Courses	2176	0	0	116	220	951	468	421	45%	100%	3155	48	40	70%	0.00	0.00	0.12	0.24	1.03	0.50	0.45	
TCS	1065	14	0	0	909	0	98	44	0%	100%	1065	28	40	70%	0.02	0.00	0.00	1.16	0.00	0.13	0.06	
Non DET activity																						
HR Training	23	0	0	0	5	5	5	9	0%	100%	23	48	40	70%	0.000	0.000	0.000	0.003	0.003	0.003	0.007	
											Sub total											
36,818		52%	6%	8%	21.3%	12.5%	10.9%	2.3%	39584													
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¹ Space Management Group, *Space utilisation: practice, performance and guidelines* (2006), <http://www.smg.ac.uk/documents/utilisation.pdf>

Education Peaks

Analysis was carried out on the average number of rooms required by DET during the day on each day of the week, shown in Figure 6. The analysis applied the same assumptions with regard to missing data outlined in Table 2. Where day of the week was, unknown or listed as ‘Varies’, the activity was distributed evenly across the week by room size, this accounted for 55% of small tutorial activity, and under 5% for all other room sizes.

The analysis in Figure 6 shows that Wednesday has the most expected DET activity with 40% of the weekly hours. The distribution of hours across the week varied by room size. The graph shows that, to accommodate the peaks in daytime activity, a number of additional rooms, as shown in Table 4, would be required. The additional net area required to provide all of these rooms would total 400sqm. Since this additional provision would be to meet infrequent peak demands, there would be significant underuse at other times but it was agreed that an area equivalent to 9 additional small tutorial rooms, capable of flexible reconfiguration, should be added to the schedule of accommodation. The ultimate space requirement should be determined in the light of initiatives to reschedule activity to reduce peak demands which will be introduced in advance of the new facility.

Figure 6. Average number of rooms required by DET over the week

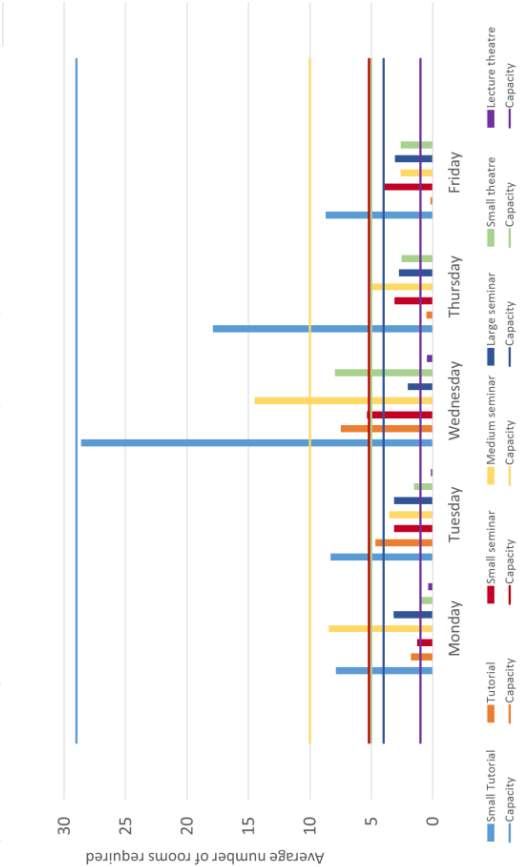


Table 4. DET rooms and average peaks

Room type	Number of rooms		
	Proposed	Highest daily average	Additional required
Small Tutorial	29	29	0
Tutorial	4	8	4
Small seminar	5	6	1
Medium seminar	10	15	5
Large seminar	4	4	0
Small theatre	5	8	3
Lecture theatre	1	1	0

5 | Workspace Allocation

The Trust intends that workspace will be provided as a combination of open workspace, four person offices and a small number of individual offices. Open workspace has become increasingly popular across industries to promote collaboration and teamwork as well as valuable space efficiencies. Recent examples of successful open workspace within healthcare buildings both in the UK and internationally are shown in Figure 7.

Flexible and agile working practices have become increasingly common across a wide range of sectors including healthcare to help efficiency, collaboration and employee satisfaction. Smart Working is often seen as being purely about office design and technology. Whilst these are key enablers, Smart Working is essentially about a people and culture change. While evidence from well-designed evaluations is limited, organisations reporting success cite the following factors as critical enablers —

- Investment in preparation for new ways of working well in advance of the new workspace models
- Support from management, leading by example
- Trialling new models before full-scale rollout
- Sensitivity to particular and diverse needs
- A commitment to on-going evaluation and reflection
- Appropriate information and communications technology
- Access to appropriate office support and meeting space
- Consistent workspace allocation based on objective criteria

Figure 7. Open plan workspace in recent healthcare buildings



Workstation allocations are commonly used to calculate the workspace needs based on the amount of time employees spend undertaking desk based activities. It is therefore based on role requirements, rather than status. The methodology for allocation of workspace varies between organisations. The Cabinet Office recently led a cross-departmental programme to introduce Smart Working with an average workstation allocation of 8:10 WTE, a guideline supported by the British Council for Offices (BCO). This allocation is to account for staff on annual leave, sick leave, training and performing other non-desk based tasks. This is often considered to be a generous allocation, particularly for agile working environments and where staff with clinical and training commitments are not predominantly desk-bound². At this ratio, there will be considerable flexibility in terms of how workspace is allocated – in clusters to promote team working and to allow effective dedication where deemed appropriate.

The Trust provided data on staff and WTE numbers by directorate which was used to inform the model in Figure 8 which identifies the area required to provide workspace under different workspace allocations. At a typical workstation allocation of 8:10 per WTE, the Trust would require approximately 3,900sqm. Should the Trust provide a whole workstation for each WTE (10:10), this would increase by 1,000sqm. To provide each employee with their own dedicated workstation to accommodate current working patterns of the staff being focused on particular days of the week would require a further 2,000sqm.

² The Way We Work: A Guide to Smart Working in Government, Cabinet Office, (2013)

³ HBN 00-03: Clinical and clinical support spaces, Department of Health, (2013)

The total headcount provided by the Trust included all staff, including those who are based on site occasionally. The indicative workstation provision may therefore be an overestimate of that required. An additional provision of 15 workstations for the workforce skills development unit and growth in workforce in DET has been added to the schedule of accommodation.

Figure 8. Workforce activity model

	Directorate				Total	Approx GIA (sqm)**
	Central	CYAF	AFS	DET		
Number of staff						
Total	104	279	109	69	716	-
WTE	104	140	64	69	513	-
Workstation Allocation						
10:10 ^{total}	104	279	109	69	716	6802
10:10 ^{WTE}	104	140	64	69	513	4874
8:10 ^{WTE}	84	112	52	56	413	3924

*WTE = most number of trainees in on one day of the week (Wednesday)

** Based on an average of 9.5sqm per workstation inc support

Support space

The scheduled support space is based on the number of workstations in line with HBN 00-03³ and Health and Safety Executive (HSE)⁴ guidelines. In addition, the Trust provided information on staff meeting requirements. These were modelled with a 20% uplift for ad hoc meetings, identifying the need for five meeting rooms of varying sizes. It

⁴ Welfare at Work, Health and Safety Executive, (2011)

is recommended that these are shared by all directorates to ensure effective utilisation.

6| Schedule of Accommodation

The room requirements for therapy, education and staff space discussed in this report were used to produce the indicative schedule of accommodation for the relocation of Tavistock and Portman NHS Foundation Trust.

The total gross departmental area (GDA) for the indicative schedule is 7,177sqm. Guidelines for circulation, planning and engineering allowances for outpatient accommodation suggest 43%⁵. Because of the lower complexity of the Trust's facility, an allowance of 35% (which would include items such as local IT hubs) has been applied. As the design process goes forward, this allocation should be reviewed where there may be an opportunity to reduce the overall GDA further, particularly in relation to teaching and staff space which typically requires lower circulation allowances.

As discussed through the report, should scheduling and resource restraints limit a more even distribution of clinical and education activity across the week, an even greater space allowance would be required. It is therefore recommended that the Trust considers to what extent the activity could be rescheduled to achieve better space economy.

⁵ HBN 12: Out-patients department, Department of Health (2004)

7| Conclusions and Recommendations

This report has provided an indication of the room and space requirements for the relocation of Tavistock and Portman NHS Foundation Trust headquarters. A number of variables and assumptions have been included within the analysis that will require ongoing validation as part of the planning and design progresses to ensure any changes are reflected in the final design solution.

The indicative schedule of accommodation is notably greater than that in the Outline Business Case (OBC). In order to achieve space efficiencies and reduce the overall area and building costs, the Trust is recommended to consider a range of opportunities. These include:

- Management of DNAs to avoid peaks
- Validate growth projections
- Confirmation of Camden CAMHS activity to be provided onsite
- Provision of some clinical activity offsite
- Trial smoothing clinical peaks throughout the week through rescheduling and workforce redesign
- Potential to distribute clinical activity more evenly over the year
- Possibility of providing more therapy room capacity through out of hours working

- Potential to pool therapy rooms between services, particularly during peak times
- Timetabling of DET activity to increase weekend and evening use of space
- Possibility of increasing the proportion of remote learning by harnessing new technology
- Provision of 1:1 supervision activity and other course components within the individual office spaces already provided
- Develop Trust policy on workstation allocation and agility factors of the staff
- Trial scheduling to ensure room continuity where required
- Trial flexible workspace allocation in advance of the new facility

Design Development

It is recommended that the Trust and its design team should consider a number of ways to achieve further space efficiencies including:

- Establishing circulation, planning and engineering allowances appropriate to the specific nature of the Trust's accommodation
- Review the sizes of bookable rooms to identify opportunities to reduce the area required
- Opportunities to consolidate support space across the different directorates, particularly appropriate for some facilities including staff rooms, breakout spaces and WCs

As the design goes forward, the design team should ensure that it includes any specific design requirements set out in the building policies to enable the efficient provision of services. This would include, for example, the provision of separate reception and waiting for the Portman Clinic.

Continued Validation

The data provided by the Trust and used in this analysis has been derived from a number of different sources and it has not been possible to resolve all associated queries. Given this, it will remain essential for the Trust to continue to validate key assumptions. However, a balance should be taken between ensuring the latest planning assumptions are sufficient for strategic decisions while avoiding non value added over-precision.

Appendix A: Indicative schedule of accommodation

Tavistock & Portman NHSFT Indicative Schedule of Accommodation				V7.0	
Directorate	Room Description	area/unit (sqm)	Number of spaces	Total (sqm)	
Main entrance				80	80
CYAF therapy					
Sub total				445	445
CYAF	Reception: 2 person (child)	10	1	10	10
CYAF	Reception: 2 person (ado & GIDS)	10	1	10	10
CYAF	Wait (child)	34	1.5	51	51
CYAF	Wait (ado & GIDS)	20	1.5	30	30
CYAF	Therapy room: 3 person	10	27	270	270
CYAF	Therapy room: 12 person	24	1	24	24
CYAF	WC	2.5	8	20	20
CYAF	WC disabled	4.5	2	9	9
CYAF	Stores	20	1	20	20
CYAF	Switch	1	1	1	1
AFS therapy					
Sub total				258	258
AFS	Reception: 2 person (adult)	10	1	10	10
AFS	Reception: 2 person (Portman)	10	1	10	10
AFS	Wait (adult)	14	1.5	21	21
AFS	Wait (Portman)	6	1.5	9	9
AFS	Therapy room: 3 person	10	10	100	100
AFS	Therapy room: 12 person	24	3	72	72
AFS	WC	2.5	4	10	10
AFS	WC disabled	4.5	1	4.5	4.5
AFS	Stores	20	1	20	20
AFS	Switch	1	1	1	1
Central and corporate functions					
Sub total				622	622
Central	Workstation: 1 person	4	76	304	304
Central	Workspace: 1 person	12	8	96	96
Central	Staff room & kitchen	20	1	20	20
Central	Breakout	6	6	36	36
Central	1:1 interview	8	6	48	48
Central	Copy room	6	3	18	18
Central	Archives	30	1	30	30
Central	WC	2.5	6	15	15
Central	WC disabled	4.5	1	4.5	4.5
Central	Stores	20	1	20	20
Central	Switch	15	2	30	30

Directorate	Room Description	area/unit (sqm)	Number of spaces	Total (sqm)
CYAF staff space				
CYAF	Workstation: 1 person	4	99	396
CYAF	Workspace: 1 person	12	13	156
CYAF	Staff room & kitchen	20	3	60
CYAF	Breakout	6	7	42
CYAF	1:1 interview	8	7	56
CYAF	Copy room	6	4	24
CYAF	WC	2.5	7	17.5
CYAF	WC disabled	4.5	1	4.5
CYAF	Stores	20	3	60
CYAF	Switch	1	1	1
Sub total				
				817
AFS staff space				
AFS	Workstation: 1 person	4	46	184
AFS	Workspace: 1 person	12	6	72
AFS	Staff room & kitchen	20	1	20
AFS	Breakout	6	4	24
AFS	1:1 interview	8	4	32
AFS	Copy room	6	2	12
AFS	WC	2.5	3	7.5
AFS	WC disabled	4.5	1	4.5
AFS	Stores	20	2	40
AFS	Switch	1	1	1
Sub total				
				397
DET staff space				
DET	Workstation: 1 person	4	68	272
DET	Workspace: 1 person	12	3	36
DET	Staff room & kitchen	20	1	20
DET	Breakout	6	4	24
DET	1:1 interview	8	4	32
DET	Copy room	6	2	12
DET	WC	2.5	3	7.5
DET	WC disabled	4.5	1	4.5
DET	Stores	20	1	20
DET	Switch	1	1	1
Sub total				
				429
Shared staff space				
All	Meeting room: 40	60	2	120
All	Meeting room: 20	36	1	36
All	Meeting room: 12	18	2	36
Trainees	Workstation: 1 person	4	136	544
Trainees	Staff room & kitchen	20	3	60
Trainees	Breakout	6	9	54
Trainees	1:1 interview	8	9	72
Trainees	Copy room	6	5	30
Trainees	WC	2.5	8	20
Trainees	WC disabled	4.5	1	4.5
Sub total				
				976.5

Directorate	Room Description	area/unit (sqm)	Number of spaces	Total (sqm)
Education space				
DET	Lecture Theatre & Control	165	1	165
DET	Small Lecture Theatre	60	5	300
DET	Large Seminar	36	4	144
DET	Medium Seminar	18	10	180
DET	Small Seminar	12	5	60
DET	Tutorial	12	4	48
DET	Small tutorial	8	29	232
DET	Library & resource centre	75	1	75
DET	WC	2.5	12	30
DET	WC disabled	4.5	4	18
DET	Stores	20	2	40
DET	Switch	1	1	1
Sub total				1293
Education space				
Therapy sub total		703		
Support sub total		3241		
Education sub total		1293		
Net Departmental Area (sqm)				
5317				
Circulation, planning & engineering				
35%				
1,861				
Gross Departmental Area (sqm)				
7,177				
NB. Does not include Belsize Avenue (25sqm)				

BOARD OF DIRECTORS (PART 1)

Meeting in public

Tuesday 27th June 2017, 2.00 – 5.00pm

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

AGENDA

PRELIMINARIES			
1.	Chair's Opening Remarks Prof Paul Burstow, Trust Chair		Verbal -
2.	Apologies for absence and declarations of interest Prof Paul Burstow, Trust Chair	To note	Verbal -
3.	Minutes of the previous meeting Prof Paul Burstow, Trust Chair	To approve	Enc. p.1
3a.	Outstanding Actions Prof Paul Burstow, Trust Chair	To note	Enc. p.7
4.	Matters arising Prof Paul Burstow, Trust Chair	To note	Verbal -
REPORTS			
5.	Service User Story Mr E Henry - D55 Student	To note	Verbal -
6.	Service Line Report: DET Social Care, Leadership & Management Mr Paul Dugmore, Portfolio Manager, Social Care, Leadership and Management	To discuss	Enc. p.8
7.	Trust Chair's and NED's Reports Prof Paul Burstow, Trust Chair	To note	Verbal -
8.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To discuss	Enc. p.22
9.	Finance and Performance Report Mr Terry Noys, Deputy CEO and Finance Director	To note	Enc. p.31
10.	Training and Education Report Mr Brian Rock, Director of E&T/ Dean	To note	Enc. p.37
11.	Objectives for the Board Mr Paul Jenkins, Chief Executive	To approve	Enc. p.44
12.	Safeguarding Annual Report Dr Rob Senior, Medical Director	To approve	Enc. p.53
13.	Complaints at GIC Ms Amanda Hawke, Complaints Manager	To note	Enc. p.66

14.	Reference Costing Exercise	To approve	Enc.	p.71
	Mr Terry Noys, Deputy CEO and Finance Director			
15.	Audit Committee Terms of Reference	To approve	Enc.	p.82
	Mr Terry Noys, Deputy CEO and Finance Director			
16.	Outline Business Case for Trust wide Scheduling	To approve	Enc.	p.90
	Mr David Wyndham-Lewis, Director of IM&T			
CLOSE				
17.	Notice of Future Meetings:			
	<ul style="list-style-type: none">25th July, Board of Directors' Meeting, 2.00-5.00pm, Board Room12th September, Directors' Conference, 2.00 – 5.00pm, Lecture Theatre26th September, Board of Directors' Meeting, 2.00-5.00pm, Lecture Theatre10th October, Joint Boards Meeting, 2.00 – 5.00pm, Lecture Theatre31st October, Board of Directors' Meeting, 2.00 – 5.00pm, Lecture Theatre			