The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors Part One

Agenda and papers
of a meeting to be held

2pm – 4pm
Tuesday 26th June 2012

Board Room,
Tavistock Centre,
120 Belsize Lane,
London, NW3 5BA

Board of Directors

2pm – 4pm, Tuesday 26th June 2012

Agenda

Preliminaries

1. **Chair's Opening Remarks**
   Ms Angela Greatley, Trust Chair

2. **Apologies for Absence**

3. **Minutes of the Previous Meeting** — *(Minutes attached)* *For approval*

4. **Matters Arising**

Reports & Finance

5. **Trust Chair's and Non-Executive Directors' Reports**
   Non-Executive Directors as appropriate

6. **Chief Executive's Report** — *(Report attached)*
   Dr Matthew Patrick, Chief Executive — *For noting*

7. **Finance & Performance Report** — *(Report attached)*
   Mr Simon Young, Director of Finance & Deputy CEO — *For discussion*

8. **Capital Budget Revision** — *(Report attached)*
   Ms Pat Key, Director of Corporate Governance & Facilities — *For approval*

9. **Responsible Officer's Report** — *(Report attached)*
   Dr Rob Senior, Medical Director — *For discussion*

Corporate Governance

10. **Board of Directors' Objectives** — *(Report attached)*
    Dr Matthew Patrick, Chief Executive — *For discussion*

11. **Committee Reports & Minutes** — *For noting*
    Committee Chairs

Conclusion

12. **Any other business**

13. Notice of future meetings

Tuesday 26th June 2012 : Board of Directors
Thursday 28th June: Board of Directors Annual Review
Tuesday 31st July 2012 : Board of Directors
Wednesday 12th September 2012 : Directors Conference, 10am – 5pm
Thursday 13th September 2012 : Board of Governors
Tuesday 25th September 2012 : Board of Directors
Tuesday 30th October 2012 : Board of Directors
Wednesday 21st November 2012 : Directors Conference
Tuesday 27th November 2012 : Board of Directors
Thursday 6th December 2012 : Board of Governors

Meetings of the Board of Directors from 2012 onwards will be from 2pm until 5pm, and are held in the Board Room. Meetings of the Board of Governors are from 2pm until 5pm, and are held in the Lecture Theatre. Directors' Conferences are from 12noon until 5pm, except where stated

Board of Directors

Meeting Minutes (Part One)

2pm – 4.30pm, Tuesday 29th May 2012

Present:			
Mr Malcolm Allen Dean	Mr Martin Bostock Non-Executive Director	Ms Angela Greatley Trust Chair	Mr Altaf Kara Non-Executive Director
Ms Louise Lyon Trust Director	Ms Joyce Moseley Non-Executive Director	Ian McPherson Non-Executive Director	Dr Matthew Patrick Chief Executive
Dr Rob Senior Medical Director	Mr Richard Strang Non-Executive Director	Mr Simon Young Director of Finance	
In attendance:			
Miss Terri Burns Assistant to the Trust Secretary	Dr Rita Harris CAMHS Director (participating)	Ms Jane Chapman Governance & Risk Advisor (item 13)	Ms Justine McCarthy-Woods Consultant Clinical Psychologist (items 12 & 14)
Ms Linda Young Consultant Clinical Psychologist (item 14)	Mr Gervase Campbell HR Advisor (item 16)		
Apologies:			
Ms Lis Jones Nurse Director			

AP	Item	Action to be taken	Resp	By
1	3	Miss Burns to amend minutes of the previous meeting	LC	Immed
2	5	Dr Harris to circulate Day Unit report to the Board	RH	Immed
3	11a	Miss Burns to amend Annual Report before sending to auditors and Monitor	TB	Immed

1. Trust Chair's Opening Remarks

Ms Greatley welcomed everyone to the meeting. She thanked Miss Carney for her outstanding work as Trust Secretary and wished her well on her new role. She also welcomed Julie Hill, the new Trust Secretary, who was observing the meeting. Jeremy Keeley was also observing in preparation for the Board Annual Review.

2. Apologies for Absence

As above.

3. Minutes of the Previous Meeting

AP1 The minutes were approved, subject to some minor amendments. **Miss Burns to make amendments.**

4. Matters Arising

Action points 5 and 6 had been completed. Action point 4 is to be completed by Ms Lyon and Ms Smith, not Dr Patrick.

5. Trust Chair's and Non-Executive Directors' Reports

Richard Strang and Martin Bostock

Mr Strang and Mr Bostock reported that they had attended a King's Fund conference on acquisitions and mergers. They felt that those that have taken place have not been successful and the reason has been a lack of cohesive strategy.

Mr Strang had read a paper from the Day Unit and felt it was extremely well presented. It could be used as a marketing tool and as an example to other
AP2 departments. **Dr Harris to circulate to the rest of the Board.**

6. Chief Executive's Report

Dr Patrick added to Ms Greatley's thanks of Miss Carney and welcomed Ms Hill.

Dr Patrick briefly mentioned the closure of the Monroe Family Assessment Service and noted that it will be discussed later in a separate item.

Dr Patrick reported that he had attended the Trust open evening and it had appeared to be a very successful event. Mr Allen reported over 200 people attending. It wouldn't be until recruitment figures came in for the next year that its success could be fully determined.

Ms Greatley stated that the staff survey was worth noting. Dr Patrick highlighted that there were positive points alongside negative, such as the ministerial visit and announcement and the closure of the Monroe service.

7. Finance & Performance Report

Mr Young reported that the quarterly budget presented in March did not account for the phasing of student fees. The paper presented to the Board now did allow for this and so leaves a small surplus.

The Tavistock Consulting Service have announced further income and higher expenditure. The Finance department will discuss this with them.

Mr Young reported that the savings made have been good so far but income was not so good. There is some work to be done to recover the income shortfall. There have been two voluntary redundancies agreed but the savings are not

applicable to the first quarter.

Mr Young reported that the Board needed to approve a £50k spend on preparation for the Day Unit relocation, prior to planning approval. This was agreed.

Ms Moseley noted that it was clear from the accounts how tight things are. She asked if the VRS was proceeding as expected. Mr Young answered that it is uncertain at the moment. There are still people waiting for their quotes.

Mr Strang asked why there was a shortfall from Big White Wall. Mr Young reported that there had been some error in communication and he would need to look into it. Mr Strang expressed concern that this was the second time that an inaccuracy had been noted in the accounts and it was important to ensure the figures were up to date. Mr Young explained that this was due to the Finance department not being given accurate information.

8. Corporate Governance Report

It was noted that the Governors had been consulted and had given very thoughtful responses. It was agreed that the emergency powers had been used properly and in accordance with the Trust's Constitution, Annex 4, Paragraph 3.2. The Board of Directors ratified the decision taken by the Chief Executive and the Trust Chair to close the Monroe Family Assessment Service.

9. Committee Reports & Minutes

None.

10. Annual Plan

Pages 1 – 18 were discussed in Part 1 of the meeting.

Dr Patrick noted that the Board have been involved in the Plan from the very beginning. Mr Young expressed his thanks for those who have had input.

Mr Strang suggested that the Board take a conservative view of the income. He also suggested including a quote from the staff survey. Mr Bostock felt that the Plan as a whole was very well written.

Mr Young asked for suggestions for p.18. Ms Lyon suggested including the Governor Quality Report sub-group.

11. Annual Report & Accounts

a. Annual Report

Mr Young reported that slight amendments had been made in accordance with the recommendations of the auditors. Some minor amendments were suggested by Non-Executive Directors. **Miss Burns to make amendments before sending the report to the auditors for their final opinion.**

AP3

Mr Bostock felt that the Trust had made some very good achievements in a difficult year.

b. Annual Accounts

Mr Young reported that there have been no significant changes to the accounts. The Audit Committee have reviewed them, along with the Management Representations letter.

Mr Strang reported that the internal audit was generally complimentary and the committee was happy with the way the accounts had been put together.

The accounts were approved and the letter was agreed.

12. Quality Report

Ms Lyon reported that she was reassured that KPMG had given limited assurance on the Quality Report. A lot of hard work had been done to achieve this. Ms Greatley reported that the Governors had been positively engaged in the process.

Ms Greatley asked if there was anything that those working on the report would have done differently if they had more time. Ms McCarthy-Woods said she would have liked to have focussed on equalities and to have included picture and comments from service users.

Mr Strang reported that KPMG had told the Audit Committee that those involved had worked much more closely with them than in previous years.

13. Annual Complaints Report

Ms Chapman reported that this was the first published Annual Complaints Report from the Trust. It is not mandatory to publish it, however a huge amount of work goes into each complaint. The figures have been uploaded to the national database. Ms Greatley stated that publishing the report shows how well the Trust is doing and that we are being open.

The report was approved.

14. Service Line Report – Adolescent

Ms Lyon reported that the Adolescent department is currently in transition, therefore the report was operational rather than strategic.

Ms Young reported that there is a continued commitment to young people's health. There is an on-going issue around over and under performance which

needs continued focus. One way this is being addressed is by creating more small, community based services.

Ms McCarthy-Woods reported that the DNA rate has fallen from the previous year. The department is also keeping to the 11 week wait. She also reported positive responses to the patient survey.

Mr Bostock expressed concern that 62% of the work was done by trainees. Ms Young said that this reflects the setting of a training institution. Dr Patrick highlighted that trainees have postgraduate qualifications and often have several years experience. It is also reassuring from a cost effectiveness point of view.

Ms Moseley stated that she was very pleased to hear that the department is continuing. She has recently been made chair of Transition 2 Adulthood and so has a particular interest.

Mr Kara asked if there was an expectation or target for how staff spend their time. Ms Young reported that this is an on-going consideration which needs to be more clearly articulated than previously. Mr Kara also felt that clearer explanation was needed of what over and under performance meant and where the figures relating to these came from.

Dr McPherson asked what greater levels of local services meant in terms of service provision for staff. Ms Young stated that it is important that there is enough supervision provided to those staff. Dr Patrick also highlighted the importance of price consideration Discussion with commissioners is needed to ensure continuing profitability. Dr Harris felt that the future lies in working partnerships, especially with the voluntary sector.

15. Monroe Family Assessment Service

Dr Harris reported that a consultation was taking place on how the court service could operate on a smaller scale in the Trust. The service as it was is unviable due to cuts in payment for the work carried out.

Dr Harris expressed her disappointment at the closure and said that it had been a very difficult process. Most of the staff had been reassigned within the Trust. Everything possible had been tried to keep the service open.

The report was noted.

16. Workforce Statistics

Mr Campbell reported that the only major change from last year was that the headcount has reduced. Ms Moseley asked why the reduction was so small. Dr Patrick noted that the Westminster service had added 25 new staff to the Trust and there has also been reassignment where possible to avoid redundancies.

Mr Bostock was disappointed that there was no explanation for the reasons

behind the statistics. Mr Campbell stated that the report would need to be delayed in going to the Board for senior managers to carry out this work. Dr Patrick suggested setting some objectives earlier in the year and then assessing them against the statistics to see if they have been achieved. The Board agreed that they would like to see more trend data and commentary in future.

Mr Strang suggested that it wold be interesting to see the disciplinary and grievance statistics for the last five years, including the number, how long they go on for and at what stage they are closed.

Ms Moseley stated that it would be useful to have a HR strategy presented in the same way as service line reports.

17. Any Other Business

None.

18. Notice of Future Meetings

Noted.

Outstanding Action Part 1

The Tavistock and Portman NHS
NHS Foundation Trust

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date
1	Mar-12	8. Budget 2012/13	Mr Young to prepare quarterly reports on stand-alone services	Simon Young	May-12
2	Mar-12	8. Budget 2012/13	Mr Young to provide monthly tracking of financial targets within Finance & Performance Reports	Simon Young	May-12
3	Mar-12	12. Equalities Report	Ms Klauber to amend report to update objectives	Trudy Klauber	May-12
4	Mar-12	12. Equalities Report	Ms Klauber to prepare short summary of objectives for Board members	Trudy Klauber	Jun-12
5	Jan-11	10. Estates & Facilities Report	Ms Key to investigate whether the Public Services Bill affects the NHS and FTs in particular	Pat Key	As appropriate

Red denotes actions overdue
Amber denotes actions due this month

Board of Directors : June 2012

Item : 6

Title : Chief Executive's Report

Summary :

This paper covers the following items:

1. Cathy Urwin
2. Productivity
3. UCL Partners
4. E-mental Health
5. And Finally…

For : Discussion

From : Chief Executive

Chief Executive Report

1. Cathy Urwin

1.1 It is with real sadness that I have to update the Board on the untimely death of one of our Senior Members of staff, Cathy Urwin. Cathy was a Consultant Child Psychotherapist and eminent research fellow who made a major contribution to child development research.

1.2 Cathy's research contribution, for which she earned an international reputation, was focused very much on the experience of babies and children and the factors that contributed to such experience.

1.3 She was also deeply respected as a clinician, and loved by her colleagues and by her many supervisees.

1.4 Cathy's death followed a very short illness, the speed of which I think has contributed to the shock felt by those who knew her. Her loss is keenly felt by all of her many colleagues across the Trust, but perhaps especially by those in the Child Psychotherapy discipline with whom she worked most closely.

2. Productivity

2.1 Over the past month work on productivity and continued. The productivity programme board is now working closely with staff side on the development of clear proposals for consultation. These proposals will be published to all staff in early July.

2.2 These proposals will cover the three year period of the Annual Plan, as opposed to focusing on just one year.

2.3 Because the work involves planning for a small reduction in the number of staff employed within the organisation, it is essential that we ensure that there is clarity and transparency around how decisions are made, and that we ensure that the approaches taken across the Trust are in keeping with agreed Trust-wide principles. These principles have already been shared with all staff following consultation and agreement with staff side.

2.4 Simon Young, Chair of the productivity programme board, will be reporting progress to the Board in more detail at this meeting.

3. UCL Partners

3.1 Since its authorisation in 2009, UCLP has grown from the original 5 founding organisations to comprise a partnership comprising 31 organisations, from mental health to major acute, university to community provider.

3.2 The combined turnover of the partners and members is now in the region of £8bn, and the partnership covers in excess of 4 million people living and working in North and East London, and beyond.

3.3 The Board will recall that UCLP aspires to be patient led, population focused, working across traditional boundaries and drawing on academic expertise across disciplines in biomedicine and beyond.

3.4 The number of authorised themes has now grown from 7 to 11, and there are now more than 70 programmes or projects live at any one time. These currently include a strong portfolio of mental health projects, in which we are very positively engaged.

3.5 More recently the new Local Education and Training Board for north central and north east London has been hosted within UCLP.

3.6 Taking all of these factors into account it is clear that active participation with UCLP is of real importance to our Trust, not least because of the degree to which we share key aims.

3.7 I am taking over a place on the UCLP Executive Board from Wendy Wallace (CEO of Camden and Islington Foundation Trust), and attended my first Board meeting on Monday 11th June. This place is one of two that represent the five member mental health trusts. The other place is being taken up by John Brouder, CEO of North East London Foundation Trust

4. E-mental Health

4.1 Over the past month I have also attended a number of meetings focused on the national development of e-mental health. This in part relates to our Trust's involvement as a provider through Big White Wall, but more importantly to the need for a clear national strategy that connects the newly published NHS Information Strategy and the Mental Health Strategy – No Health Without Mental Health.

4.2 One key perspective shared by both of these DH strategy documents is an emphasis on the need for a shift in ownership of mental health and wellbeing, from professional to service users.

4.3 Many aspects of online service provision are well suited to supporting this shift, in particular when services are based around more social models of health and wellbeing, the promotion of self-management and peer support, access to and ownership of information, and in some cases involve principles derived from social networking.

4.4 More recently, the Mental Health Network has very helpfully joined discussions convened by the Department of Health. Flowing from this I have taken on the role of chairing a small group tasked with developing a think piece on these ideas for publication.

4.5 Making use of new technology and new methods of communication will be critical if we are to deliver not only on the spirit of both the Information and Mental Health strategies, but also on the content and substance within such difficult economic times.

4.6 It will be important that providers across different sectors, together with service users, can connect with one another in a meaningful way to drive this agenda forward, and the written piece will, I hope, suggest how this may be taken forward.

5. And Finally…

5.1 On Thursday June 21st many doctors, including some within our own Trust, will be taking limited industrial action. This action, where it takes place, will involve doctors in attending work, but only being available for urgent clinical demands.

5.2 The action is being taken in relation to changes to the pension arrangements for doctors.

5.3 While I share some of the strong feelings about proposed changes, I myself did not vote in favour of the strike. This is largely because I feel that it will only serve to undermine the medical profession's position of potential leadership, at a time when the credibility of clinical leadership within the health service is of tremendous importance.

Dr Matthew Patrick
Chief Executive Officer

June 2012

Board of Directors : June 2012

Item : 7

Title : Finance and Performance Report

Summary:

After two months a surplus of £112k is reported before restructuring, £44k above the revised budget surplus of £68k. Income from Tavistock Consulting and from Training have exceeded budget, though there are also shortfalls in departmental consultancy and the Day Unit. Savings across all directorates have exceeded the target, but some of these will be non-recurrent.

The service line report is to be provided next month. The latest forecast for the year will also be provided at the next meeting.

The cash balance at 31 May was £2,223k.

For : Information.

From : Simon Young, Director of Finance

1. External Assessments

1.1 Monitor

1.1.1 Monitor has confirmed that the Trust's financial risk rating for quarter 4 of 2011/12 was 3, and the governance rating was Green.

1.1.2 The Annual Plan was submitted to Monitor at the end of May. Following their review, a response is expected in July. The Plan should lead to a Financial Risk Rating of 3. It is currently expected that the actual rating for the year will also be a 3 in all four quarters. It is also expected that the governance rating will remain Green.

2. Finance

2.1 Income and Expenditure 2012/13

2.1.1 After May the trust is reporting a surplus of £112k before restructuring costs, £44k above budget. Income is £91k below budget, and expenditure £135k below budget.

2.1.2 An element of the income budget was re-profiled in May to take account of the seasonal variations of the TCS work. This increased the expected surplus for May from £11k to £83k. This will not affect the planned outturn of £150k surplus for the year.

2.1.3 The improvement in month on income is due to increased work for TCS which is now cumulatively above target in addition to higher training income which has been offset by low pupil numbers on the Day Unit. The expenditure budget is £135k below budget, the majority of which is in Child & Family.

2.1.4 Appendices A and B show that significant savings have been achieved by month 2, exceeding the target, though some of these may be non-recurrent. However, the income shortfalls are not covered by a reserve, and it is essential that income improves in the coming months.

2.1.5 There is also a shortfall in clinical income mainly due to BWW. These main income sources and their variances are discussed in sections 3, 4 and 5.

2.1.6 For an externally funded Finance project, the £22k underspend to date (within the Finance line) is matched by a £22k shortfall on other income, since the funding is only released in line with costs.

2.1.7 The key financial priorities remain to achieve income budgets; and to identify and implement the additional savings required through service redesign.

2.1.8 The month 3 report will include the latest forecast for the year, following review with all key budget-holders. Expenditure budgets will also be revised to take account of agreed savings, including those from approved voluntary redundancies (see 6.1).

2.2 Cash Flow (Appendix C)

2.2.1 The actual cash balance at 31 May was £2,223k which is an increase of £425k in month and £611k above plan. The increase is due to NHS funding paid in advance from two commissioners. The year-to-date receipts and payments are summarised in the table below.

	Cash Flow year-to-date		
	Actual £000	Plan £000	Variance £000
Opening cash balance	2,357	2,357	0
Operational income received			
NHS (excl SHA)	2,033	1,570	463
General debtors (incl LAs)	1,025	945	80
SHA for Training	1,889	1,841	48
Students and sponsors	328	420	(92)
Other	26	36	(10)
	5,301	4,812	489
Operational expenditure payments			
Salaries (net)	(2,547)	(2,434)	(113)
Tax, NI and Pension	(1,854)	(1,810)	(44)
Suppliers	(997)	(1,315)	318
	(5,398)	(5,559)	161
Capital Expenditure	(38)	0	(38)
Interest Income	1	2	(1)
Payments from provisions	0	0	0
PDC Dividend Payments	0	0	0
Closing cash balance	2,223	1,612	611

3. Training

3.1 Training income is £40k above budget in total after two months, with Training Fees being the main reason.

3.2 Income from university partners is expected to be in line with budget. The key area of uncertainty is, as always, fee income from students and sponsors for the academic year starting in October.

4. Patient Services

4.1 Activity and Income

4.1.1 All contract values have now been agreed. Total contracted income for the year is in line with budget. Part of the budgeted income for the year is dependent on meeting our CQUIN[†] targets agreed with commissioners and achievement is reviewed on a quarterly basis.

4.1.2 There are more significant variances, both positive and negative, in other elements of clinical income, as shown in the table on the next page.

[†] Commissioning for Quality and Innovation

4.1.3 The income budget for named patient agreements (NPAs) was reduced this year from £230k to £205k. £93k of the total budget is for the Portman, with smaller amounts for other directorates. After May actual income is £3k below budget which is in Portman.

4.1.4 Court report income (which is budgeted at £195k for the year, of which £140k is for the Portman) was £12k above budget after May.

4.1.5 Monroe income is below budget after 2 months. The service has closed on 2nd June and the budgets will be revised in future accordingly.

4.1.6 Day Unit was £31k below target. The service is working to secure the additional income required to meet their target.

4.1.7 Project income is forecast to be balanced for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.

	Budget £000	Actual £000	Variance %	Full year Variance based on y-t-d	Comments
Contracts - base values	1,925	1,926	0.1%		
NPAs	34	31	-8.0%	-16	
Projects and other	188	176		–	Income matched to costs, so variance is largely offset.
Day Unit	168	136	-18.7%	-188	
Monroe	35	14	-61.5%	-24	Service closes June
FDAC 2nd phase	86	86	0.0%	0	Income matched to costs, so variance is largely offset.
Court report	32	44	36.5%	71	
Total	2,469	2,414		-157	

5. Consultancy

5.1 TCS income was £151k in May (including some income omitted from the April report, as mentioned at the last meeting) and is £184k cumulatively, significantly up compared to previous years at this stage, and £4k above budget. The expenditure budget is currently balanced.

5.2 Departmental consultancy is £62k below budget after two months. The majority of the shortfall is within Portman partially due to an £8k credit note relating to the old year. Actions to recover the shortfall will be required to deliver against plan.

6. Voluntary Redundancy Scheme 2012

6.1 18 applications have so far been approved. In most cases, the staff will be leaving in August and September. An update will be given at the meeting on the costs and on the expected savings (net of any replacement posts at lower pay scales and/or less time). The savings will be taken from budgets next month; and this will substantially reduce the remaining productivity target for the year, which currently stands at £744k (in the annual budget column of Appendix B).

Simon Young
Director of Finance
15 June 2012

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST **APPENDIX A**

INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2012-13

		May 12			CUMULATIVE			2012-13
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	FULL YEAR REVISED BUDGET £000
INCOME								
1	CLINICAL	1,236	1,221	(15)	2,469	2,414	(55)	14,813
2	TRAINING	1,310	1,359	49	2,565	2,605	40	17,175
3	CONSULTANCY	159	164	5	257	200	(58)	1,469
4	RESEARCH	13	21	8	26	29	3	155
5	OTHER	76	57	(19)	153	132	(20)	917
TOTAL INCOME		**2,795**	**2,822**	**28**	**5,470**	**5,380**	**(91)**	**34,529**
OPERATING EXPENDITURE (EXCL. DEPRECIATION)								
6	CLINICAL DIRECTORATES	1,501	1,484	17	3,002	2,936	65	18,034
7	OTHER TRAINING COSTS	510	491	19	1,007	990	17	7,584
8	OTHER CONSULTANCY COSTS	77	112	(36)	154	153	1	974
9	CENTRAL FUNCTIONS	581	528	53	1,159	1,040	119	6,945
10	TOTAL RESERVES	(33)	0	(33)	(67)	0	(67)	(44)
TOTAL EXPENDITURE		**2,635**	**2,615**	**20**	**5,254**	**5,119**	**135**	**33,494**
EBITDA		**159**	**207**	**48**	**216**	**261**	**45**	**1,035**
	ADD:-							
12	BANK INTEREST RECEIVED	1	1	0	2	1	1	11
	LESS:-							
11	DEPRECIATION & AMORTISATION	44	44	0	88	88	(0)	530
13	FINANCE COSTS	0	0	0	0	0	0	0
14	DIVIDEND	33	33	(0)	61	61	(0)	366
SURPLUS BEFORE RESTRUCTURING COSTS		**83**	**130**	**48**	**68**	**112**	**44**	**150**
15	RESTRUCTURING COSTS	0	14	(14)	0	14	(14)	1,600
SURPLUS/(DEFICIT) AFTER RESTRUCTURING		**83**	**117**	**34**	**68**	**99**	**30**	**(1,450)**
EBITDA AS % OF INCOME		5.7%	7.3%		3.9%	4.8%		3.0%

THE TAVISTOCK AND PORTMAN NHS TRUST **APPENDIX B**

INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2012-13

		May-12			CUMULATIVE			2012-13
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED ANNUAL BUDGET £000
	INCOME							
1	NHS LONDON TRAINING CONTRACT	605	605	0	1,209	1,209	0	7,254
2	TRAINING FEES & OTHER ACA INC	404	456	52	807	835	29	6,702
3	POSTGRADUATE MED & DENT'L EDUC	6	16	10	13	23	10	76
4	JUNIOR MEDICAL STAFF	98	84	(14)	177	178	1	954
5	CHILD PSYCHOTHERAPY TRAINEES	197	197	1	360	360	0	2,189
6	R&D	13	21	8	26	29	3	155
7	CLINICAL INCOME	1,075	1,073	(3)	2,147	2,133	(14)	12,883
8	DAY UNIT	84	56	(28)	168	136	(31)	1,007
9	MONROE	18	7	(10)	35	14	(22)	211
10	FDAC	43	45	1	86	86	(0)	518
11	TCS INCOME	120	151	31	180	184	4	1,004
12	DEPT CONSULTANCY INCOME	39	13	(26)	77	16	(62)	465
13	COURT REPORT INCOME	16	40	24	32	44	12	195
14	EXCELLENCE AWARDS	10	10	0	19	19	0	116
15	OTHER INCOME	67	47	(19)	133	113	(20)	801
	TOTAL INCOME	**2,795**	**2,822**	**28**	**5,470**	**5,380**	**(91)**	**34,529**
	EXPENDITURE							
16	EDUCATION & TRAINING	305	292	13	609	589	20	5,172
17	PORTMAN CLINIC	98	100	(2)	209	197	12	1,334
18	ADULT DEPT	220	207	12	428	420	8	2,933
19	SAMHS EDUCATION & TRAINING	74	77	(3)	151	154	(3)	151
20	MEDNET	17	12	6	35	23	12	210
21	ADOLESCENT DEPT	95	99	(4)	193	200	(8)	1,375
22	C & F CENTRAL	769	745	24	1,539	1,478	61	9,356
23	MONROE & FDAC	57	73	(16)	114	146	(32)	686
24	DAY UNIT	62	72	(9)	125	135	(10)	722
25	SPECIALIST SERVICES	96	77	19	196	160	36	1,199
26	COURT REPORT EXPENDITURE	12	23	(11)	12	23	(11)	70
27	TRUST BOARD & GOVERNORS	9	8	1	18	15	3	108
28	CHIEF EXECUTIVE OFFICE	29	25	4	57	49	9	344
29	COMMERCIAL DIRECTORATE	52	47	5	104	98	6	624
30	FINANCE, ICT & INFOMATICS	157	128	29	314	277	37	1,886
31	CENTRAL SERVICES DEPT	187	189	(2)	374	359	15	2,245
32	HUMAN RESOURCES	53	49	4	106	83	23	634
33	CLINICAL GOVERNANCE	35	34	2	71	66	5	415
34	TRUST DIRECTOR	34	28	7	65	55	10	390
35	PPI	9	10	(0)	18	18	(0)	108
36	SWP & R+D & PERU	24	19	5	48	37	12	291
37	R+D PROJECTS	0	0	0	0	0	0	0
38	PGMDE	5	3	2	11	6	5	66
39	NHS LONDON FUNDED CP TRAINEES	178	169	9	340	340	(0)	2,189
40	TAVISTOCK SESSIONAL CP TRAINEES	5	4	1	9	8	1	57
41	FLEXIBLE TRAINEE DOCTORS	17	23	(5)	37	46	(9)	100
42	TCS	70	106	(36)	140	141	(1)	891
43	DEPARTMENTAL CONSULTANCY	7	7	0	14	12	2	83
44	DEPRECIATION & AMORTISATION	44	44	0	88	88	(0)	530
45	PROJECTS CONTRIBUTION	(8)	(8)	(1)	(17)	(16)	(1)	(100)
46	IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	0	0	0
47	PRODUCTIVITY SAVINGS	(33)	0	(33)	(67)	0	(67)	(744)
48	INVESTMENT RESERVE	(0)	0	(0)	0	0	0	100
49	CENTRAL RESERVES	0	0	0	0	0	0	600
	TOTAL EXPENDITURE	**2,680**	**2,660**	**20**	**5,343**	**5,207**	**135**	**34,024**
	OPERATING SURPLUS/(DEFICIT)	**115**	**163**	**48**	**127**	**172**	**45**	**505**
50	INTEREST RECEIVABLE	1	1	(0)	2	1	(1)	11
51	UNWINDING OF DISCOUNT ON PROVISION	0	0	0	0	0	0	0
52	DIVIDEND ON PDC	(33)	(33)	(0)	(61)	(61)	(0)	(366)
	SURPLUS/(DEFICIT)	**83**	**130**	**47**	**68**	**112**	**44**	**150**
53	RESTRUCTURING COSTS	0	14	(14)	0	14	(14)	1,600
	SURPLUS/(DEFICIT) AFTER RESTRUCTURING	**83**	**144**	**34**	**68**	**99**	**30**	**(1,450)**

Appendix C

2012/13 Plan

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	2,357	1,919	1,612	1,262	1,389	1,167	1,601	706	297	305	877	747	2,357
Operational income received													
NHS (excl SHA)	527	1,043	950	1,040	981	950	940	982	949	940	981	950	11,233
General debtors (incl LAs)	494	451	633	684	581	806	602	552	520	840	636	557	7,356
SHA for Training	911	930	911	1,239	1,259	1,239	673	692	673	818	948	929	11,222
Students and sponsors	250	170	170	110	0	200	800	250	100	750	100	100	3,000
Other	18	18	18	18	18	18	18	18	18	18	18	18	216
	2,200	2,612	2,682	3,091	2,839	3,213	3,034	2,495	2,261	3,365	2,683	2,554	33,027
Operational expenditure payments													
Salaries (net)	(1,217)	(1,217)	(1,217)	(1,217)	(1,218)	(2,017)	(1,969)	(1,169)	(1,169)	(1,369)	(1,388)	(1,169)	(16,336)
Tax, NI and Pension	(910)	(900)	(900)	(900)	(900)	(900)	(900)	(864)	(864)	(864)	(864)	(864)	(10,630)
Suppliers	(512)	(803)	(872)	(820)	(919)	(1,017)	(986)	(822)	(587)	(527)	(528)	(526)	(8,919)
	(2,639)	(2,920)	(2,989)	(2,937)	(3,037)	(3,934)	(3,855)	(2,855)	(2,620)	(2,760)	(2,780)	(2,559)	(35,885)
Capital Expenditure	0	0	0	(25)	(25)	(175)	(75)	(50)	(133)	(33)	(34)	(642)	(1,192)
Loan	0	0	0	0	0	1,500	0	0	500	0	0	500	2,500
Interest Income	1	1	1	0	1	1	1	1	1	0	1	1	10
Payments from provisions	0	0	(45)	(2)	0	0	0	0	0	0	0	0	(47)
PDC Dividend Payments	0	0	0	0	0	(170)	0	0	0	0	0	(170)	(340)
Closing cash balance	1,919	1,612	1,262	1,389	1,167	1,601	706	297	305	877	747	430	430

2012/13 Actual/ *Forecast*

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	**2,357**	**1,798**	2,223	1,372	1,499	1,277	1,712	817	407	415	988	857	2,357
Operational income received													
NHS (excl SHA)	**510**	**1,523**	450	1,040	981	950	940	982	949	940	981	950	11,196
General debtors (incl LAs)	**511**	**514**	633	684	581	806	602	552	520	840	636	557	7,436
SHA for Training	**894**	**995**	911	1,239	1,259	1,239	673	692	673	818	948	929	11,270
Students and sponsors	**259**	**69**	170	110	0	200	800	250	100	750	100	100	2,908
Other	**3**	**23**	18	18	18	18	18	18	18	18	18	18	206
	2,177	**3,124**	2,182	3,091	2,839	3,213	3,034	2,495	2,261	3,365	2,683	2,554	33,016
Operational expenditure payments													
Salaries (net)	**(1,324)**	**(1,223)**	(1,217)	(1,217)	(1,218)	(2,017)	(1,969)	(1,169)	(1,169)	(1,369)	(1,388)	(1,169)	(16,449)
Tax, NI and Pension	**(910)**	**(944)**	(900)	(900)	(900)	(900)	(900)	(864)	(864)	(864)	(864)	(864)	(10,674)
Suppliers	**(494)**	**(503)**	(872)	(820)	(919)	(1,017)	(986)	(822)	(587)	(527)	(528)	(526)	(8,601)
	(2,728)	**(2,670)**	(2,989)	(2,937)	(3,037)	(3,934)	(3,855)	(2,855)	(2,620)	(2,760)	(2,780)	(2,559)	(35,724)
Capital Expenditure	**(8)**	**(30)**	0	(25)	(25)	(175)	(75)	(50)	(133)	(33)	(34)	(642)	(1,230)
Loan	**0**	**0**	0	0	0	1,500	0	0	500	0	0	500	2,500
Interest Income	**0**	**1**	1	0	1	1	1	1	1	0	1	1	9
Payments from provisions	**0**	**0**	(45)	(2)	0	0	0	0	0	0	0	0	(47)
PDC Dividend Payments	**0**	**0**	0	0	0	(170)	0	0	0	0	0	(170)	(340)
Closing cash balance	**1,798**	**2,223**	1,372	1,499	1,277	1,712	817	407	415	988	857	541	541

Board of Directors : June 2012

Item : 8

Title : Capital Budget Revision

Summary :

The Board approved capital expenditure of £80k for the renewal of the hot and cool heating systems in the lecture theatre and a new acoustic ceiling. This proposal is to extend this project to include a complete overhaul of the lighting system and controls and redecoration of the walls to further improve the acoustics. The revised budget cost is £124k inclusive of VAT and fees.

For : Approval

From : Pat Key, Director of Corporate Governance and Facilities

Lecture Theatre Capital Project

1. The original scope of the works, as submitted in the three year capital programme 2011, was to be an upgrade of the existing heating and cooling within the Lecture Theatre. This is a combination of surface cooling and wet heating. Both systems are dated and are limited in the amount of effective localised control available to the users. It is proposed to upgrade the current facility, improving the internal heating to allow better energy control of the space. As part of the project the ceiling will be replaced to allow better acoustic capability plus a reconfiguration and upgrade of the audio and visual aids including the existing induction loop. The budget agreed for these works was **£80k**.

2. In order to maximise the benefits of replacing the existing ceiling, and following consultation with Malcolm Allen, it is proposed to make additional improvements to benefit the following functions - conferences, audio visual and e-learning. It is proposed that the project now includes an upgrade of the current lighting systems plus acoustic wall finishes. The lighting upgrade is to incorporate five scene settings:

    2.1 Welcome - A general scene used for students and conference delegates entering and leaving the auditorium.

    2.2 Discussion - The lighting to be dimmed to around 70% whilst the lighting over the podium would be full on.

    2.3 Presentation - The lighting in the auditorium would be reduce to 50% the lighting over the podium reduce down to 30% and the focus of the speaker at the lectern 100%.all other lighting would be off.

    2.4 AV - Similar to scene three except that the circuit over the podium would be off, to stop any light spill onto the projection screen. The auditorium lighting would be reduced to 25%intensity, to get the best possible contrast for the slides or video data projection, whilst at the same time providing sufficient illumination for the students to take notes.

    2.5 Video - Demonstration bench; the lecturer would be providing a demonstration or conducting Q&A requiring a flip chart. This would be like scene 4 except that the lighting over the podium would be raised to 25% and the accent spots on the demonstration would be at 80%. This is to provide the lecturer with enough illumination to see and at

the same time provide sufficient light for the video camera filming.

3. The existing wall finishes no longer offer sufficient acoustic absorption. New wall finishes will improve sound recording levels and repel external noise interference. In addition it is generally agreed that the wall coverings need to be updated. The change will have a significant impact to the overall appearance of the lecture theatre. The availability of the Lecture Theatre to undertake these works is very limited (30 July – 30 August) and therefore other elements of improvement have not been included in this project at this stage. In discussion with the Dean, it is possible that a further phase might be requested in subsequent financial years.

4. The revised budget cost for the project is **£124k inclusive of VAT and fees**.

Pat Key
Director of Corporate Governance & Facilities
June 2012

Board of Directors : June 2012

Item : 9

Title : Responsible Officer's Report

Purpose:

The purpose of this report is to update the Board about progress in relation to the revalidation of doctors in the Trust. Dr Senior was appointed as the responsible officer by the Board in September 2010. The medical appraisal for revalidation policy was approved by the Board in November 2011. Organisational readiness to support revalidation is on track. Progress on outstanding actions is reported via the CQSG Patient Safety and Clinical Risk work-stream.

This report focuses on the following areas:

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

For : Noting

From : Dr Rob Senior, Medical Director

Report from the Trust Responsible Officer regarding the implementation of GMC medical revalidation

1. Background

1.1 What is Revalidation

1.1.1 Revalidation is the process by which licensed doctors will have to demonstrate to the General Medical Council (GMC) that they are up to date and fit to practice and that they are complying with the relevant professional standards. In future, all licensed doctors will need to revalidate regularly if they wish to keep their licence to practise medicine. Revalidation will mean that doctors will need to demonstrate that they continue to meet standards that are set by the GMC and that they are continuing to learn and develop their skills and knowledge.

1.2 What is a 'Responsible Officer' and for what are they responsible?

1.2.1 The Responsible Officer Regulation came into force in January 2011. All doctors must report to the 'Responsible Officer' (RO) of the organisation where the doctor works. This is a new statutory role, usually the Medical Director. Every five years, the RO will make a recommendation to the GMC about whether a doctor should be revalidated, basing their recommendation on the doctor's annual appraisals and the folder of information. The RO has to assure the quality of medical appraisals and will therefore not be able to conduct the appraisals in most organisations. There is therefore a need for a group of formally trained appraisers in each Trust.

1.2.2 Regarding revalidation, the RO has a responsibility for all consultant, associate specialist, and staff grade doctors in the Trust, including those with honorary contracts. Junior doctors in training and all GP's who work for the Trust look to the Deanery or the Primary Care Trust (or their successor organisations) for their RO, respectively.

1.2.3 The Responsible Officer must:

1.2.3.1 Ensure the Trust carries out regular appraisals on medical practitioners;

1.2.3.2 Ensure the Trust has procedures in place to investigate concerns about a medical practitioner's fitness to practice; and

1.2.3.3 Where appropriate, make referrals to the GMC and make recommendations to the GMC about fitness to practice; and maintain records about practitioners' fitness to practice evaluations, including appraisals and investigations or assessments.

2. How will revalidation work?

2.1 Every doctor will have an annual appraisal based on standards approved by the GMC. The appraisal includes a set of standards from the GMC's *Good Medical Practice*, and specialist standards set by the appropriate Royal College. There are four main domains for standards:

- Knowledge, skills and performance;
- Safety and quality;
- Communication, partnership and teamwork; and
- Maintaining trust.

2.2 The doctor will be asked to keep a folder of information about their practice (including clinical audit data, continuing professional development (CPD) information, and feedback from colleague and patient questionnaires). All doctors will need to seek independent feedback from patients and colleagues at least once in the five-year period.

2.3 Revalidation will not involve a point-in-time assessment of a doctor's knowledge and skills but will be based on a continuing evaluation of their practice in the context of their everyday working environment. It is designed to affirm the good practice of doctors, and encourage professional development. For most doctors, revalidation will not mean having to do new things or change the way they work, as local appraisal systems are already in place. Areas for concern should be identified well in advance, followed up with local support or action – remediation and rehabilitation.

2.4 The Royal College of Psychiatrists has produced guidance about revalidation for psychiatrists (available on the RCPsych website). The latest document, *CR172*: *Revalidation Guidance for Psychiatrists* (March 2012), has been updated from *CR161: Revalidation and Guidance for Psychiatrists* (published in 2010) to reflect current GMC guidance (General Medical Council, 2010*a*).

2.5 The College has also issued *good practice guidance for appraisal* (2010).

2.6 All doctors will bring to their appraisal supporting information that provides evidence about the 12 GMC attributes, and reflects the doctor's particular practice and other professional roles. The supporting information will fall under four broad headings:

- General information – providing context about what you do in all aspects of your work;
- Keeping up to date – maintaining and enhancing the quality of professional work;
- Review of practice – evaluating the quality of the doctor's professional work;
- Feedback on practice – how others perceive the quality of the doctor's professional work.

2.7 There are six types of supporting information over and above general information that doctors will be expected to provide and discuss at their appraisal at least once in each five-year cycle:

- quality improvement activity;
- feedback from colleagues;
- feedback from patients (where applicable);
- continuing professional development (CPD);
- significant events; and
- review of complaints and compliments.

2.8 The Royal College of Psychiatrists has worked with the other Colleges through the Academy of Medical Royal Colleges to produce a document on the supporting information for revalidation. At present this is still in draft format, but the College are currently recommending that psychiatrists participate in three key quality improvement activities:

- case-based discussion (10 in the five year cycle);
- clinical audit (psychiatrists will need to participate in two audits of significant areas of their practice in each five year cycle); and
- clinical outcome measures.

2.9 Non-clinical practice e.g. research, teaching, medico-legal, management will need to meet Royal College standards, the details of which are still being decided.

3. What has happened nationally to date?

3.1 The GMC has been working with other organisations to introduce revalidation (including the four UK health departments and doctors' representative bodies such as the BMA). Work has been undertaken by the medical Royal Colleges and Faculties to develop standards for the appraisal and revalidation of specialist doctors and GPs.

3.2 The licence to practice was introduced on 16 November 2009. The licence was the first step towards revalidation.

3.3 Since 2009, all trusts have had to complete an 'Assuring the Quality of Medical Appraisal' (AQMAR) self-assessments of their readiness for revalidation. This has required organisations to return development plans to address any shortfalls.

3.4 Pilot studies have been undertaken to test the mechanisms for revalidation. The GMC carried out an extensive consultation of their proposals in May 2010. The response was published in October 2011. One of the outcomes of this consultation was to extend the pilots.

3.5 Revalidation is expected to begin at the end of 2012, after all pilots have been completed.

4. What have we done in this Trust?

4.1 Dr Rob Senior, the Medical Director, was formally approved by the Board of Directors in September 2010 as the Responsible Officer for the Trust. His role is in line with the competency framework and job description for the role of the RO. He has attended the relevant training for ROs and is accessing a regional 'Responsible Officer Support Network' of peer support via NHS London.

4.2 An Associate Medical Director (Dr Jessica Yakeley) has been appointed as Revalidation and Appraisal Lead for the Trust.

4.3 Dr Senior, with the Appraisal Lead and Medical HR Lead, Mr Gervase Campbell, have completed the AQMAR self-assessments of readiness for revalidation in 2009, 2010, 2011, and 2012, and action plans are in place to address the gaps identified. This Trust is broadly in line with the majority of other trusts in our level of preparedness. The

action plan for further development sits within the Patient Safety and Clinical Risk work-stream of the Clinical Quality, Safety, and Governance (CQSG) Committee, led by Dr Yakeley.

4.4 Developing our appraisal system

4.4.1 Dr Yakeley has written a Trust policy for medical appraisal for revalidation in line with GMC guidelines, which was approved by the Board of Directors in November 2011. The Policy was sent to all doctors in the Trust.

4.4.2 We have identified a sufficient number (10) of consultant appraisers in the Trust across the three medical disciplines.

4.4.3 All of these appraisers have now received formal training in appraisal for revalidation.

4.4.4 A support system for consultant appraisers within the Trust has been established, and appraisers are meeting termly to discuss and peer review appraisals.

4.4.5 We are developing a system to ensure that all doctors in the Trusts are being appraised annually, including locums and non-consultant grade doctors. Trainees will be covered by their ARCP, unless they go beyond a five-year cycle, in which case they will need further appraisal. We have established a database recording all doctors in the Trust, their named appraisers, and the dates of their annual appraisals.

4.5 Informing our consultants about revalidation

4.5.1 We hold regular consultant meetings where we have discussed appraisal and revalidation, including a recent formal training session provided by an external trainer.

4.5.2 Dr Yakeley has circulated the new Revalidation and Appraisal Policy, as well as a summary of this Policy, to all the consultants.

4.5.3 The HR Revalidation Lead, Gervase Campbell, conducted a survey of all the consultants in the Trust of their knowledge and views on revalidation in 2011.

4.6 Information systems

4.6.1 Mr Campbell and Dr Yakeley have researched the market for the provision of specifically designed electronic appraisal systems and e-portfolio for revalidation, and recommended

that the Trust is better off purchasing a ready-made system than designing its own. The Trust has agreed to fund the purchase, implementation and training for this. We are currently awaiting the GMC's final recommendations for revalidation before choosing a system.

4.7 Multi-source feedback

4.7.1 Dr Senior and Dr Yakeley have piloted the Royal College of Psychiatrists multi-source feedback tool for colleagues.

5. Outstanding actions to be completed.

5.1 By December 2012. Person responsible – Dr Yakeley, reporting to Dr Senior and the CQSG Committee.

5.2 Clarify and consolidate our clinical governance and HR systems

5.2.1 Clarify the respective roles and responsibilities of the HR Revalidation Lead and the Clinical Governance and Quality Manager in the overall process of appraisal and revalidation.

5.2.2 Establish that a robust system is in place for the central collection of information held by HR regarding the appointment of all doctors in the Trust, doctor's participation in clinical audit, and multisource feedback.

5.2.3 Ensure that a reliable system is in place in order that complaints and clinical incident reports regarding medical clinicians come to the attention of the Responsible Officer. Currently the Governance and Risk Advisor works closely with the Revalidation and Appraisal Lead (Dr Yakeley) and informs her and the Medical Director of all complaints and clinical incident reports regarding doctors.

5.3 Ensure that HR resources are in place and appropriately funded for the tasks outlined.

5.4 E-Portfolio

5.4.1 Identify and purchase the most appropriate and cost-effective e-portfolio system.

5.4.2 Train all of our doctors in how to use the e-portfolio (this will record the results of their annual appraisals, and supporting information such as the results of Multi-Source Feedback, number of CPD hours, record of case based discussions,

involvement in audits, results of record keeping audits, complaints and Serious Untoward Incidents, meetings of their PDP group, accreditation for educational supervision).

5.5 Multi-source feedback

5.5.1 Depending on the results of the pilot, implement an appropriate feedback tool for colleagues.

5.5.2 Research and discuss how to best obtain feedback from patients, taking into account the complexities of our patient population and treatments offered.

5.6 Identify the cost of implementing the above.

5.6.1 Indications are from early exploration of IT systems, including discussions with system providers, that the total figure including HR support will be less than £10k.

6. What are the Boards' Responsibilities?

6.1 The Board of Directors has a responsibility to provide sufficient funds and resources to enable the Responsible Officer to discharge their duties.

6.2 The Board also needs to have assurance that:

6.2.1 Appraisal systems for doctors are fit for revalidation purposes;

6.2.2 There is a robust appointment process for new doctors;

6.2.3 The general performance information held by the Trust is reviewed, including clinical indicators and outcomes for patients;

6.2.4 There are well governed procedures for the investigation of practitioners;

6.2.5 Concerns are addressed with appropriate measures; and

6.2.6 Records of the above bullet points are kept.

6.3 While noting the above, the Board of Directors is invited to recognise that, compared with the acute sector and mental health trusts with in-patient facilities, this Trust is a relatively low risk organisation and, for example, our doctors are not regularly

performing high risk procedures. As a small specialist Trust, the number and range of our medical staff is also small.

Dr Rob Senior,
Medical Director
June 2012

Board of Directors : June 2012

Item : 10

Title : Board of Directors Aims & Objectives 2012/13

Purpose:

Attached are the 2012/13 aims and objectives for the Board of Directors.

For : Discussion

From : Angela Greatley, Trust Chair

Board of Directors' Aims and Objectives 2012/13

Overarching Aims

Strategy

- Create an inspiring strategy that takes into account the Trust's accountability for meeting patient, student and public need; and the Trust's mission, focused as it is on making a significant contribution to mental health and wellbeing.
- Locate outcomes that matter to patients, students and other users of our services at the centre of all of our work. Aim is to create a culture in which outcomes are owned jointly by service users and staff, and integrated into all of our activities with the aim of constantly improving the quality of what we do.
- Actively seek and promote creative partnerships as a means of supporting development, innovation, and delivery of the Trust's mission.
- Develop our understanding of emerging local and national education and training markets in order to maximise our contribution, also looking to the potential for international development.
- Focus on successful productivity and performance in order to remain financially sustainable while delivering affordable excellence in all areas of service.
- Develop our understanding of the potential impact on the Trust of changes in local, regional and national health, social care and education markets.

Developing People and the Organisation

- Build on the annual Board review to ensure maximum performance as a unitary board.
- Ensure that Trust staff are trained and equipped to meet the demands of reconfigured and evolving services.
- Actively seek and engage with the views of staff and ensure these views contribute to the shaping and future development of the organisation and its services.
- Ensure that 'equalities' retains a high priority in the Trust's clinical, education, consultancy and research programmes.

Governance

- Develop understanding of the Health and Social Care Act 2012 in relation to roles of Governors and Directors.
- Ensure that the Constitution is updated to reflect changes within the Health and Social Care Act 2012, and is presented to the AGM for approval.
- Develop the relationship between the Board of Governors and Board of Directors, to ensure that they work well together in order to ensure effective governance of the Trust.
- Work with Governors so that the Trust further develops relationships with members and the public.

Performance: Quality and Finance

- Ensure that productivity gains are realised whilst maintaining the high quality and safety of Trust services.
- Ensure that the Trust retains unqualified registration with the Care Quality Commission (CQC).
- Ensure that the Trust retains a Monitor Financial Risk Rating of 3 or above.
- Ensure that the Trust retains a green rating for governance.
- Ensure that the Trust meets the requirements of education regulatory bodies and meets the requirements of the commissioners of education and training.
- Promote close working with the Trust's customers, purchasers, commissioners, and university and other collaborative partners to respond to emerging need and associated business opportunities.

Special Emphasis for the Year

Special Emphasis for the year	Aim	Objective	Review Date
External environment and place in the market	Ensure that the Trust is optimally positioned in relation to the developments in emerging health, social care and education markets, managing risks and maximising opportunities	Engage actively with local and national providers in order to deliver new products and reconfigured clinical and education services	In 2012/13
		Explore national and international opportunities for the development of clinical services, education and training	In 2012/13
		Review Annual Plan and annual objectives in order to further develop a strategic response to market developments	October 2012, making use of Board away day.
		Ensure that the Trust actively engages with the development of Clinical Commissioning, and the commissioning of Education and Training	In 2012/13

Special Emphasis for the year	Aim	Objective	Review Date
Performance	Ensure that the Trust delivers on the objectives contained within the Annual Plan according to the timetable set out	Retain CQC Registration without condition	Quarterly
		Monitor Finance Risk Rating of 3 or better across all four quarters	Quarterly
		Monitor Governance Rating of Green across all four quarters	Quarter 4
		Ensure that the Annual Plan 2012/13 – 2014/15 encompasses effective longer-term strategy to achieve performance objectives	Annual Plan cycle, starting Summer 2012
		Implement reconfigured service lines	June 2012
		Use reconfigured service line data, including quarterly forecasting, to drive performance monitoring and planning	Consider as a part of service line updates to the Board of Directors

Special Emphasis for the year	Aim	Objective	Review Date
Productivity	Ensure that the Trust delivers on national and local productivity challenges, including the QIPP programme	Monitor action plans for delivery of productivity targets for 2012/13 up to 2015	Annual Plan cycle; July 2012
		Ensure Trust is prepared to react to reductions in demand for its services	Quarterly
		Ensure that the CQSG provides continuously improved assurance of quality to the Board	Quarterly
	Ensure the Senior management team has effective long term planning and sustainability established	Ensure that effective succession plans are in place	6 monthly at Board Lunch between NEDs and CEO
Customer Relations	Maintain an awareness of the impact on the Trust of changes in the NHS, social care, education and training markets both nationally and locally, and in the Trust's markets more specifically	Ensure that political and local intelligence forms an integral part of Annual Plan development	Annual Plan cycle
		Ensure that education and training intelligence forms and integral part of Trust plans	Annual Plan cycle
	Ensure that staff work responsively with sector-wide development and with emerging commissioner arrangements	All members of Board to take up opportunities for local engagement, and are 'played into' emerging architecture where appropriate	Ongoing

Special Emphasis for the year	Aim	Objective	Review Date
Quality and Safety	Ensure that the Trust continues to focus on the quality and safety of all its services, locating patient, student, and customer experience at the centre of all of our work and developments	Ensure that patient experience and public expectation are reviewed regularly by CQSG and form part of its report to the Board	Quarterly
		Develop the integration of outcomes as measured and monitored in routine practice, in order to continuously improve quality	Quarterly
		Use patient experience and outcome data routinely as a component of Service Line Reports	Consider as a part of service line updates to the Board of Directors

Special Emphasis for the year	Aim	Objective	Review Date
Members and Governors	Develop the relationship between the Board of Governors and Board of Directors, to enhance joint working and improve governance	Ensure that the Trust delivers on objectives around capacity and capability in this area	?
		All members of the Board of Directors to take up opportunities to engage with individual Governors and the Board of Governors including joint work on specific issues e.g. working with the public and the membership	Ongoing
		Make Constitutional Changes required to meet Health and Social Care Act	Approve at AGM in October 2012
		Ensure that Elections are held on time within agreed framework	Date to be agreed
		Ensure new Governors are inducted	November – March 2013