

Board of Directors : January 2011

Item : 7a

Title : Finance and Performance Report

Summary:

After nine months, a surplus of £247k is reported; this is £141k below budget, but well ahead allowing for the contingency. There continue to be cumulative income shortfalls on Consultancy and Clinical income which have been offset by Training income and by under spends across the organisation. In Month 9, the surplus decreased by £43k.

For the year as a whole, the net variance is expected to be well within the contingency reserve, and the Trust is expected to achieve its planned £150k surplus.

The cash balance at 31 December was £2,775k, above Plan. Cash is expected to remain ahead of plan for the rest of the year, subject to achievement of planned income and expenditure. The cash forecast for 2011/12 is unchanged and remains satisfactory.

For : Discussion

From : Simon Young, Director of Finance

1. **External Assessments**

1.1 **Monitor**

1.1.1 The third quarter Monitor is expected to maintain the planned financial risk rating of 3 and a Green governance rating, though these have not been officially confirmed yet. Both ratings are expected to remain unchanged for the final quarter.

2. **Finance**

2.1 **Income and Expenditure 2010/11 (Appendices A, B and C)**

2.1.1 After nine months, income is £570k below budget, and expenditure £430k below budget. The Trust's surplus of £247k is £141k below budget; but allowing for the contingency reserve, we are still well in line to achieve the year-end budget of £150k.

2.1.2 After 9 months £117k of the overall adverse income variance is offset by directly related under spends; this is mainly on Child Psychotherapy Trainees, where numbers are slightly lower than Plan. There are some smaller phasing differences both positive and negative in other areas.

2.1.3 Apart from these differences, the income shortfall includes £262k for Consultancy, with TCS under target by £59k and departmental consultancy under by £204k. There are also shortfalls in Clinical and Training (see sections 3 and 4 below).

2.1.4 Research income is below budget by £96k and this trend is expected to continue.

2.1.5 There is an under spend of £430k, of which some £163k is directly related to lower activity and income (2.1.2 above). The majority of the remainder can be attributed to vacancies in Child & Family £121k, Portman £100k and Adult £60k. These under spends have been offset by an over spend in TCS of £91k (as reported previously) due to delayed 2009/10 payments for associate consultants and termination costs.

2.1.6 The forecast outturns for income and expenditure, shown in the right-hand columns of Appendix B and summarised in Appendix A, are based on reviews with all Directors, though some smaller areas remain uncertain, including departmental consultancy (see 5.2 below). There remains a contingency reserve to cover unexpected changes.

2.2 Cash Flow (Appendix C)

2.2.1 The actual cash balance at 31 December was £2,775k, compared to the Plan of £1,877k. The balance is £897k above Plan, whereas it was £2,320k above in October (the last month reported to the Board) and 1,336k above in November. The reduction in November was because of the £900k early payment that had been received in October. The reduction in December is primarily due to NHS contract income not being received in month due to the some sales invoices being raised too late in the month; as these have now been raised, the receipts are expected in January. General Debtors were above plan in December, mainly due to £348k received from a partner organisation. Salaries remained below plan, as reported above.

	Cash Flow year-to-date		
	Actual £000	Plan £000	Variance £000
Opening cash balance	3,645	3,645	0
Operational income received			
NHS (excl SHA)	7,517	8,667	(1,150)
General debtors (incl LAs)	5,683	4,919	764
SHA for Training	8,587	8,108	479
Students and sponsors	1,926	1,900	26
Other	379	162	217
	<u>24,092</u>	<u>23,756</u>	<u>336</u>
Operational expenditure payments			
Salaries (net)	(10,909)	(11,222)	313
Tax, NI and Pension	(8,056)	(8,227)	171
Suppliers	(5,594)	(5,294)	(300)
	<u>(24,559)</u>	<u>(24,743)</u>	<u>184</u>
Capital Expenditure	(220)	(470)	250
Interest Income	8	15	(7)
Payments from provisions	0	(103)	103
PDC Dividend Payments	(192)	(223)	31
Closing cash balance	<u>2,775</u>	<u>1,877</u>	<u>897</u>

2.2.2 The details by month are given in Appendix C, which also shows the forecast for the remainder of this year. Sales invoices for our main contracts for January were sent out at the end of December, before the change of finance systems on 4 January. In line with the implementation plan, it was not possible to issue invoices on the new system for the first two weeks; but as these were for smaller amounts, and they will be issued in the remainder of the month, the delay should not have a major impact on receipts.

2.2.3 The closing balance for the year is little changed from the last forecast. The cash projections for 2011/12, updated for the last report, are also not changed. Subject to achieving the productivity improvements needed to deliver a small surplus in 2011/12, the cash balances are expected to remain satisfactory throughout the year.

2.2.4 The Trust's liquidity, using Monitor's formula and including the £2m financing facility, remains satisfactory.

3. **Training**

3.1 Training income is £186k above budget in total after nine months, mainly due to university income over performing by £210k due to backdated payments for last year. We also received an additional £40k for medical training in November.

3.2 These gains have been offset by a shortfall of £47k on Child Psychotherapy Trainees, but this shortfall is much reduced from earlier months.

4. **Patient Services**

4.1 **Activity and Income**

4.1.1 As reported previously, total contract income for the year is below budget. This is due partly to the CQUIN elements and also due to one contract which is expected to be £33k below budget. This has been offset by a small favourable variance on cost and volume activity.

4.1.2 The CQUIN element of the contracted income is forecast to underachieve by £30k by the end of the year. This is a considerable improvement from the previous quarter due to the improved data quality of patient records.

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

4.1.4 After nine months, named patient agreements (NPAs) actual income is £26k below budget, which is spread across the service lines. If extrapolated for the full year, this would give an adverse variance of £33k, but some improvement on this is expected in the final quarter.

4.1.5 Court report income was £16k below budget after nine months. The majority of the under performance was from Portman which has been offset by C&F over performance.

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	7,141	7,106	-0.5%	-111	-123	
Cost and vol variances	2	18		37	37	
NPAs	187	161	-14.0%	-33	-20	
Projects and other	1,968	1,771		-	-150	Income matched to costs, so variance is largely offset.
Day Unit	760	853	12.2%	124	100	Pupil numbers now slightly lower.
Monroe	576	473	-17.8%	-139	-100	£34k relates to prior year adjustment
FDAC	249	281	12.9%	43	0	
Court report	191	175	-8.3%	-21	0	
Total	11,075	10,839		-100	-256	

4.1.6 Monroe income is £102k below budget after nine months. There was low activity again during December due to the unit moving location which resulted in an £30k adverse movement in month.

4.1.7 Day Unit is currently over performing by £92k cumulatively due to high pupil numbers.

4.1.8 Project income is forecast to be £150k below budget for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.

4.2 Clinical performance

4.2.1 Information on waiting times and DNAs (did not attend) for quarter 3 has been delayed, and will be included in next month's report.

5. **Consultancy**

- 5.1 TCS income was £55k in December, higher than the budget of £38k. However, the cumulative income of £460k remains £59k behind budget. Our forecast for the year assumes at present that budget is achieved for the remaining three months.
- 5.2 Departmental consultancy is £204k below budget after nine months.

Simon Young
Director of Finance
17 January 2011

Appendix A

Do not print this page.

Appendix B

Do not print this page.

Cash Flow 2010/11

Appendix C

2010/11 Plan

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	3,645	4,081	3,704	3,521	3,193	2,776	2,185	2,333	2,250	1,877	2,242	2,126	3,645
Operational income received													
NHS (excl SHA)	924	1,010	914	1,005	1,038	917	904	1,038	917	905	1,036	917	11,525
General debtors (incl LAs)	838	417	880	550	402	379	556	474	423	783	591	458	6,751
SHA for Training	894	914	895	894	914	894	895	914	894	894	915	894	10,811
Students and sponsors	300	150	150	100	0	200	650	250	100	500	100	100	2,600
Other	18	18	18	18	18	18	18	18	18	18	18	18	216
	2,974	2,509	2,857	2,567	2,372	2,408	3,023	2,694	2,352	3,100	2,660	2,387	31,903
Operational expenditure payments													
Salaries (net)	(1,247)	(1,247)	(1,247)	(1,246)	(1,247)	(1,247)	(1,247)	(1,247)	(1,247)	(1,246)	(1,247)	(1,247)	(14,962)
Tax, NI and Pension	(859)	(921)	(921)	(921)	(921)	(921)	(921)	(921)	(921)	(921)	(921)	(921)	(10,990)
Suppliers	(434)	(719)	(784)	(697)	(622)	(510)	(509)	(510)	(509)	(510)	(509)	(510)	(6,823)
	(2,540)	(2,887)	(2,952)	(2,864)	(2,790)	(2,678)	(2,677)	(2,678)	(2,677)	(2,677)	(2,677)	(2,678)	(32,775)
Capital Expenditure	0	0	0	(20)	0	(100)	(200)	(100)	(50)	(60)	(100)	(90)	(720)
Interest Income	2	1	2	2	1	2	2	1	2	2	1	2	20
Payments from provisions	0	0	(90)	(13)	0	0	0	0	0	0	0	0	(103)
PDC Dividend Payments	0	0	0	0	0	(223)	0	0	0	0	0	(223)	(446)
Closing cash balance	4,081	3,704	3,521	3,193	2,776	2,185	2,333	2,250	1,877	2,242	2,126	1,524	1,524

2010/11 Actual/Forecast

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	3,645	3,787	3,488	3,566	3,504	3,095	2,784	4,653	3,586	2,775	3,047	2,830	3,645
Operational income received													
NHS (excl SHA)	892	1,017	829	785	805	1,109	677	1,184	218	905	1,036	917	10,375
General debtors (incl LAs)	709	387	588	610	369	178	1,761	426	654	740	540	410	7,373
SHA for Training	874	854	1,015	970	911	959	1,935	87	983	894	915	894	11,290
Students and sponsors	277	102	86	126	165	315	538	143	174	500	50	50	2,526
Other	24	35	29	35	53	32	69	59	42	18	18	18	433
	2,776	2,396	2,547	2,526	2,304	2,593	4,979	1,900	2,070	3,057	2,559	2,289	31,997
Operational expenditure payments													
Salaries (net)	(1,206)	(1,192)	(1,198)	(1,184)	(1,198)	(1,173)	(1,232)	(1,264)	(1,263)	(1,246)	(1,247)	(1,247)	(14,649)
Tax, NI and Pension	(859)	(889)	(895)	(905)	(876)	(893)	(896)	(926)	(918)	(921)	(921)	(921)	(10,819)
Suppliers	(570)	(615)	(377)	(502)	(640)	(543)	(965)	(696)	(687)	(510)	(509)	(510)	(7,123)
	(2,635)	(2,695)	(2,470)	(2,591)	(2,713)	(2,608)	(3,092)	(2,885)	(2,868)	(2,677)	(2,677)	(2,678)	(32,591)
Capital Expenditure	0	0	0	0	0	(105)	(19)	(83)	(13)	(60)	(100)	(90)	(470)
Interest Income	1	0	1	3	1	1	1	1	0	2	1	2	13
Payments from provisions	0	0	0	0	0	0	0	0	0	(50)	0	0	(50)
PDC Dividend Payments	0	0	0	0	0	(192)	0	0	0	0	0	(223)	(415)
Closing cash balance	3,787	3,488	3,566	3,504	3,095	2,784	4,653	3,586	2,775	3,047	2,830	2,130	2,130

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2010-11

APPENDIX A

		Dec-10			CUMULATIVE			FULL YEAR 2010-11		
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST OUTTURN £000	BUDGET VARIANCE £000
INCOME										
1	CLINICAL	1,219	1,287	68	11,075	10,839	(236)	14,669	14,427	(242)
2	TRAINING	1,276	1,317	41	12,237	12,423	186	16,065	16,251	186
3	CONSULTANCY	111	127	16	1,186	923	(262)	1,615	1,352	(262)
4	RESEARCH	28	23	(4)	248	152	(96)	331	235	(96)
5	OTHER	53	26	(27)	454	293	(161)	613	452	(161)
TOTAL INCOME		2,687	2,781	94	25,199	24,630	(570)	33,293	32,717	(576)
OPERATING EXPENDITURE (EXCL. DEPRECIATION)										
6	CLINICAL DIRECTORATES	1,516	1,607	(91)	13,645	13,395	250	18,122	17,826	296
7	OTHER TRAINING COSTS	483	483	0	5,112	4,841	271	6,575	6,304	271
8	OTHER CONSULTANCY COSTS	53	68	(15)	473	569	(96)	630	725	(95)
9	CENTRAL FUNCTIONS	540	590	(50)	4,880	4,875	6	6,494	6,491	3
10	TOTAL RESERVES	0	0	0	0	0	0	386	299	87
TOTAL EXPENDITURE		2,592	2,747	(155)	24,110	23,679	430	32,207	31,646	562
EBITDA		95	34	(61)	1,090	950	(139)	1,085	1,071	(14)
ADD:-										
12	BANK INTEREST RECEIVED	2	3	(1)	15	11	4	20	16	(4)
LESS:-										
11	DEPRECIATION	42	42	0	382	380	2	509	491	(18)
13	FINANCE COSTS	0	0	0	0	0	0	0	0	0
14	DIVIDEND	37	37	0	335	335	0	446	446	0
RETAINED SURPLUS		17	(43)	(63)	389	247	(141)	150	150	(36)
EBITDA AS % OF INCOME		3.5%	1.2%		4.3%	3.9%		3.3%	3.3%	

	Dec-10			CUMULATIVE			FULL YEAR 2010-11		
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST £000'S	REVISED BUDGET VARIANCE £000
INCOME									
NHS LONDON TRAINING CONTRACT	623	623	(0)	5,609	5,609	(0)	7,479	7,479	(0)
TRAINING FEES & OTHER ACA INC	405	421	16	4,401	4,580	180	5,616	5,796	180
POSTGRADUATE MED & DENT'L EDUC	6	0	(6)	52	19	(33)	70	36	(33)
JUNIOR MEDICAL STAFF	86	101	14	778	865	87	1,037	1,125	87
CHILD PSYCHOTHERAPY TRAINEES	155	172	17	1,397	1,349	(48)	1,863	1,815	(48)
R&D	28	23	(4)	248	152	(96)	331	235	(96)
CLINICAL INCOME	1,026	1,127	101	9,298	9,056	(242)	12,288	12,046	(242)
DAY UNIT	84	82	(2)	760	853	92	1,014	1,114	100
MONROE	60	30	(30)	576	473	(103)	780	680	(100)
FDAC	28	33	5	249	281	32	332	332	0
TCS INCOME	38	55	16	519	460	(59)	730	671	(59)
DEPT CONSULTANCY INCOME	73	72	(0)	667	463	(204)	885	681	(204)
COURT REPORT INCOME	21	15	(6)	191	175	(16)	255	255	0
EXCELLENCE AWARDS	10	10	(0)	88	87	(1)	118	117	(1)
RENTAL INCOME	0	0	0	0	0	0	0	0	0
OTHER INCOME	43	17	(26)	365	206	(160)	495	335	(160)
TOTAL INCOME	2,687	2,781	94	25,199	24,630	(570)	33,293	32,717	(576)
EXPENDITURE									
EDUCATION & TRAINING	301	312	(11)	3,477	3,391	86	4,395	4,309	86
PORTMAN CLINIC	135	124	11	1,215	1,090	125	1,620	1,470	150
ADULT DEPT	258	303	(46)	2,339	2,290	49	3,112	3,042	70
MEDNET	18	16	2	166	167	(2)	221	222	(2)
ADOLESCENT DEPT	129	114	14	1,160	1,115	45	1,546	1,501	45
ADOLESCENT PROJECTS	0	10	(10)	15	43	(28)	15	43	(28)
C & F CENTRAL	592	629	(37)	5,308	5,203	105	7,084	6,978	105
C&F PROJECTS	168	174	(7)	1,508	1,474	34	1,941	1,907	34
MONROE & FDAC	82	89	(7)	734	738	(4)	979	983	(4)
DAY UNIT	64	72	(8)	576	611	(35)	768	803	(35)
SPECIALIST SERVICES	62	74	(12)	545	609	(64)	732	797	(64)
COURT REPORT EXPENDITURE	9	0	9	79	55	24	105	81	24
TRUST BOARD & GOVERNORS	10	9	0	86	77	9	115	106	9
CHIEF EXECUTIVE OFFICE	26	29	(4)	232	245	(14)	308	322	(14)
PERFORMANCE & INFORMATICS	78	80	(2)	693	677	15	930	915	15
FINANCE & ICT	91	114	(23)	820	884	(64)	1,093	1,157	(64)
CENTRAL SERVICES DEPT	181	210	(29)	1,653	1,801	(147)	2,197	2,347	(150)
HUMAN RESOURCES	56	66	(9)	540	489	51	709	658	51
CLINICAL GOVERNANCE	31	43	(12)	281	250	31	374	344	31
TRUST DIRECTOR	29	14	15	264	237	27	348	320	27
PPI	17	16	1	121	117	4	166	162	4
SWP & R+D & PERU	31	20	11	281	198	83	375	292	83
R+D PROJECTS	0	0	0	0	(0)	0	0	(0)	0
PGMDE	9	4	5	82	55	27	109	82	27
NHS LONDON FUNDED CP TRAINEES	155	155	(0)	1,397	1,259	138	1,863	1,725	138
TAVISTOCK SESSIONAL CP TRAINEES	9	5	4	83	63	20	111	91	20
FLEXIBLE TRAINEE DOCTORS	8	6	3	73	73	(0)	97	97	(0)
TCS	49	58	(9)	441	532	(91)	587	677	(90)
DEPARTMENTAL CONSULTANCY	4	10	(6)	32	37	(5)	43	48	(5)
DEPRECIATION	42	42	0	382	380	2	509	491	18
PROJECTS CONTRIBUTION	(10)	(12)	1	(91)	(100)	9	(121)	(130)	9
IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	0	0	0	0	0
CENTRAL RESERVES	0	0	0	0	0	0	386	299	87
TOTAL EXPENDITURE	2,634	2,789	(155)	24,491	24,059	433	32,716	32,137	580
OPERATING SURPLUS/(DEFICIT)	53	(8)	(61)	708	571	(137)	576	580	4
INTEREST RECEIVABLE	2	3	1	15	11	(4)	20	16	(4)
UNWINDING OF DISCOUNT ON PROVISION	0	0	0	0	0	0	0	0	0
DIVIDEND ON PDC	(37)	(37)	0	(335)	(335)	0	(446)	(446)	0
SURPLUS/(DEFICIT)	17	(43)	(60)	389	247	(141)	150	150	0

Board of Directors : January 2011

Item : 7b

Title : 2010/11 Q3 Monitor Governance Declarations

Summary:

The Trust continues to meet all of the targets and indicators in the 2010/11 Compliance Framework, with one exception which is set out in this report. Action plans are in place to ensure that this remains the case.

The overall score remains at 0.5, which should again result in a Green rating for governance. The Board of Directors is asked to approve the following declaration:

For one or more targets the Board cannot make Declaration 1* and has provided relevant details on worksheet "Targets and Indicators" in this return. The Board confirms that all other healthcare targets and indicators have been met over the period (after the application of thresholds) and that sufficient plans are in place to ensure that all known targets and national core standards that will come into force will also be met.

Details of any elections held (including turnout rates) and any changes in the Board or Board of Governors are included on worksheet "Board Changes and Elections" in this return.

* The wording of Declaration 1 is that all healthcare targets and indicators have been met and that sufficient plans are in place to ensure that they will continue to be met.

For : Approval

From : Director of Corporate Governance and Facilities,
Director of Finance & SIRO

2010/11 Monitor's Quarter 3 Governance Declaration

1. Declaration of performance against healthcare targets and indicators

1.1 The Monitor template for our quarterly return sets out a list of targets and indicators, in line with the Compliance Framework 2010/11 document. The 7 targets and indicators which apply to this Trust are given in the table below. Our assessment of our result for Quarter 3 is unchanged from Quarter 2.

1.2 One target is not currently being met, leading to a score of 0.5. All other targets and indicators are being met and plans are sufficient to ensure that they continue to be met. Further details are given below.

1.3 The Trust should therefore continue to receive a green governance rating.

Target / Indicator	Weighting	Quarter 3 result	
Data completeness: 99% completeness on all 7 identifiers	0.5	Failed to Meet	0.5
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	0.5	Achieved	
Moderate CQC concerns regarding the safety of healthcare provision	1.0	No	
Major CQC concerns regarding the safety of healthcare provision	2.0	No	
Failure to rectify a compliance or restrictive condition(s) by the date set by CQC within the condition(s) (or as subsequently amended with the CQC's agreement)	4.0	No	
Registration conditions imposed by Care Quality Commission		No conditions	
Restrictive registration conditions imposed by Care Quality Commission		No conditions	
		Total score	0.5
		Indicative rating	

2. Care Quality Commission registration

- 2.1 The Trust was registered by the CQC on 1 April 2010 with no restrictions. Actions continue throughout the year to ensure that this status is retained, assurance is considered by the CQSG Committee.
- 2.2 The Trust remains compliant with the CQC registration requirements. In advance of the next review by the CQSG Committee, the members of the Management Committee confirmed at their meeting on 13 January that they are not aware of any breaches to these requirements.

3. Self certification against compliance with requirements regarding access to healthcare for people with a learning disability

- 3.1 The self certification was reviewed and approved by the Board in April 2010.

4. Data Completeness

- 4.1 The targets set for mental health FTs is 99% completeness on seven of the patient identifiers in the Mental Health Minimum Data Set (MHMDS) [†]. A Foundation Trust which does not meet 99% for all seven (see table below) scores 0.5 points. Because this failure is rated 0.5 rather than 1.0, it does not by itself prevent the FT from retaining a green governance rating. [‡]
- 4.2 Details of the seven identifiers and our current completeness were given with the quarter 2 governance declaration. The position has not changed: we remain at or close to the 99% target for six identifiers, but significantly below 99% for marital status.
- 4.3 We do not intend to make the recording of marital status compulsory, for the reasons stated before. If we take some steps to encourage higher recording, this could improve the score, but it would be very unlikely to reach 99%. This position has been reported to Monitor.
- 4.4 It may be noted that in Monitor's current consultation on amendments to the Compliance Framework for 2011/12, no change on this target is being proposed.

[†] 2010/11 Compliance Framework, Appendix B, table 1 (page 45) and note 15 (page 48).

[‡] 2010/11 Compliance Framework, paragraphs 61 to 64 and Diagram 5 (pages 17 and 18).

Board of Directors : January 2011

Item : 8

Title : Corporate Governance Report

Summary:

This paper reports on the following items:

1. Monitor Updates
2. The White Paper
3. Memorandum of Understanding between Monitor and the Care Quality Commission
4. The Mid Staffordshire NHS Foundation Trust Public Inquiry
5. Recent appointments

For : Noting

From : Trust Secretary

Corporate Governance Report

1. Monitor Updates

1.1 Monitor's review of foundation trusts

1.1.1 Monitor have published *NHS foundation trusts: review of six months to 30 September 2010*. There were 130 foundation trusts at the end of Quarter Two in 2010/11. Monitor's report is based on the data submitted by FTs on a quarterly basis.

1.1.2 Below are the Quarter Two statistics on foundation trusts. Categories into which the Trust fits are highlighted in red.

Table 1: NHS Foundation Trust Statistics at 30 September 2010¹

Type of FTs		
Total	130	
Acute	74	56.9%
Mental Health	40	30.8%
Specialist	16	12.3%
FTs by Strategic Health Authority²		
North West	27	71%
South West	16	62%
Yorkshire & The Humber	16	73%
London	15	39%
East of England	14	54%
West Midlands	12	44%
North East	10	91%
South Central	7	47%
South East Coast	7	41%
East Midlands	6	46%
Governance Risk Ratings		
Green	77	59.2%
Amber-Green	36	27.7%
Amber-Red	6	4.6%
Red	11	8.5%
Financial Risk Ratings		
5 (lowest risk)	14	10.8%
4	55	42.3%
3	50	38.5%
2	9	6.9%
1	2	1.5%
FTs in significant breach of terms of authorisation		
Total	10	7.7%
Combined actual net surplus Q2		
Total	£213m	
EBITDA margin		
Total	6.9%	

¹ As at January 2011, there were 132 Foundation Trusts

² Percentages are of foundation trusts out of potential foundation trusts in each health authority

1.1.3 Monitor's document can be found at <http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/reports-nhs-foundation-trusts/nhs-foundation-trusts-quarterly--27>

2. The White Paper

2.1 On 12th July 2010, the Department of Health published its NHS White Paper, *Equity and Excellence: Liberating the NHS*, which set out the Government's long-term vision for the future of the NHS. On 15th December 2010, the Department of Health published *Legislative Framework and Next Steps*, which sets out the Government's response to White Paper consultation and explains how it has modified its original proposals.

3. Memorandum of Understanding Between Monitor and the Care Quality Commission

3.1 Monitor has published a revised Memorandum of Understanding with the Care Quality Commission, which sets out the statutory responsibilities of both organisations, the general principles for collaboration and cooperation and their working arrangements.

3.2 The MoU can be found on Monitor's website: <http://www.monitor-nhsft.gov.uk/home/about-monitor/what-we-do/working-other-healthcare-organisations>

4. The Mid Staffordshire NHS Foundation Trust Public Inquiry

4.1 Robert Francis QC is chairing the public inquiry into the role of commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire NHS Foundation Trust, which will build on the work of his earlier independent inquiry into the care provided by Mid Shaffordshire. Monitor has been designated as a core participant.

4.2 The final report is expected to be published in summer / autumn 2011.

4.3 The Inquiry's website is <http://www.midstaffspublicinquiry.com/home>

4.4 The final report of the independent inquiry is available on loan from the Trust Secretary.

5. Recent Appointments

5.1 Chief Executive of NHS North Central London

- 5.1.1 Caroline Taylor has been appointed as the new Chief Executive for the NHS North Central London. Ms Taylor succeeds Rachel Tyndall. Ms Taylor was previously Chief Executive of NHS Croydon and CEO Lead for London specialist commissioning.

Louise Carney
Trust Secretary
18th January 2011

Board of Directors : January 2011

Item : 9

Title : Trust Policies: Safeguarding Children Policy

Summary :

Policy and Procedures for Safeguarding Children and the Management of Suspected Child Abuse.

For : Approval

From : Medical Director

Policy and Procedures for Safeguarding Children and the Management of Suspected Child Abuse

Version:	Version 4 replaces version 3 June 2008
Ratified by:	Board of Directors
Approved by	Management Committee
Date ratified:	
Name of originator/author:	Dr Rob Senior , Sonia Appleby
Name of responsible committee/individual:	Dr Rob Senior
Date issued:	
Review date:	June 2013 <i>(unless external requirement to update earlier)</i>

Contents

Section		Page
1	Introduction and Purpose	4
2	Scope	5
3	Roles and Responsibilities	6
4	Procedures for Dealing with Suspected Abuse	8
4.1	Recognition of Abuse	8
4.2	Opportunities and Obstacles in Identifying Safeguarding Issues	8
4.3	Informing the Named Professionals for Safeguarding Children	11
4.4	Recording information	11
5	Sharing Information	11
6	Referral to Children's Services	13
6.1	Tasks Usually Undertaken by Social Services	14
6.2	Tasks for Child and Family Department Professionals	14
6.4	Out of Hours advice	15
7	Allegations Made Against Clinic Staff and Trainees	15
8	Investigation by Local Authority Social Service Department and Police Child Protection Team	16
9	Child Protection Conferences	19
10	Role of Trust Staff During Initial and Review Conferences	19
11	Legal Advice and Management When There is a Threat of Violence	20
12	Supporting Staff involved in Child Protection	20
13	Managing Press Involvement	20
14	Complaints	21
15	Implementation of Policy and Training Requirements	21

16	Process for Monitoring Compliance with this Policy	22
17	Archiving Arrangements	23
18	Equality Impact Statement	23
19	References	23
20	Associated Documents	24
Appendix A	Role of CAMHS and Adult Services in Safeguarding Children	25
Appendix B	Gloucester House – The Children’s Day Unit Policy and Procedures	28
Appendix C	Recognition of Abuse : Guidelines for Staff	38
Appendix D	Flow Charts	41
Appendix E	Glossary	45
Appendix F	EQIA Form	54

1 Introduction and Purpose

1.1 Introduction

Tavistock and Portman Foundation NHS Trust (the Trust) is committed to promoting the safeguarding of children and protecting them from the risks of harm as required by section 11(2) (a) Children Act 2004: safeguarding children is everyone's responsibility. The Trust's approach to child protection has been developed in line with the London Child Protection Procedures (2007) Working Together to Safeguard Children 2010, When to Suspect Child Maltreatment, 2009 which supersedes What to Do If You Are Worried a Child is Being Abused, 2006, The Protection of Children In England: A progress Report 2009 and the Government's Response a Year On, 2010.

1.2 Background: Why are Procedures Necessary?

- 1.2.1 Safeguarding children has three distinct domains: identifying children who have specific needs, children where there are welfare concerns regarding the quality and/or consistency of their parenting and a child or an unborn child who is at risk of, or have suffered significant harm, most commonly referred to as child protection.
- 1.2.2 Children can be abused in any section of our society. Abuse occurs in all ethnic and regional groups and in all classes. Children may be abused by family members, (adults, young people and children), family friends, professionals and carers and by strangers.
- 1.2.3 Professionals need to be sensitive to the child's needs, the distress which investigations may arouse in the family and that the needs of the child and his/her family may conflict. In all cases the welfare, well-being and protection of the child must be paramount. As a Trust we endorse and promote the 'right people, doing the right thing...and in the right time' to safeguard children and young people. (See The Government's Response to Lord Laming One Year On, 2010 paragraph 3).
- 1.2.4 Responding to and managing suspicions and allegations of child abuse demands much of professionals: recognising that our society embraces a variety of child-rearing practices that requires sensitivity to the customs and views of families, while at the same time distinguishing what constitutes acceptable child care and what does not.
- 1.2.5 It is vital that professionals make no lasting presumptions either that abuse has occurred, or that it has not happened without following Trust procedures and the London Child Protection Procedures, 2007.

- 1.2.6 The effective management of child protection requires a multidisciplinary approach supported by sharing information in a timely manner with appropriate professionals. Sharing information with other professionals is a fundamental aspect of enabling a child's safety and protection. No professional should ever intervene alone. All concerns must be shared with others.
- 1.2.7 In order that the child's best interests are served, it is important that, during an investigation of child protection, discussion within the professional network has priority over that with parents and carers until it is clear there is no conflict between the interests of the child and his/her parents/carers. The same principle of priority is applicable in circumstances where there are concerns and/or allegations of child protection where a professional is suspected. (See London Child Protection Procedures, 2006, pages 447-461).
- 1.2.8 Where contradictions or inconsistencies, real or apparent, arise between the procedures set out in this document and those for the area in which the child lives, these should be resolved by discussion between the agencies' safeguarding leads.

2 Scope

- 2.1 These procedures are intended for the use of all staff at the Trust. They are supplementary to the London Child Protection Procedures, 2007, Working Together to Safeguard Children, 2010 and When to Suspect Child Maltreatment, 2009 and local arrangements for complying with the London Child Protection Procedures.
- 2.2 Copies of the aforementioned documents are available from the Named Doctor or the Named Professional.
- 2.3 These procedures apply to all child patients (0-18) and the unborn, of any nationality, whether they are being treated on the National Health Service or privately.
- 2.4 In addition, those clinicians assessing and treating adults have a duty to be competent regarding child development, family functioning and parental capacity and crucially have the same duty of care to safeguard and protect children.
- 2.5 Throughout this document, where **child** (aged 1- 12 years) is mentioned, this should be understood to include **young person** (aged 13 – 17 years).

3 Roles and Responsibilities

3.1 Chief Executive

3.1.1 The Chief Executive as the Accountable Officer has overall responsibility for ensuring the implementation of effective Child Protection Procedures.

3.2 Named Doctor/Named Senior Professional

3.2.1 The Named Doctor and Named Professional will take the professional lead within the Trust on child protection matters. They should have expertise on children's health and development, the nature of child abuse, local arrangements for safeguarding children and promoting their welfare.

3.2.2 They provide a source of advice and expertise to fellow professionals, support the interface with other agencies and play an important role in promoting good professional practice in safeguarding children.

3.2.3 They are responsible for overseeing the effective conduct of the Trust's internal case reviews and will ensure investigation and response to child protection complaints on behalf of the Trust.

3.2.4 They review the Trust's policy and procedures, practices and multi-agency working. They ensure that appropriate child protection standards are adhered to.

3.2.5 The accountabilities of the Named Doctor and Named Professional will be clearly identified in their job descriptions along with their responsibilities in relation to this policy and procedure.

3.3 Director of Human Resources

3.3.1 The Director of Human Resources is responsible for:

- Ensuring the Trust's Recruitment and Retention Policies comply with relevant legislation and guidance relating to staff working with children and include Enhanced Criminal Records Bureau checks.
- Ensuring that the trust induction programme and mandatory training programmes include safeguarding and child protection training as defined by the training needs analysis (refer to the Staff Training Policy).

3.4 Case Co-ordinator formerly known as the Case Consultant

3.4.1 The Case Co-ordinator has responsibility for individual cases, as set out in detail within this policy and procedure.

3.4.2 Where a serious incident has occurred staff will **also** follow the requirements set out in the Trust's Serious Incident Policy.

3.5 Clinical Directors, Associate Directors, Service Line Managers and Heads of Discipline

3.5.1 Clinical Directors, Associate Directors, Service Line Managers and Heads of Discipline are responsible for:

- Promoting working practices that ensure the welfare of children and young people.
- Ensuring all staff attend all relevant training in respect of safeguarding and child protection: induction, mandatory and PDP training as required by the Trust
- Ensuring that staff who are affected in any way by child protection issues receive the appropriate help and support they require, either by referral to the Named Professionals, the Staff Advisory Service or by direct referral to Occupational Health.

3.6 All Staff

3.6.1 All staff are required to work to promote children's rights as detailed in the Article of the United Nations Convention on the Rights of the Child 1989. This is in line with the requirements of the Human Rights Act 1998. All Trust staff (employed, honorary or volunteers) have a duty to safeguard and promote the welfare of children (section 5, Children Act 2004). To meet their responsibilities, all individual staff must ensure:

- They attend training provided by the Trust in respect of safeguarding and child protection
- They are aware of how to obtain help and advice in relation to child protection matters
- They follow the London Child Protection Procedures, 2007 when there are child protection concerns.
- They understand the sharing of personal information about children and families held by them is not disclosable without consent of the data subject. However, the law permits the disclosure of confidential information necessary to safeguarding children in the interest of the child, i.e. protecting the child will override the child's right to confidentiality. Staff should take advice from the Named Professionals in complex cases and ensure that any confidential information shared is done in the child's best interests.

- They seek advice initially from the Case Co-ordinator, their Line Manager or the Named Professionals in all complex cases and understand that child protection issues should never be managed by a single professional.
- They report any allegation or concern of child protection regarding a member of staff to the Named Professional.

4 Procedures for Dealing with Suspected Abuse

4.1 Recognition of Abuse

4.1.1 To assist staff a summary set of guidelines on recognising abuse is shown at **Appendix C**. This should only act as a guide to staff as child abuse can manifest in a way that may not at first be understood as abuse. Staff are reminded to remain vigilant and be open to evidence of safeguarding and child protection either through direct care of the child or through learning of possible safeguarding concerns and child protection from other patients e.g. parent/carers.

4.2 Opportunities and Obstacles in Identifying Safeguarding Issues

4.2.1 Safeguarding and child protection cases may arise in the following ways:

- Planned referral for psychosocial assessment where possible abuse is suspected
- Concerns which arise during the course of an assessment and/or treatment

4.2.3 Any physical or sexual abuse disclosed by a child to a member of staff/trainee/clinical associate should immediately be reported to the Case Co-ordinator. An urgent internal discussion should take place and a referral should be made to the Children's Services in the area the child currently lives.

4.2.4 However, if the Case Co-ordinator is not available (e.g. sick leave/annual leave) the Team Leader or another Case Co-ordinator from the same clinical team should provide cover for the case.

4.2.5 If a member of staff/trainee/clinical associate observes signs indicative of possible physical abuse, they should ask the child and parent/carer how the injuries were sustained. If the explanations given are not totally plausible and consistent and as such raise concern as to possible abuse, the staff member/trainee/clinical associate should indicate a need to discuss

this further with colleagues, including Children's Services and inform the Case Co-ordinator immediately.

- 4.2.6 If a child appears to be suffering from neglect, the staff member/trainee/clinical associate should gain relevant information from the parent/carer/child and discuss with the Case Co-ordinator. The parent/carer should be informed if a referral to Children's Services is made.
- 4.2.7 If a child appears to be suffering from emotional abuse, which may cause significant harm, the Case Co-ordinator must be informed.
- 4.2.8 In all cases where the Case Co-ordinator considers that a child is likely to be at risk of further abuse and/or silencing these concerns must not be discussed with the parents/carers before contacting Children's Services.
- 4.2.9 Thereafter, Children's services might instigate either a section 17 (Child in Need Assessment) or a section 47 (Child Protection investigation) the Children Act 1989.
- 4.2.10 In cases where there is some doubt about whether to refer to Children's Services contacting the appropriate Local Authority's Assessment and Referral Team Manager to discuss concerns may assist in progressing matters.

4.2.11 Understanding the obstacles to recognizing maltreatment

There are obstacles among healthcare professionals to recognizing child maltreatment and to accepting that child maltreatment commonly occurs. Some of these obstacles relate to the healthcare practitioners' professional and personal experiences (including maltreatment) or lack of training.

Other obstacles include the following:

1. concern about missing a treatable disorder	7. uncertainty about when to mention suspicion, what to say to parent(s) or carer(s) and what to write in the clinical file
2. healthcare professionals are used to working with parents and carers in the care of children and fear losing the positive relationship with a family already under their care	8. losing control over the child protection process and doubts about its benefits
3. discomfort of disbelieving, thinking ill of, suspecting or wrongly blaming a parent or carer	9. child protection processes can be stressful for professionals and time-consuming
4. divided duties to adult and child patients and breaching confidentiality	10. personal safety
5. understanding the background and reasons why the maltreatment might have occurred, especially when there is no perceived intention to harm the child	11. fear of complaints, litigation and dealings with professional bodies
6. difficulty in saying that a presentation is unclear and there is uncertainty about whether the presentation really indicates significant harm	12. fear of seeking support from colleagues

(See When to Suspect Child Maltreatment, July 2009, page 16)

4.3 Informing the Named Professionals for Safeguarding Children

- 4.3.1 The Trust's Named Doctor or Professional must be notified of all cases of suspected and known child abuse.
- 4.3.2 A member of staff/trainee/clinical associate who has a concern about actual or suspected abuse of any kind must immediately inform the Case Co-ordinator, who should formally notify either the Named Doctor or Lead Professional for Safeguarding Children.

4.4 Recording Information

- 4.4.1 Detailed contemporaneous records (within 24 hours, ideally on the same day) must be kept by all involved and must clearly differentiate between fact, reported information and opinion. (Keeping fact and opinion in separate pages or paragraphs in records is advised).
- 4.4.2 The reasons for any decisions made must be recorded clearly, including the decision(s) and reason(s) why the child was not referred to Children's Services.
- 4.4.3 When the Trust is using RiO 'validating' your records must be undertaken in a timely manner as well as being mindful regarding who will have access to the records, and where there are particular sensitivities ensuring there is a traceable manual record.

5 Sharing Information

- 5.1 The importance of sharing information with other agencies is fundamental.

- 5.1.1 Sharing Information effectively enables:

- (i) improved communication between professionals;
- (ii) a better understanding of what should be shared, with whom and under what circumstances, and the dangers of not doing so;
- (iii) building confidence and trust with partners and families;
- (iv) better knowledge of other agencies services;
- (v) less duplication for families

5.2 Confidential Information

- 5.2.1 Confidential information is 'information not normally in the public domain or readily available from another source, it should have a degree of sensitivity and value and should be subject to a duty of confidence.'

5.3 Common Law Duty of Confidence

5.3.1 A breach of confidentiality is when a person shares information with another in circumstances where it is reasonable to expect that the information will be kept confidential. However, all professionals have a duty to disclose information where failure to do so would result in a child or children or others suffering from neglect or physical, sexual or emotional abuse.

5.4 Public Interest and Proportionality

5.4.1 The public interest 'test' can be used to make judgements regarding managing confidential information:

It is in the public interest:

- (i) to protect children and other people from harm;
- (ii) to promote the welfare of children;
- (iii) to prevent crime and disorder;
- (iv) alternatively, non-disclosure may also be, in some circumstances, in the public interest.

5.5 Overall Legal Position

5.5.1 The law does not prevent individual sharing of information with other practitioners to assist a child if:

- (i) those likely to be affected consent;
- (ii) the public interest in safeguarding the child's welfare overrides the need to keep the information confidential
- (iii) disclosure is required under a Court Order or other legal obligation

5.6 Sharing Information Checklist

- 5.6.1
1. Is there a legitimate reason to share information?
 2. Is there a necessity to identify the individual?
 3. If the information is confidential, has consent been obtained?
 4. If consent to share information is refused, do the circumstances meet the 'public interest test'?
 5. Ensure the right information is disclosed appropriately
(See London Child Protection Procedures, 2007, pages 101-117)

6 Referral to Children's Services

- 6.1 Informing Children's Services should be undertaken by the Case Co-ordinator, an alternative Case Co-ordinator or the Team Leader.
- 6.2 Where the case is already known to Children's Services, the Case Co-ordinator will need to speak to the allocated social worker or their line manager.
- 6.3 Where the case is not known to Children's Services, the Case Co-ordinator will refer to the Referral and Assessment Duty Social Worker or Manager.
- 6.4 Telephone referrals to Children's Services will usually require a facsimile confirmation on the same day where possible, sent to a named professional via a Safe Haven fax machine. An acknowledgement should be received by telephone within one working day, if this has not taken place **within** 2 working days dependent on the severity of concerns, contact Children's Services.
- 6.5 **Information Checklist when making a Referral to Children's Services**
- 6.5.1
1. Full Names, D.O.Bs and gender of Children and Adults Living in the Household
 2. Address of Family Home, GP and School(s)
 3. Identity of Adult with PR (parental responsibility)
 4. Ethnicity, First Language and Religion
 5. Salient Events in Family History
 6. Cause for Concern
 7. Any Special Needs of Child or Parent
 8. Child's Current Whereabouts
 9. Details of the Alleged Perpetrator and Relationship to the Child
 10. Other Agencies Currently, or in the Past, involved with the Family
 11. Parental Agreement to the Referral obtained or not
- (See London Child Protection Procedures, 2006).

6.1 Tasks Usually Undertaken by Children's Services

6.1.1 Children's Services will:

- (i) check whether there is already salient information about the child within the local authority and request checks for information with the Police. And ensure that the wishes and feelings of the child are known under the Children Act 1989 as amended by section 53 Children Act 2004;
- (ii) consult with other agencies that have direct knowledge of the child and family;
- (iii) decide whether a meeting is necessary and if so whether it should be a Strategy Meeting or Professionals' Meeting;
- (iv) convene a Strategy Meeting with local agencies, (in urgent situations the Children's Services Team Manager will hold strategy discussions by telephone);
- (v) plan who and when investigations/assessments will be done. This will include considering the part played by professionals in the local authority where the child is residing and any other authority involved if the child is subject to a Care Order and working in conjunction with the police to achieve a best interview (ABE), if required;
- (vi) if it is clear there no child protection concerns, Children's Services will record on the file the decision not to proceed and consider any actions, which may be required to safeguard the child's needs and welfare.
- (vii) alternatively, the Strategy Meeting/Discussion may decide to commence a child protection investigation. under section 47, Children Act 1989.

6.2 Tasks for Trust Professionals

6.2.1 Trust clinicians need to be prepared to give information to the Police and Children's Services Department.

6.2.2 Attend Strategy Meetings and Conferences as necessary. This is not just important because we may be the referrers but staff may have a major contribution in considering the issues concerning the child, e.g. development, mental health state, emotional vulnerability, functioning of the family and parental capacity.

- 6.2.3 Prepare reports for Child Protection Initial and Review Conferences.
- 6.2.4 Requests or Court Directions for court reports should always be discussed with Case Co-ordinators and Team Leaders
- 6.2.5. If it is clear there is no child protection concern, there must be a record on the file/RiO why the decision to proceed no further has been made.
- 6.2.6 To assist and participate in any Serious Case Review or Child Death Review processes conducted under the auspices of a Local Safeguarding Children Board.

6.3 Out of Hours Advice

- 6.3.1 If a concern arises after office hours (after 5 pm. or at the weekends) consideration must be given as to whether the local Children's Services Out of Hours or Emergency Team should be informed at once rather than waiting until the next working day.
- 6.3.2 Camden Out of Hours or Emergency Team can be reached by phoning the local authority and asking for the Out of Hours or Emergency Team. (0207 278 4444). If you are dealing with a non-Camden child, you must contact the local authority where the child ordinarily lives.
- 6.3.3 If there are any difficulties in getting through, particularly in cases of emergency, the Police Child Protection Team should be contacted. For Camden the telephone numbers are: 0207 388 6953 or 0207 725 4547.

7 Allegations Made Against Clinic Staff (including bank and honorary), Trainees, Clinical Associates

- 7.1 If an allegation is made against a member of staff this must be taken as seriously as any other allegation and treated in the same way.
- 7.2 Staff who hear or witness abuse caused by a staff member/trainee/clinical associate should record their concerns and report the matter immediately to the Team Leader, who must notify their Service Line Managers and Associate Director, who should advise either the Named Doctor or the Named Professional for Safeguarding Children.
- 7.3 If the allegation is against the Case Co-ordinator, the Associate Director should be informed.
- 7.4 The staff member against whom the allegation is made should be informed of this by the Associate Director and Team Leader.

- 7.5 The Trust's designated senior manager should not investigate the matter or interview the member of staff, child or potential witnesses. The primary task of the designated senior officer is to ensure there are written records, which are dated and signed by the person reporting the allegation and any potential witnesses.
- 7.6 Before any referral to the Local Authority Designated Officer (LADO) is made one of the following criteria must be met, which should not be deterred by the staff member's resignation:
- (i) behaviour that has harmed a child or may have harmed a child;
 - (ii) possibly committed a crime against or related to a child;
 - (iii) behaved towards a child or children in a way that indicates they are unsuitable to work with children
- 7.7 The Clinical Directors and Director of Human Resources should be notified, if any of the above criterion is met.
- 7.8 Where there is not sufficient substance in an allegation to warrant a child protection investigation there should be an internal inquiry to:
- (i) consider whether the behaviour of the professional raises cause for which should be addressed by further training/supervision or disciplinary proceedings.
- 7.9 Either the Case Co-ordinator, Team Leader, Service Line Manager or Associate Director will meet with the parents/carers with or without the young person as appropriate, to inform them of the proceedings.
- 7.10 Staff should also be aware of the Trust's Whistle-Blowing procedure, which can be found in the suite of policy documents on the Trust Intranet.
- 7.11 In addition, staff can access an independent charity (Public Concern at Work) whose lawyers can provide free confidential advice about how to raise a concern about malpractice at work: www.pcaw.co.uk (See London Child Protection Procedures, 2007 pages 503-504).

8 Investigations by Local Authority Children's Services and Police Child Protection Teams

- 8.1 The statutory responsibility for investigating any suspected child abuse lies with two agencies: **THE LOCAL AUTHORITY CHILDREN'S SERVICES** and **THE POLICE CHILD PROTECTION TEAM**. Children's Services have a duty to investigate where there is any cause for concern that a child may have

been abused and the Police have a responsibility to investigate criminal acts.

8.2 Investigations are carried out under section 47, the Children Act 1989 in partnership with the parents/carers so long as such investigations do not prejudice the welfare of the child.

8.3 The following are the guidelines for their investigations:

'The scope of the enquiry, including siblings and other children at possible risk of harm

The need for any paediatric or specialist assessment;

How to meet the best interest of the child/ren in the enquiry, taking into account any additional needs such as that arising from disability or a need for an interpreter, speech and language therapist

How the child's wishes and feelings will be ascertained so that they can be taken into account

When, how and who will undertake interviews with the children and if a video interview will be used;

Any further action if consent for an interview or medical assessment is refused;

The needs of other children in contact with the alleged abuser/s including all children within the household;

Who other than the family should be interviewed, by whom, when and for what purpose;

Agree what other actions may be needed to protect the child or provide interim services and support, including securing the safe discharge of a child in hospital

What information may be shared, with whom and when taking in account the possibility of information sharing placing a child at risk of significant harm or jeopardising police investigations

Any implications for disciplinary action

Any legal action required

The need for further strategy meetings/discussions;

Timescales, agency and individual responsibility for agreed actions, including the timing of police investigations and relevant methods of evidence gathering.'

(See London Child Protection Procedures, 2007).

- 8.4 In special circumstances for instance where the child's mental state is of concern, the child has severe disabilities or particular learning difficulties, or the child is very young, professionals from specialist child mental health services may be asked to consult to or undertake these interviews.
- 8.5 The investigation established the facts and assesses the level of risk to the child and any other children in the same house.
- 8.6 Throughout the investigation all professionals should keep an open mind about the concerns.
- 8.7 The number of investigations/examinations of the child should be kept to the minimum necessary to clarify the child's situation.
- 8.8 Parents/carers and other key family members are consulted and informed at all stages in the investigation unless it is clearly in the interests of the child that there should be some delay in doing so. This consultation /information giving must extend to all those with parental responsibility in so far as is possible.
- 8.9 Issues of gender, race, culture, religion, language, and disability must be taken into account.
- 8.10 Appropriate interpreters should be used where English is not the language used by the family or where the child or parent has specific communication needs.

Note: Children have the right under the Criminal Justice Act: Memorandum of Good Practice 1992 to be interviewed in their first language.

- 8.11 If the investigation is a part of an assessment in the course of court proceedings, leave of the Court must be sought in advance for any examinations.
- 8.12 Detailed contemporaneous records must be kept by all involved and must clearly differentiate between fact, reported information and opinion.
- 8.13 Professionals are advised to keep fact and opinion in separate pages in records

9 Initial and Review Child Protection Conferences

- 9.1 Child Protection Conferences are convened under the procedures of the relevant local authority. The Initial Child Protection Conference decides whether the child is at risk of abuse whether a child protection plan is required and, if so, the membership of the child protection core group.
- 9.2 Thereafter, the Review Child Protection Conference should review the progress of the Child Protection Core Group focussed upon the child's safety; the child's needs, the capacity of the parents/carers and their ability to meet the child's needs parental/carer understanding of professionals' concerns and their ability to change.
- 9.3 Parents/carers and other family members are invited to attend Initial and Review Child Protection Conferences unless there are valid reasons for excluding them.
- 9.4 It is **essential** that key Trust staff attend these Conferences.
- 9.5 Trust staff must be alert to a child being subject to a Child Protection Plan for more than two years and/or having a history of child protection plans and discuss these matters with the Case Co-ordinator or the Named Doctor or Named Professional.

10 Role of Trust staff during Initial and Review Conferences

- 10.1 Following an Initial or Review Child Protection Conference, the Trust may continue to have a significant role with the child and his/her family as part of the Child Protection Plan. Apart from continuing any existing treatment, this may include any of the following:
- Contributing to the comprehensive assessment of the child and family or adult
 - Carrying out further specified investigations
 - Providing therapeutic treatment
 - Providing reports for Court (subject to the Directions of the Court)
 - Attending Court (subject to the Directions of the Court)
 - Be available for consultation, by phone if need be, to discuss interviewing the child to assist police and social work colleagues.
- 10.2 Legal advice and support in the preparation of Court Reports and the giving of evidence can be obtained from the legal team of the relevant Local Authority.
- 10.3 In addition, staff also have access to the Trust's solicitors via the Director of General Services where appropriate.

11 Legal Advice and Management When There is a Threat of Violence

- 11.1 The Case Co-ordinator and Team Leaders should be informed whenever there is considered to be a risk of violence either to the child concerned or to any other person so that appropriate arrangements for security e.g. alerting porter staff, can be made. In the exceptional circumstances, where it is thought that there is an extremely high risk of violence, it may be appropriate to inform and request a police presence prior to interviews. However this should be discussed with the Associate Director and Head of Department prior to any appointment being offered.

12 Supporting Staff Involved in Child Protection

- 12.1 The Trust recognises that involvement in any aspect of child protection can be stressful for staff. It is therefore committed to offering help and support for any staff that have concerns. Staff are advised at induction that the Trust provides a Staff Advisory Service which can be accessed by any member of staff, where a trained professional will offer one-to-one support. In addition, staff should raise concerns directly with the Case Co-ordinator or Team Leader or the Named Professionals.
- 12.2 Staff who provide teaching and training may become aware of a safeguarding and child protection concern via concerns raised by students and trainees. Staff should encourage students/trainees who raise concerns that are external to the Trust that such concerns must be reported to the correct organisation. Occasionally, staff may need to assist students/trainees to escalate their concerns through the appropriate line management structures within their agencies. In circumstances, where the Trust staff member encounters difficulties in assisting the students/trainees, they should inform either the Designated Doctor or the Named Professional.

13 Managing Press Involvement

- 13.1 If there is a possibility of the Press seeking information on a case where the Child Protection process is actually or potentially involved then it is essential that legal advice is sought from the relevant Local Authority where the child resides. In these circumstances, staff should consult with the Case Co-ordinator or Team Leader and the Named Professional.

14 Complaints

- 14.1 Complaints about failure to follow these procedures should be addressed to the Chief Executive.
- 14.2 Complaints will be dealt with following the Complaints Procedures for the Trust and/or Camden Safeguarding Children Board.
- 14.3 Carers and children/young people have a right to complain under section 24(d) Children Act 1989 and for looked after children and young people under section 26 the Children Act 1989.

15 Implementation of Policy and Training Requirements

- 15.1 This policy will be made available to staff via the Trust intranet and the content of the policy will be communicated through induction training and mandatory training sessions for all staff.
- 15.2 The Named Professionals will ensure that all child protection training programmes are reviewed and updated annually and in line with current legislation to provide practitioners will skills appropriate to their needs. The Trust will access Camden Safeguarding Children Board Training Programmes which provides Level 3 multi-agency training for practitioners who are directly working with children and families.
- 15.3 The Trust has determined via a training needs analysis process that **all** staff should have Level 1 safeguarding and child protection awareness as part of the mandatory training for the Trust. This is delivered through the INSET training.
- 15.4 Adult practitioners and non-clinical staff will receive Level 2 training. Adult clinicians are expected to be cognisant of 'the child' and their need for care and safety when conducting assessment/treatment of adults. (See Appendix A). In addition, all clinical staff with direct care of either children or parents, will receive training relevant to their role. This will be delivered via experienced staff in the Trust (Named Doctor and Named Professional), other trainers where appropriate and via the Camden Safeguarding Children Board.

15.2 Review of Training as Part of Annual Performance Review

15.2.1 Managers undertaking individual performance reviews of staff must include reference to mandatory safeguarding children training according to the appropriate level for their role and ensure that the individual's Professional Development Plan incorporate appropriate training requirements and arrangements are made for staff to access relevant training.

15.3 Transfer of Previous Training

15.3.1 Staff who have previously worked in health and former social services departments and are employed in a clinical role where advanced safeguarding children training is required must complete Trust-wide and local induction training. However, if in a previous role a member of staff has completed an advanced, updating session within the previous twelve months then they will be exempt from further training for the first year of employment subject to documentary proof of training.

16 Process for Monitoring Compliance with this Policy

16.1 The Trust will monitor compliance with this policy and procedures in the following way:

- the Staff Training and Development Committee will monitor uptake of child protection training as part of their continual monitoring of mandatory training and report this to the Corporate Governance and Risk Sub group of the CQSG. The Subgroup will escalate training issues to the CQSG if necessary;
- the Named Doctor for Safeguarding will provide an annual report to the Patient Safety and Risk Sub group of the CQSG who will present it to the Board via the CQSG. This report will address any externally imposed changes in relation to safeguarding children procedures. In addition they will highlight any issues that have arisen in respect of either safeguarding children or the delivery and uptake of training in line with the requirements set out in the policy;
- the Named Professional for Safeguarding Children will review any incidents relating to Safeguarding and report concerns/investigations/lessons learned to the Patient Safety and Risk Sub group;

- the Named Doctor will be responsible for adding any specific safeguarding children risks to the Operational Risk Register as they arise and this Risk Register will be monitored through the Trust Risk Management Procedures;
- the Named Professionals will undertake a spot check audit of cases with child protection concerns and in those departments where adults are also parents to ensure that the Trust's records show that all relevant procedures have been followed. If this audit raises concerns the named professional will make recommendations to the patient Safety and Risk Sub group and an action plan will be developed and followed. Any action plan will be monitored by the Patient Safety Sub Group:
- should the Trust be directly or indirectly involved in a section 8 enquiry under the Children Act 1989 this will immediately be flagged as a risk on the register and the Board will be informed both of the process and the outcome.

17 Archiving Arrangements

- 17.1 On ratification of this policy, the policy author must ensure that the Trust retains archived copies of the previous policy. This will be done by completion of a 'new policy' form and in liaison with the policy coordinator.

18 Equality Impact Statement

- 18.1 The impact of this policy on staff, and potential or prospective staff to the Trust has been fully assessed with positive impacts identified. A copy of the EQIA is shown at **Appendix F**.

19 References

Children Act 1989 and 2004

http://www.opsi.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm

http://www.opsi.gov.uk/acts/acts2004/ukpga_20040031_en_1

When to Suspect Child Maltreatment July 2009

www.nice.org.uk

Working Together to Safeguard Children, Department for Children's Schools and Families, 2010

<http://publications.dcsf.gov.uk/eOrderingDownload/00305-2010DOM-EN.PDF>

www.publications.dcsf.gov.uk

20	Associated Documents
-----------	-----------------------------

The Tavistock and Portman Policy and Procedures for Safeguarding Children and the Management of Suspected Child Abuse, 2008

Working Together to Safeguard Children, 2010

Safeguarding Children Abused through Domestic Violence, 2006

London Child Protection Procedures, 2010

http://www.londonscb.gov.uk/files/2010/procedures/london_cp_procedures_v.3_15.02.10.pdf

Safeguarding Children from Abuse Linked to Belief in Spirit Possession, May 2007

Safeguarding Children in whom Illness is Fabricated or Induced, March 2008

Safeguarding Children and Young People from Sexual Exploitation, June 2009

Safeguarding Disabled Children, July 2009

When to Suspect Child Maltreatment CG89, 2009

The Protection of Children in England: A Progress Report, 2009

The Government's Response to Lord Laming One Year On, 2010

Memorandum of Good Practice DoH 1992*

Integrated Risk Management Strategy 2007/2009

Incident Reporting Policy

Policy for the Management and Investigation of Serious Incidents

Recruitment and Selection Policy (re CRB Checks)

Staff Training and Development Policy

APPENDIX A

Extract from Working together to Safeguard Children, 2010

Role of CAMHS and Adult Services in Safeguarding Children

Child and Adolescent Mental Health Services (CAMHS)

Standard 9 of the NSF is devoted to the 'Mental Health and Psychological Wellbeing of Children and Young People'. The importance of effective partnership working is emphasized, and this is especially applicable to children and young people who have mental health problems as a result of abuse and/or neglect. Some forms of emotional distress may, however, fall short of being an identifiable mental health issue. It is also important that the more general need to promote emotional

Well-being among children and young people is not neglected as an essential component of safeguarding.

In the course of their work, child and adolescent mental health professionals will therefore want to identify as part of assessment and care planning whether child abuse or neglect, or domestic violence, are factors in a child's mental health problems, and ensure that this is addressed appropriately in their treatment and care. If they think a child is currently affected, they should follow local child protection procedures. Consultation, supervision and training resources should be available and accessible in each service

Child and adolescent mental health professionals have a role in the initial assessment process in circumstances where their specific skills and knowledge are helpful. In addition, assessment and treatment services may need to be provided to young people with mental health problems or with other emotional difficulties who offend. The assessment of children with significant learning difficulties, a disability or sensory and communication difficulties may require the expertise of a specialist learning disability service or CAMHS.

CAMHS also have a role in the provision of a range of psychiatric and psychological assessment and treatment services for children and families. Services that may be provided, in liaison with local authority children's social care services, include the provision of reports for court, and direct work with children, parents and families. Services may be provided either within general or specialist multi-disciplinary teams, depending on the severity and complexity of the problem. In addition, consultation and training may be offered to services in the community – including, for example, social care schools, primary healthcare professionals and nurseries.

Adult Mental Health Services

Adult mental health services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child suffering or likely to suffer significant harm. This may be as a result of a service's direct work with those who may be mentally ill, a parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. Adult mental health staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse to children. Staff should be able to consider the needs of any child in the family of their patient or client and to refer to other services or support for the family as necessary and appropriate, in line with local child protection procedures. Consultation, supervision and training resources should be available and accessible in each service.

In order to safeguard children of patients, mental health practitioners should routinely record details of patients' responsibilities in relation to children, and consider the support needs of patients who are parents and of their children, in all aspects of their work, using the Care Programme Approach. Mental health practitioners should refer to Royal College of Psychiatrists policy documents, including *Patients as Parents* and *Child Abuse and Neglect: the Role of Mental Health Services* and SCIE Guide 30.

Close collaboration and liaison between adult mental health services and children's social care services are essential in the interests of children. It is similarly important that adult mental health liaise with other health providers, such as health visitors and general practitioners. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm. The expertise of substance misuse services and learning disability services may also be required. The assessment of parents with significant learning difficulties, a disability, or sensory and communication difficulties, may require the expertise of a specialist psychiatrist or clinical psychologist from a learning disability service or adult mental health service.

Assessing the Impact of Parental Mental Ill-Health

When a parent receives mental health services in the community or is hospitalized, it is crucial to identify which patients are parents and include the following as a part of the assessment:

- Is the patient a parent?
- Is the patient the main carer?
- Does the patient have contact with children?
- How many? How old? Gender? Names?

- Where are the children? Who looks after them? Who is responsible for them?
- Who is living in the household?
- How are the children? Does anyone have concerns? E.g. other parent, partner, health visitor, GP school (you will need to obtain patient consent to make these enquiries unless you suspect a child has been or is likely to be harmed)
- Are there other services or agencies involved?
- Does the disorder influence or impair the patients' ability to look after the child(ren)?
- In what way?
- Who assists in child care, if the patient is unwell?
- Are there practical arrangements or sources of support, which could assist the patient and the children?

(see www.lscb-llr.org.uk?index/guidance/guidance_adult_mh-child_protection.htm)

From April 2010, under section 131A of the Mental Health Act 1983, there is a duty on hospital managers to ensure that if a child or young person under the age of 18 is admitted to hospital for mental health treatment, the environment in the hospital is suitable having regard to their age. Managers of adult services must consult with a person who can provide appropriate advice to CAMHS who would need to be involved in decisions about accommodation, care and facilities for education in hospital.

Appendix B

Gloucester House The Tavistock Children's Day Unit Safeguarding and Child Protection Policy and Procedures

1. Gloucester House The Tavistock Children's Day Unit Safeguarding and Protection Policy Statement

For the purpose of this document the term 'Day Unit Staff' should be understood to include all educational, clinical, administrative and support staff, trainees, students and volunteers working at the Day Unit on a full-time or part-time basis.

The staff team of Gloucester House the Tavistock Children's Day Unit recognise our shared responsibility to ensure the safety and well being of every child placed with us. While we would normally first want to discuss and hopefully resolve with the child's parents/carers, any concerns that might arise. However, Day Unit staff members have a legal responsibility to inform both our own senior managers and also the Safeguarding section of the Social Services department in which the child lives if we have any reason to believe that any child attending the Day Unit may be suffering from neglect or any form of physical, emotional or sexual abuse.

2. Key Policies and Documents

As part of the Child and Family Department of the Tavistock Clinic, the Day Unit is required to be aware of, and abide by, the 'Policy and Procedures for Safeguarding Children and the Management of Suspected Child Abuse', drawn up by the Tavistock and Portman NHS Foundation Trust, 2010. These complement the London Child Protection Procedures of the London Safeguarding Board, 4th edition, 2010; and adhere to the law as defined in the Children Act 1989 and to the advice given by HM Government in the document 'Working Together to Safeguard Children', 2010.

(Please refer to appendix 1 for a list of relevant reports held at the Day Unit.)

3. Recognition of Abuse

While abuse may be identified because of one sign or symptom e.g. a particular physical injury, it is common for children who have been abused to show a range or cluster of indicators. It is therefore essential that, when suspicions are aroused by a specific presentation, the child is assessed on more general physical, emotional and behavioural axes.

Any form of abuse should be considered within the wider context of what else is known about the child and family; any previous concerns about the child's welfare; and the extent to which the school and parents/carers can communicate and work together to resolve difficulties.

Categories of Abuse

Any/all of the following categories of abuse are recognised as reason/s why a child may be made subject to a Child Protection Plan

physical injury: actual or likely physical injury to a child, or failure to prevent physical injury (or suffering) to a child, including deliberate poisoning, suffocation and induced illness.

neglect: persistent or severe neglect, or the failure to protect a child from exposure to any kind of danger, including cold or starvation, or extreme failure to carry out important aspects of care, resulting in the significant impairment of the child's health or development, including non-organic failure to thrive.

sexual abuse: actual or likely sexual exploitation of a child or adolescent. The child may be dependent and/or developmentally immature.

emotional abuse: actual or likely severe adverse effect on the emotional and behavioural development of a child caused by persistent or severe emotional ill treatment or rejection.

Categories of Harm

The Children Act 1989 defines harm as:

- i. **Ill-treatment** – including sexual abuse and non-physical ill treatment such as emotional abuse.
- ii. **The impairment of health and development** – health means physical or mental health and development means physical, intellectual, social and/or behavioural development.
- iii. **Harm needs to be demonstrated as significant.** The judgement of significance means comparing the health or development of the child in question with that which could be expected of a similar child – that is a child with similar attributes and needs.
- iv. **Harm has to be shown to be attributable to the absence of a reasonable standard of parental care.** A comprehensive assessment implies looking at that issue in considerable detail.

4. The Welfare of the Child is Paramount

Children can be abused in any section of our society. Abuse occurs in all groups and in all classes. Children may suffer abuse by a family member or family friend, a peer or an older child, by professionals, by those who are in a caring role and by strangers.

Professionals responding to safeguarding and child protection concerns have to be sensitive to the child's needs and the distress which investigations are likely to arouse in the child and their families. In addition, professionals must be aware our society embraces a variety of child rearing practices and be sensitive to the customs, views and practices held by different groups within our community and society. Notwithstanding the aforementioned, professionals must also be able to distinguish what is an acceptable level of child care practice and what is not, within the context of the law in the United Kingdom.

The complexity of the task requires that:

- no professional should work in isolation. There is a duty to share information about children in need/children in need of protection with other professionals in relevant agencies.
- a multi-disciplinary approach is essential in order to gain information of the wider context in which maltreatment may have occurred and to enable professionals to make informed decisions about safeguarding the child.
- in order to achieve the protection of children and work in partnership a variety of agencies need to work collaboratively. The aim is also to work in partnership with parents/carers unless this is considered not to be the child's best interests.

5. Domestic Violence

Witnessing physical and/or emotional abuse has a detrimental impact on a child's well being. If domestic violence continues, the child's achievement and behaviour at school and social relationships can be seriously affected. Day Unit staff will need to be alert to the potential impact of domestic violence on children's learning and behaviour and to seek to support them with the assistance of other services. Where possible the issue of domestic violence should be integrated into the Personal, Health and Social Education curriculum. The most likely links will be to bullying, truancy and exclusion.

6. Listening to Children

If a child trusts a member of staff enough to tell them that s/he is being abused or ill-treated it is important to take what the child is saying seriously. Day Unit staff must make it clear to the child that information relating to the child's safety cannot be kept secret and will be shared with other relevant staff. Thereafter, a verbatim, written account must be completed on the same day. Day Unit staff should not question the child other than to ascertain an understanding of the child's concerns. In circumstances where it is thought a crime has been committed, inappropriate questions may interfere with subsequent enquiries. More detailed interviews, if required, will be undertaken by Children's Services and the Police.

The role of Day Unit Staff is to actively listen to children, accurately record what has been heard and inform their line managers.

7. Record Keeping and Confidentiality

Record Keeping

Basic Principles:

- *The aim is to provide a record for other people to act on in order to keep the child safe.*
- *Recording should be objective, factual, clear and concise.*
- *Opinions and any information supporting these views must be recorded as such.*
- *State the source of information, if via a 3rd party record it as hearsay.*
- *Record reasons for any important decisions made, when and by whom.*
- *State whether the information recorded has been shared with the parent/carer and if not, why.*

Who Needs to Know?

All confidential issues relating to children and young people should be dealt with on a 'need to know' basis. Only relevant members of staff need the details relating to a child where there are safeguarding or child protection concerns. Children and young people will be particularly sensitive to other children and professionals knowing about difficulties in their lives. They will need reassurance about procedures and what is likely to happen next.

Confidentiality and Secrecy

No professional should ever promise a child to keep a secret where there are safeguarding and child protection concerns. Maintaining confidentiality can be collusive and mirror the secrecy which often surrounds abuse.

8. Gloucester House The Tavistock Children's Day Unit Procedures for dealing with Suspected Abuse

In the Day Unit, the Consultant Social Worker takes the role of senior member of staff with designated responsibility for Safeguarding and Child Protection. This role is known as the Child Protection Lead (CPL)

i. Recording and Communicating Child Protection Concerns

It is essential that the Day Unit maintains an up to date written record of all incidents which may indicate concerns about safeguarding and child protection. All Day Unit staff members need to be clear about what has been seen or heard, in order to enable decisions to be made about what should happen as a result of the information or disclosure. It is the responsibility to the Day Unit CPL to monitor this record and to keep it in a secure location.

The Day Unit '**Cause for Concern/Child Protection Incident Report**' should be filled in by the member of staff most directly involved on the same day after any incident/observation which raises a child protection or other potential cause for concern. S/he will pass it to the Head Teacher (or in their absence to the Deputy HT) as a matter of urgency. Any marks, bruising or disclosures must be brought to the Head Teacher's and/or Unit Director's attention before the child goes home. The Head Teacher will record any action which has been or will need to be taken, sign, date and then pass on the Cause for Concern/CP Incident Report as soon as possible, in person or via their tray, to the relevant Case Consultant, or in their absence, to the Day Unit consultant social worker/CPL.

The Day Unit '**Cause for Concern/Child Protection Incident Report Flow Chart**' specifies the order in which the Incident Report form should be circulated. Speed of circulation is vital. Please think ahead, e.g. if you are aware that the next person on the list is away, skip that person rather than risking the form being left in someone's drawer.

The CPL will keep a detailed monthly log of all Cause for Concern/Child Protection Incident Reports which will be reviewed regularly by the Senior Staff Group, other members of staff as appropriate and the Named and Designated Professionals.

The CPL will also ensure that Day Unit staff are made aware, on a 'need to know' basis when a child attending the Day Unit is subject to a Child Protection Plan.

ii. **Making Child Protection Referrals**

Where it has been decided (normally by the Case Consultant in consultation with the Day Unit CPL, the HT and the Unit Director) to make a referral to the appropriate Children's Services, this will usually be undertaken by the Case Consultant and/or CPL. The Unit Director will be kept informed of all such referrals.

Telephone referrals must be confirmed by a written referral (using fax and/or post) on the Common Assessment Framework (CAF) or on the electronic version of that form (eCAF), wherever possible on the same day but no later than 48 hours.

In addition, the following will be notified of the referral

- The Named and Designated Professionals for Safeguarding and Child Protection within the Tavistock and Portman NHS Foundation Trust.
- The Designated Officers responsible for coordinating action on child protection issues both in Camden (because the Day Unit is located in that borough) and in the Local Authority where the child lives.
- The Day Unit School Nurse, Ms Susan Thorp.

Where the child and his/her family are not known to Children's Services, the referral will usually be made to the Duty Social Worker or Duty Team Manager for the area in which the child lives. Alternatively, where the child is known to Children's Services, the Case Consultant or Day Unit CPL will normally communicate directly with the allocated social worker,

where there is one, or else with the appropriate team manager. A copy of the referral will be retained on the child's file in a separate Safeguarding and Child Protection section, which also holds the Cause for Concern/Child Protection Incident Reports.

iii. **Informing Parents/Carers**

Professionals need to be sensitive both to the child's needs and also to the intense level of distress/stress which investigations may arouse in the family system; and be aware that these may, at times, conflict. In all cases, the welfare and protection of the child is paramount. Information sharing and discussion within the professional network, therefore, takes priority over detailed communication with parents and carers until it is clear that there is not a conflict between the interests of the child and those of the parents/carers/family members.

Any physical or sexual abuse disclosed by a child necessitates an urgent referral to Children's Services, who should be consulted on whether or not the child needs to be seen by their G.P. or a specialist child protection doctor.

If a member of staff observes signs of possible physical abuse, s/he or an appropriate colleague, in consultation with the Head Teacher and/or Unit CPL and/or Case Consultant, should ask the child and the parent/carer how the injuries were sustained. If the explanations given are not totally plausible and consistent, the staff member should fill out a Cause for Concern/Child Protection Incident Report. The Head Teacher, Unit CPL and/or Case Consultant will decide, after discussion, whether a formal referral should be made to Children's Services.

If a child appears to be suffering from neglect or emotional abuse, this should be reported on a Cause for Concern/Child Protection Incident Report form. The Case Consultant, in consultation with the HT and CPL, should liaise with Children's Services to plan any action and/or interventions that need to be implemented.

HOWEVER In cases where Day Unit staff consider that a child may be at risk of further abuse and/or silencing as a result of prior discussions with parents/carers (e.g. suspected sexual abuse) these concerns should not be discussed with the parents/carers before contacting Children's Services.

iv. **Allegations of child abuse made against Gloucester House the Tavistock Children's Day Unit staff, including trainees, students and volunteers:**

The reader is referred to the Trust's Policy and Procedures for Safeguarding Children and the Management of Suspected Child Abuse dated 2010, section 7.

The Day Unit Clinical Director and/or a senior staff member delegated by the Director, should meet with the parents/carers, to inform them of any child protection proceedings and/or other outcomes.

v. **Transferring Child Protection Records to a child's next educational placement**

When a child transfers to another placement, the Case Consultant will incorporate into the child's written Discharge Summary a brief account of any safeguarding and child protection concerns relating to that child while s/he has been attending the Day Unit.

When a child is discharged from the Day Unit originals and photocopies of all Incident Forms will be stapled together and held on the child's clinical file. (Day Unit clinical files are maintained for 20 years before being securely destroyed).

vi. **CRB checks**

The CPL, in conjunction, with Human Resources are responsible for ensuring that the Day Unit maintains an up to date and comprehensive records of current CRB checks for all staff.

vii. **The Day Unit Child Protection Training Log**

The CPL is responsible for providing all new staff, during their first 2 working weeks, with a brief induction training session together with an information pack about the Day Unit Safeguarding and Child Protection Policies and Procedures. In addition the CLP maintains a record of all child protection training undertaken by Day Unit staff and is responsible for ensuring that all staff meet the mandatory training requirements.

9. **Safeguarding and Child Protection - Specific Circumstances**

i. **Children in Care**

Where a child is looked after by the Local Authority and there are safeguarding and/or child protection concerns, the circumstances must be subject to the same level of scrutiny as for any other child where there are concerns. A child in care will have an allocated social worker. If a

child becomes looked after by the Local Authority this is likely to lead to him/her being no longer subject to a Child Protection Plan (unless there is a probability of further risk, e.g. continuing contact with a person who presents a risk.) Care planning will address these issues and will be led by Children's Services.

ii. Children Home Alone

It is an offence under section 1(1) of the Children and Young Persons Act 1933 to neglect or abandon a child under the age of 16 for whom a parent or carer has responsibility.

Factors to take into account are:

- level of maturity of the child particularly if looking after younger siblings.
- any difficulties or particular needs of the child being left.
- the time of day that parents are not at home and for how long they are away.
- any health and safety issues within the home.

Children attending the Day Unit are children with educational, social and emotional needs, therefore if there are concerns these children are being left alone, this must be managed as a safeguarding concern.

iii. Sexual contact between children

Sexual behaviour that is a cause for concern includes:

- sexually abusive behaviour involving threats, bribery or coercion.
- where a level of sexual knowledge is displayed that is inconsistent with what would normally be expected given the child's age and level of development.
- Children with special needs are particularly vulnerable because they may not have the emotional, intellectual or physical resources to resist abuse.

iv. Stranger abuse

Stranger abuse can occur during a school outing e.g. at the swimming baths and supervising staff are advised to be vigilant about any potential risk. Day Unit staff must be report any incidents to Children's Services, who will advise regarding when and who will inform the child's parents. The Police will investigate referrals of this nature. They offer support for the alleged victim, will accompany children and young people to medical examinations where required and have a key role in the child protection investigation.

v. Children on the Internet

The lead agency for investigating concerns about access to, and the distribution of, Internet pornography is the Police. Where there are concerns about child exploitation or abuse, these must be referred to Children's Services under child protection procedures.

(Policy revised in September 2010 by Patricia Langton, CPL for the Day Unit)

Appendix C

What is Abuse and Neglect?

1.32 Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children.

Physical abuse

1.33 Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Emotional abuse

1.34 Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse

1.35 Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect

1.36 Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers);

or

- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs

(Working Together to Safeguard Children, 2010)

Significant Harm

There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements. Each of these elements has been associated with more severe effects on the child, and/or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment. Sometimes, a single traumatic event may constitute significant harm, for example, a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm.

In each case, it is necessary to consider any maltreatment alongside the child's own assessment of his or her safety and welfare, the family's strengths and supports⁸, as well as an assessment of the likelihood and capacity for change and improvements in parenting and the care of children and young people.

Under section 31(9) of the Children Act 1989 as amended by the Adoption and Children Act 2002:

'harm' means ill-treatment or the impairment of health or development, including, for example, impairment suffered from seeing or hearing the ill-treatment of another;

'development' means physical, intellectual, emotional, social or behavioural development;

'health' means physical or mental health; and

'ill treatment' includes sexual abuse and forms of ill-treatment which are not physical.

Under section 31(10) of the Act:

Where the question of whether harm suffered by a child is significant turns on the child's health and development, his health or development shall be compared with that which could reasonably be expected of a similar child.

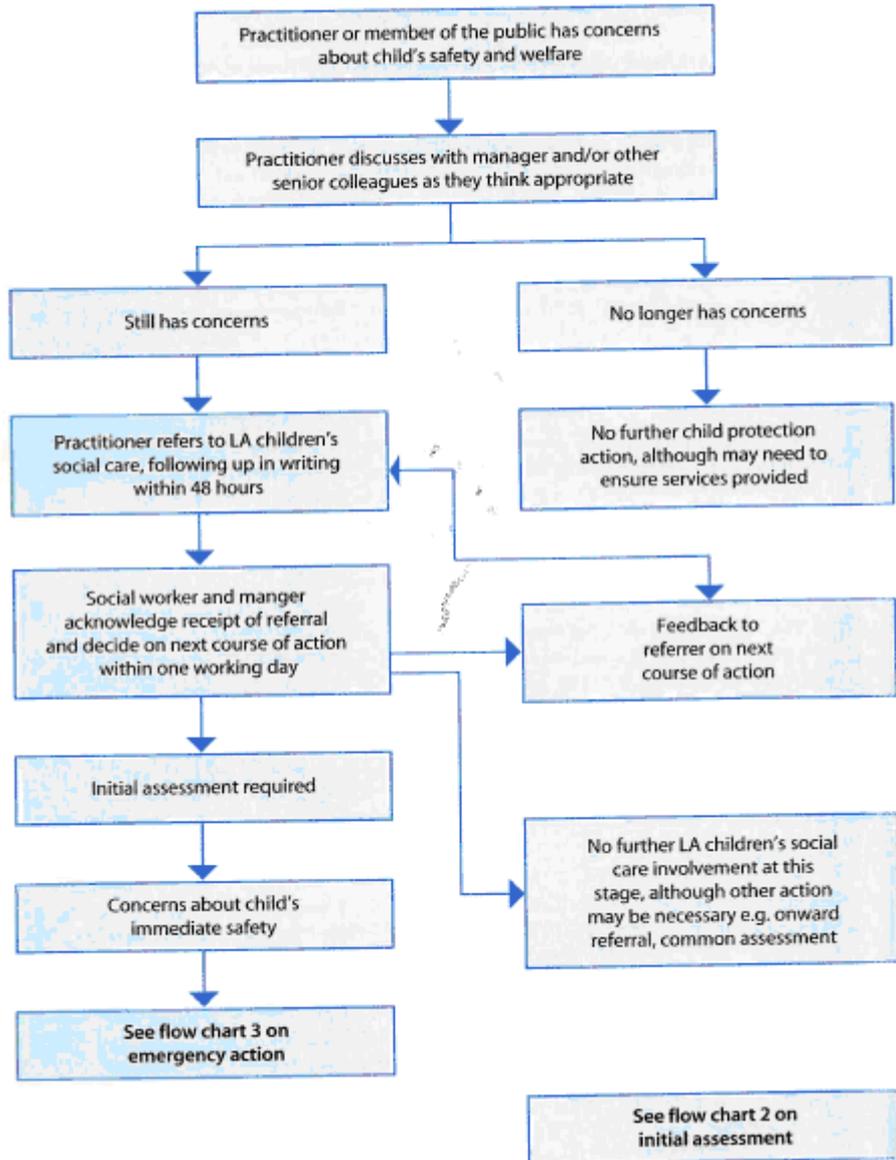
To understand and identify significant harm, it is necessary to consider:

- the nature of harm, in terms of maltreatment or failure to provide adequate care;
- the impact on the child's health and development;
- the child's development within the context of their family and wider environment;
- any special needs, such as a medical condition, communication impairment or disability, that may affect the child's development and care within the family;
- the capacity of parents to meet adequately the child's needs; and
- the wider and environmental family context.

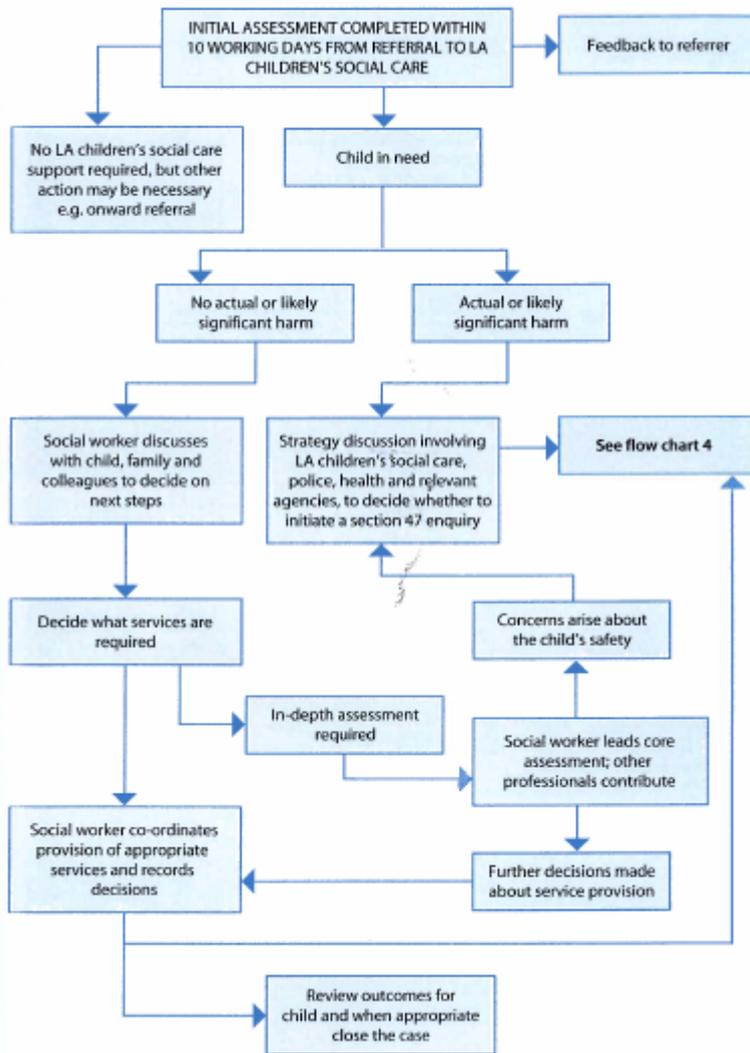
1.30 The child's reactions, his or her perceptions, and wishes and feelings should be ascertained and the local authority should give them due consideration, so far as is reasonably practicable and consistent with the child's welfare and having regard to the child's age and understanding.

Appendix D

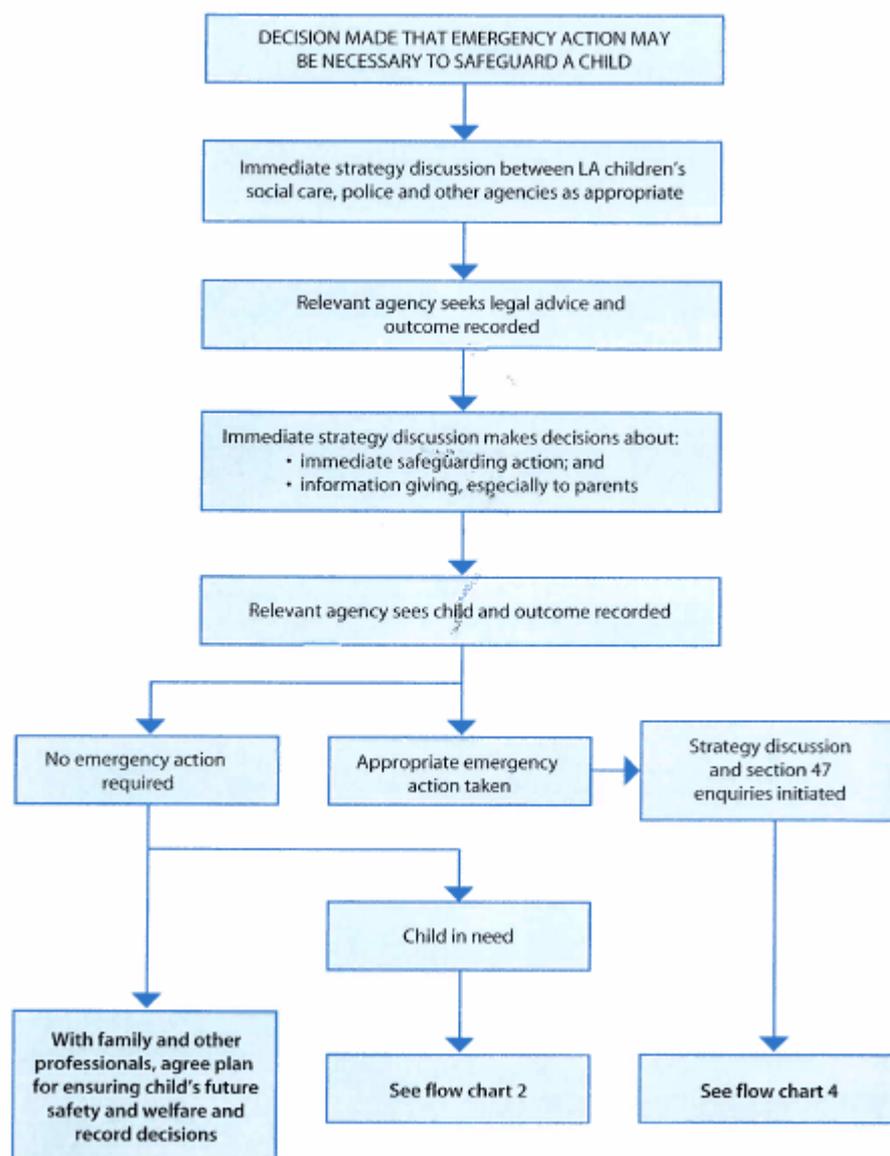
Flow chart 1: Referral



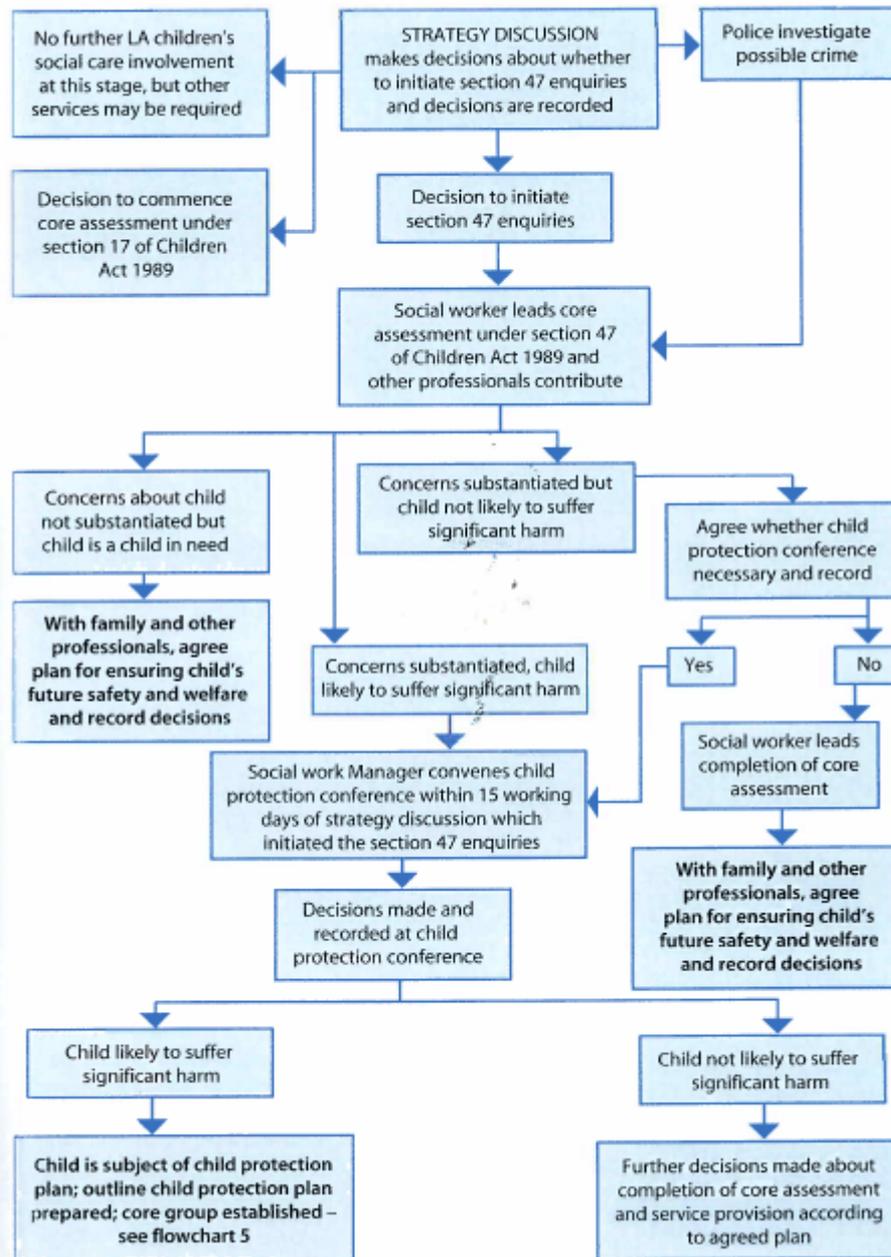
Flow chart 2: What happens following initial assessment?



Flow chart 3: Urgent action to safeguard children



Flow chart 4: What happens after the strategy discussion?



Appendix E

GLOSSARY

www.dcsf.gov.uk/everychildmatters/_glossary/

Please note some of these items have been updated, however, it has been included in these procedures as it is currently the most comprehensive glossary available. If further assistance, is required, contact the Named Professional.

The glossary will be updated in due course.

- ACPC [See: [Area Child Protection Committee](#)] now Local Safeguarding Children Board (LSCB)
- ADHD [See: [Attention-deficit hyperactivity disorder](#)]
- APIR [See: [Assessment, planning, implementation, review](#)]
- ASBO [See: [Anti-Social Behaviour Order](#)]
- [Access](#)
- [Accommodated](#)
- Additional needs [See: [Children with additional needs](#)]
- [Allocated case](#)
- [Anti-Social Behaviour Order](#)
- [Approved social worker](#)
- [Area Child Protection Committee](#)
- [Assessment of a child](#)
- [Assessment, planning, implementation, review](#)
- [Asset](#)
- [At risk](#)
- [Attention-deficit hyperactivity disorder](#)
- [Audit](#)
- [Audit Commission](#)
- [Autistic spectrum disorder](#)

B

- BEST [See: [Behaviour and Education Support Teams](#)]
- Baseline Assessment Profile [See: [Foundation Stage Profile](#)]
- [Behaviour and Education Support Teams](#)

C

- [Behavioural, emotional and social difficulty](#)
- CAF [See: [Common Assessment Framework](#)]
- [CAFCASS \(Child and Family Court Advisory Service\)](#)
- CAMHS [See: [Child and Adolescent Mental Health Services \(CAMHS\)](#)]
- CHAI (Commission for Healthcare Audit and Inspection) [See: [Healthcare Commission](#)]
- [Care order](#)
- [Care plan](#)
- [Case closed](#)
- [Case conference](#)
- [Case current](#)
- [Case review](#)
- [Change teams](#)
- [Child](#)
- [Child Safety Order](#)
- [Child and Adolescent Mental Health Services \(CAMHS\)](#)
- [Child and adolescent psychiatrist](#)
- [Child protection](#)
- [Child protection conference](#)
- [Child protection plan](#) note: child protection registers are defunct as of April 2008
- Child protection review conference [See: [Child protection conference](#)]
- [Child psychotherapist](#)
- [Childcare](#)
- [Children \(Leaving Care\) Act 2000](#)
- [Children and Young Persons Act 2008](#)
- [Children in care](#)
- [Children in need](#)
- [Children missing education \(CME\)](#)
- [Children with additional needs](#)
- [Children with complex needs](#)
- [Children's Commissioner](#)
- [Children's Fund](#)
- Children's NSF [See: [National Service Framework for Children, Young People and Maternity Services](#)]

- [Children's Plan](#)
- [Children's Trusts](#)
- [Children's centres](#)
- [Children's guardian](#)
- [Children's workforce](#)
- [Choice Protects](#)
- [Clinical Psychologist](#)
- Commission for Healthcare Audit and Inspection (CHAI) [See: [Healthcare Commission](#)]
- [Commission for Social Care Inspection](#)
- [Commissioning](#)
- [Common Assessment Framework](#)
- [Common Core](#)
- [Conduct disorder](#)
- [Connexions](#)
- [Connexions Direct](#)
- [Contact](#)
- [Core group](#)
- [Corporate parenting](#)
- [Counselling](#)

D

- [Designated senior person for child protection](#)
- [Designated teacher](#)
- [Developmental delay](#)
- [Differentiation](#)
- [Director of Children's Services](#)
- [Disabled](#)
- [Disapplication](#)
- [Drug Action Teams](#)
- [Duty officer](#)
- [Duty to Co-operate](#)
- [Dyscalculia](#)
- [Dyslexia](#)
- [Dyspraxia](#)

E

- EBD (Emotional and behavioural difficulties) [See: [Behavioural, emotional and social difficulty](#)]
- EWO [See: [Education welfare officer \(EWO\)](#)]
- [Early Years Action](#)
- [Early Years Action Plus](#)
- [Early Years Development and Childcare Partnerships](#)
- [Early intervention](#)
- [Early years](#)
- [Education Action Zones](#)
- [Education Supervision Order](#)
- [Education otherwise](#)
- [Education welfare officer \(EWO\)](#)
- [Educational psychologist](#)
- [Elective home education](#)
- [Emergency Protection Order](#)
- Emotional and behavioural difficulties (EBD) [See: [Behavioural, emotional and social difficulty](#)]
- [Episode](#)
- [Episode coordinator](#)
- Equasym [See: [Methylphenidate](#)]
- [Evidence-based practice](#)
- [Excellence in Cities](#)
- [Extended schools](#)

F

- [FRANK](#)
- [Failure to thrive](#)
- Faltering growth [See: [Failure to thrive](#)]
- [Family and friends care](#)
- [Family therapy](#)
- [Formulation](#)
- [Foundation Stage Profile](#)
- [Foundation stage](#)
- [Framework for the Assessment of Children in Need and their Families](#)
- [Fraser competency](#)

G

- Guardian ad Litem [See: [Children's guardian](#)]

H

- [Health promotion](#)
- [Healthcare Commission](#)
- [Higher level teaching assistant \(HLTA\)](#)
- [Home-school agreement](#)
- [House of Lords Decision Re: S and Re: W \[2002\] 1 FLR 815](#)
- Hyperactivity [See: [Attention-deficit hyperactivity disorder](#)]
- [Hyperkinetic disorder \(or Hyperkinesis\)](#)

I

- IRO [See: [Independent reviewing officer](#)]
- [Inclusion](#)
- [Independent reviewing officer](#)
- [Individual education plan](#)
- [Infant](#)
- Initial child protection conference [See: [Child protection conference](#)]
- [Integrated children's system](#)
- [Integration](#)

J

- [Joint commissioning](#)
- [Juvenile](#)

K

- [Key Stages](#)
- Kinship care [See: [Family and friends care](#)]

L

- LSCB [See: [Local Safeguarding Children Board](#)]
- [Lead member for children's services](#)
- [Lead professional](#)
- [Learning Support Units](#)
- [Learning and Skills Council](#)
- [Learning difficulty](#)

- [Learning disability](#)
- [Learning support unit](#)
- [Local Safeguarding Children Board](#)
- [Local authority lead officer for children's services](#)
- Local authority secure children's home [See: [Secure accommodation](#)]
- [Looked after](#)

M

- [MAPP \(Multi agency public protection arrangements\)](#)
- [Mainstream services](#)
- [Methylphenidate](#)
- [Middle school](#)
- [Moderate learning difficulty](#)

N

- [NEET \(not in education, employment or training\)](#)
- NSF [See: [National Service Framework for Children, Young People and Maternity Services](#)]
- [National Service Framework for Children, Young People and Maternity Services](#)
- [National Service Frameworks](#)
- [National curriculum levels](#)
- [National register of unaccompanied children](#)
- Needs [See: [Children with complex needs](#)]
- Needs [See: [Children with additional needs](#)]
- Needs [See: [Children in need](#)]
- [Note in lieu](#)

O

- [ONSET](#)
- [Ofsted \(Office for Standards in Education, Children's Services and Skills\)](#)
- [Oppositional defiant disorder](#)
- [Outcomes](#)
- [Outcomes framework](#)

P

- PAYP [See: [Positive Activities for Young People \(PAYP\)](#)]

- PCT [See: [Primary Care Trust](#)]
- PRU [See: [Pupil referral unit](#)]
- [Parental responsibility](#)
- [Parenting order](#)
- [Pastoral support programme](#)
- [Pathway plan](#)
- [Personal adviser](#)
- [Personal education plan](#)
- [Placement](#)
- [Police protection](#)
- [Portage](#)
- [Positive Activities for Young People \(PAYP\)](#)
- [Practitioner](#)
- Preventative [See: [Preventive](#)]
- [Preventive](#)
- [Primary Care Trust](#)
- [Primary care](#)
- [Profound and multiple learning difficulty](#)
- [Protocol](#)
- Psychiatrist [See: [Child and adolescent psychiatrist](#)]
- Psychologist [See: [Educational psychologist](#)]
- Psychologist [See: [Clinical Psychologist](#)]
- Psychotherapist [See: [Child psychotherapist](#)]
- [Pupil referral unit](#)

Q

- [Quality Protects](#)

R

- [Register of disabled children](#)
- [Residence Order](#)
- Ritalin [See: [Methylphenidate](#)]

S

- SCIE [See: [Social Care Institute of Excellence \(SCIE\)](#)]
- SENDA [See: [Special Educational Needs and Disability Act 2001](#)]

- SENDIST [See: [Special Educational Needs and Disability Tribunal \(SENDIST\)](#)]
- [Safeguarding](#)
- [School Action](#)
- [School Action Plus](#)
- [School support staff](#)
- [Secondary care](#)
- [Section 47 enquiries](#)
- [Secure accommodation](#)
- [Secure accommodation order](#)
- Secure children's home [See: [Secure accommodation](#)]
- Secure training centre [See: [Secure accommodation](#)]
- [Secure unit](#)
- [Severe learning difficulty](#)
- [Significant harm](#)
- [Social Care Institute of Excellence \(SCIE\)](#)
- [Social exclusion](#)
- [Special Educational Needs \(SEN\) Code of Practice](#)
- [Special Educational Needs and Disability Act 2001](#)
- [Special Educational Needs and Disability Tribunal \(SENDIST\)](#)
- [Special educational needs](#)
- [Special educational needs co-ordinator](#)
- [Special measures](#)
- [Specialist services](#)
- [Specific learning difficulty](#)
- [Statement of special educational needs](#)
- [Statutory assessment](#)
- [Statutory review](#)
- [Substance misuse](#)
- [Supervision](#)
- [Supervision order](#)
- [Sure Start](#)
- [Sure Start Plus](#)

T

- [Targeted services](#)
- [Teaching assistant](#)

- [Team around the child \(TAC\)](#)
- [The third sector](#)
- [Tiered service models](#)
- [Transition plan](#)

U

- [Unaccompanied asylum seeking child](#)
- [Unallocated case](#)
- [Unique pupil number](#)
- [Universal services](#)
- [Updated Drug Strategy 2002](#)

V

- [Vulnerable children](#)

W

- [Welfare](#)
- [Well-being](#)

Y

- [Years 1 to Year 14](#)
- [Young offender institution](#)
- [Young person](#)
- [Youth](#)
- [Youth Justice Board for England and Wales](#)
- [Youth Offending Team](#)
- [Youth court](#)
- [Youth worker](#)

Appendix F

Equality Impact Assessment (EQIA) :Form one – initial screening

1. Name of policy, function, or service development being assessed:
Safeguarding Children Policy

2. Name of person carrying out the assessment:
Jane Chapman Risk Adviser

3. Please describe the purpose of the policy, function or service development:
To ensure that the Tavistock and Portman NHS Foundation Trust (the Trust) meets the statutory in respect of safeguarding children and to set out procedures to be followed by staff who suspect child abuse

4. Does this policy, function or service development impact on patients, staff and/or the public?

Response: yes

If NO, this is usually an indication that the policy, function or service development is not relevant to equality. Please explain that this is the case, or explain why it is relevant to equality even though it does not impact on people:

5. Is there reason to believe that the policy, function or service development could have an adverse impact on a particular group or groups?

Response : NO *This policy sets out the Trust's strategic position and processes that the trust will employ to detect and act upon suspicions of child abuse, it will not impact in a way to disadvantage any particular group*

6. If you answered YES in section 5, how have you reached that conclusion? (Please refer to the information you collected e.g., relevant research and reports, local monitoring data, results of consultations exercises, demographic data, professional knowledge and experience)

n/a

7. Based on the initial screening process, now rate the level of impact on equality groups of the policy, function or service development:

Negative / Adverse impact:

High

(i.e. high risk of having, or does have, negative impact on equality of opportunity)

Medium.....

(i.e. some risk of having, or there is little evidence of, negative impact on equality of opportunity)

Low.....

(i.e. minimal risk of having, or does not have negative impact on equality)

Positive impact:

High

(i.e. highly likely to promote, or clearly does promote equality of opportunity)

Medium.....the intention of the policy is to protect the health and safety of all and this commits the trust to positively ensure safety of all groups irrespective to categorisation.

(i.e. likely to promote, or does have some positive impact on equality of opportunity)

Low.....

(i.e. not likely to promote, or does not promote, equality of opportunity)

Response: Low negative

Date completedreviewed and updated 20.6.10

Signed

Print nameE Jane Chapman

Board of Directors : January 2011

Item : 10

Title : Estates & Facilities Report

Summary:

The Board of Directors is asked to note:

1. The strengthening of the Estates & Facilities team
2. Capital Projects & refurbishment work 2010/11
3. The 'Green' Agenda – progress to date & future proposals
4. Proposals for 2011/12 Capital Projects

For : Discussion

From : Director of Corporate Governance and Facilities

Estates Report

1. Introduction

1.1 Since the last report to the Board of Directors in January 2010, there has been significant activity in the Estates and Facilities area which includes:

1.1.1 Consolidation of the Estates and Facilities Team

1.1.2 Capital building projects

1.1.3 Refurbishment works

1.1.4 Growth of the Green Agenda

2. Estates and Facilities Team

2.1 Mr Paul Waterman has now been in post as the Estates and Facilities Manager for a year. Mr Waterman has brought to the Trust much needed technical expertise in Building Management and also an interest and practical experience in the area of improving the patient environment. During the year, Mr Waterman has lead the Estates and Facilities Team in a programme of refurbishment as well as reviewing the many processes and procedures in the facilities domain which help the Trust run more smoothly and assist colleagues in providing a good service to staff, patients and visitors.

3. Capital Projects

3.1 The Trust considered the development of a break-out space to be located on the roof. The decision was taken that this was not the right time for the full project to go ahead but capital funding was made available to proceed with the first phase of the work regarding cloakroom provision and expansion of toilet facilities. Planning permission has been granted for the overall project which is valid for a period of five years and will allow the Trust to revisit the project at a future date. The first phase has been implemented.

3.2 The fifth floor cloakroom and toilet facilities have been completely redesigned which will be of particular benefit for conferences. An additional shower on the ground floor has been installed and the existing shower room redesigned. Both these facilities are fully accessible in line with Disability Discrimination (DDA) guidelines.

3.3 The Trust has managed through a difficult winter period to maintain sound energy control. This has resulted in a drop in energy consumption at a time of increased energy costs. The replacement of the constant temperature pumps, and the replacement and upgrade of the building energy management system, all played their part in contributing toward this reduction. Following a detailed report from building services consultants, the Trust is in the process of tendering for the replacement of the existing boilers. This will allow the Trust to deliver the heating for the building in a more energy efficient way. The current tubular boilers will be replaced by high efficiency condensing boilers that will improve the system of conversion by 15-20%. The current operating efficiency of the boilers is between 65-75%. This project will also allow the Trust to meet its obligations under the Public Sector commitment to reduce its operational energy consumption by 10% for the year 2015. The Trust has also installed automatic meter readers for the main utilities which will enable better control and understanding of the energy use within the Trust.

4. Refurbishment Works

4.1 During the year a programme of refurbishment has been undertaken.

4.2 Tavistock Centre

4.2.1 Complete refurbishment of a suite of offices on the third floor to relocate part of the Child and Family Directorate.

4.2.2 Relocation of the Monroe Family Assessment Service to first floor offices within the main building.

4.2.3 Corridors, office lighting, full redecoration of the main staircase.

4.2.4 Upgrade of the staircase lighting and the replacement of the emergency lighting.

4.2.5 The complete removal of all the known asbestos within the Tavistock Centre.

4.2.6 During 2010, the motorcycle space by the front entrance was identified as an area where the Trust was vulnerable to a potential health and safety risk. This has been addressed with the creation of a designated parking facility for motorcycle / scooter users by the front entrance to the Trust. The free space created at the front of the building will give

options to increase the cycle capacity and create a seating area for patients, staff and visitors to the Trust.

- 4.2.7 Replacement of the partitions between Seminar Rooms 1, 2, and 3 with high quality soundproofed doors which enable the space to be opened up as a large space or divided into individual rooms. Lighting to all the seminar rooms has been upgraded.

4.3 Portman

- 4.3.1 Full internal redecoration of the communication spaces and part replacement of the emergency lighting.
- 4.3.2 Upgrade of the thermostatic heating controls.

4.4 Gloucester House

- 4.4.1 Repair of external fencing.
- 4.4.2 Weatherproofing of the garden window bays.
- 4.4.3 Upgrade of the heating controls.
- 4.4.4 Specific redecoration within designated communication spaces and redecoration of the children's therapy room.
- 4.4.5 Upgrade and replacement of all the emergency lighting plus the replacement of the lighting to low energy fittings in the dining room.

5. Tavistock Centre Plans

- 5.1 Energy Efficiency is high on the Trust's agenda. 5.2 – 5.6 below address future capital proposals which are to be assessed and prioritised in order to meet the Trust's commitment on energy as well as to determine which would be most beneficial to the services offered in the building and which would be the most cost efficient.

5.2 Emergency staircase window upgrade

- 5.2.1 Currently the building as a whole loses between 25 – 30% of its heat loss through the windows. By replacing the existing staircase windows a reduction in building heat loss of 6 – 8 % can be achieved. In addition, consideration should be given to re-cladding these walls externally to protect the spiralling concrete and provide additional insulation. The external

walls to the two secondary staircases are only 150mm thick and are therefore a source of excessive heat loss.

5.3 Roof insulation

5.3.1 The Tavistock Centre is similar to the majority of buildings of this type constructed during the 1960s and has poor roof and wall insulation. This, in addition to the poor quality glazing, makes the building hard to heat during the winter months. Inadequate roof insulation also means the top floor is more likely to overheat in summer, adding to the energy consumption, as the Trust then needs to utilize the air conditioning with in the Lecture Theatre.

5.3.2 The introduction of new roof insulation would considerably reduce the heat loss for the building as a whole and have little impact on the delivery of the service during its implementation.

5.4 Phasing window replacement

5.4.1 The existing glazing has poor thermal performance and during the winter months many rooms within the building can become cold and drafty.

5.4.2 The south side of the building suffers from excessive heat gain during the summer and this can make many of the rooms uncomfortably hot. To replace the existing windows with a modern glazing system would cause major disruption to the delivery of service and the possibility of additional decant cost. A phased approach to the replacement of the windows would allow for greater flexibility in what work can be done and sound project management would remove the need to decant users.

5.5 Upgrade to Lecture Theatre

5.5.1 The current heating and cooling within the Lecture Theatre is a combination of surface cooling and wet heating. Both systems are dated and are limited in the amount of effective localized control available to the users of the space.

5.5.2 A new system of comfort cooling will allow greater comfort for the users and better energy control for the Trust. As part of the project the existing ceiling could be replaced to allow better acoustic capability plus a reconfiguration and upgrade of the audio and visual aids including the existing induction loop.

5.6 Metering System

5.6.1 In order to build upon energy saving, anticipated when the new boilers are installed, a system of metering should be put in place to monitor and control energy at a more localised level. Part of this would be the upgrade and replacement of each floor's main electrical control panel. Currently the only floor where we have this system in place is the first floor (the board was replaced as part of the refurbishment to the Monroe offices). Following completion of these works there would be greater control and monitoring of individual floor energy consumption.

6. Gloucester House and accommodation for the Day Unit Service

6.1 The building is dated in appearance and has been recommended for decommissioning as a children's school, by the Ofsted inspectors. To bring the building up to an acceptable standard, the current outstanding remedial works will require a significant allocation of funding and this would be necessary on an ongoing basis if Ofsted were to agree that it is an acceptable site for the service.

6.2 It does, however, remain the case that the building itself is not considered inherently suitable for the service. An options appraisal has been initiated and a long list of options regarding the service relocation has been discussed and a short list drawn up by the Day Unit Steering Group. The short listed options are to be separately evaluated against both non financial and financial criteria after which these appraisals will be reconciled in a cost benefits analysis. The proposed timetable for this work is:-

Options Cost Benefits Analysis	March 2011
Acquire lease / commence construction (dependent on CBA)	January 2012
Service move (if moved to an existing building)	September 2012
Service move (if moved to a new building)	January 2013

6.3 It will be important to work with specialist agents, both before and after the cost benefit analysis is complete, and to keep an open mind about opportunities for relocation rather than being constrained by considering options sequentially.

7. Sustainability, Health, Environment and Development (SHED) Unit

7.1 Re-naming

7.1.1 In 2010, the Green Group renamed itself to better reflect its concerns and activity. It is now called the Sustainability, Health, Environment and Development (SHED) Unit.

7.2 Membership

7.2.1 In the spring of 2010, a Non-Executive Director, Mr Martin Bostock was appointed to be the environmental lead on the Board of Directors. In December 2010, a Governor, Ms Sara Godfrey, who is a Senior Policy Advisor with the Department of Energy and Climate Change, became a member of the SHED Unit.

7.3 Action to raise staff awareness

7.3.1 The SHED Unit organised an environmental awareness day in November 2010, with the help of Envido, a leading provider of energy, low-carbon and sustainability solutions for private and public sector organisations. This included consultations on IT, travel and catering issues in the Trust. There were also open workshops for all staff on 'All Things Green'. To encourage people to attend, SHED Unit members provided refreshments and free gifts of degradable flower pots, bulbs and seeds. Attendance was not huge but there was a lot of enthusiasm amongst those who did attend and valuable future-oriented conversations with key staff in the trust, including from the IT Department and the café took place. The event also brought several new members into the SHED Unit.

7.3.2 The autumn mandatory staff training (INSET) day included a talk from SHED Unit members Mr Paul Waterman and Ms Bernadette Wren. These presentations focussed on the need for Trust staff to act with a greater awareness of issues of sustainability.

7.3.3 SHED Unit member Kathryn Tyler (then the Trust's Communications Specialist) developed a SHED Unit Communications Strategy to help us develop a stronger presence and a distinct identity in the Trust. She created a distinctive logo for use on posters to inform staff and visitors of environment-relevant information and SHED Unit events, and to remind staff of ways to save energy.

7.3.4 The SHED Unit sent out communications to staff on various topics related to energy saving and re-cycling. Staff were informed about the new recycling contract, and about replacement lighting appearing at different places across the trust. At the Day Unit all the emergency lighting has been replaced with LED lights; this gives an exceptionally long lifetime up to 50,000 hrs and drastically reduces maintenance costs. Other measures put in place are the use of light sensors in the refurbished areas - an energy reduction of almost 50 %.

7.4 Other SHED activity

7.4.1 To attend more effectively to the waste created in the Trust, and to improve recycling rates, the Trust entered into a new contract with GRUNDON, a large waste re-cycling firm. Grundon take the plastic, cardboard and glass, as well as the usual paper and metal, all in one container. The distinctive blue and white bins were placed in 20 locations around the Trust during the summer. The Trust continues to recycle all confidential material in the large (more costly) all-blue bins. A recent audit of bin use revealed that staff still need encouragement to more efficiently dispose of waste according to bin type.

7.5 Planned events and activities for 2011

7.5.1 The SHED Unit will help develop and support action in the Trust to decrease our CO₂ output to meet statutory targets, with a focus on financial and social gains as well as environmental.

7.5.2 The SHED Unit will contribute to re-writing the Trust carbon management plan and support the more effective measurement of CO₂ baseline levels across different sections of Trust activity.

7.5.3 The SHED Unit will continue to campaign to increase bike and public transport travel and reduce car use. There are plans for a list of those staff who already cycle to encourage them to 'buddy' more timid cyclists and to help them find quiet routes to work. It is proposed to develop a cycle maintenance area and plan a cycle awareness day.

7.5.4 In February 2011, the SHED Unit plan to hold a film screening of 'A Crude Awakening', a powerful documentary about the peaking of the earth's oil supplies and highlighting the need for sustainable alternative energy sources.

- 7.5.5 The SHED Unit is planning a Trust-wide 'Switch Off Day' in early summer 2011. This will be a well-publicised day when all staff will be asked to actively consider their use of appliances for a day: printers, PC's, the lift, car etc. Any drop in energy consumption on that day will be measured.
- 7.5.6 The SHED Unit has devised a year's Communication Plan with monthly themes on various topics. In January 2011 the theme will be IT, highlighting the good work towards energy-efficiency and waste reduction already undertaken by the IT Department (e.g. virtualisation of servers), and educating staff about the savings to be made when they switch off their PCs at night, and the effects of cluttering desktop with apps.

8. Community Sites for Clinical Services

- 8.1 Work has begun to consider which of the clinical services would be better provided located in community settings. The main drivers for this initiative are improving access and service quality for our patients and co-location with GP practices, schools, local authorities and other partner organisations would be the preferred option to deliver these objectives. Consultation with the Clinical Directors and Associate Directors is planned in order to consider models of care that involve location of more Trust services away from the main sites.
- 8.2 In addition the Managers of the Clinical Directorates are engaged in a project to explore efficient use of existing Trust premises. The Corporate Governance & Facilities Directorate have undertaken an audit of the main meeting rooms at the Tavistock Centre, particularly focussing on the training needs of the Trust, and it is apparent that whilst there is real need for additional space at certain times of the week, there is space available at other times. In order to utilise space better, work with Education and Training regarding timetabling is under discussion. There will also be a drive during the year to ensure that staff make greater efforts to cancel room bookings, for all uses, when they are no longer needed.
- 8.3 The move to more community sites would enable the Tavistock Centre to be more of a focus as the head quarters for the Trust as well as the primary location for training and tier four clinical services.

Director of Corporate Governance & Facilities
17th January 2011

Board of Directors : January 2011

Item : 11

Title : Service Line Report – CAMHS Training

Summary :

This paper provides an overview of the CAMHS Training Service Line, including:

- Current activity
- Management structure
- Priorities and opportunities
- Challenges

For : Discussion

From : Associate Dean CAMHS Training

Service Line Report – CAMHS Training

1. Introduction

- 1.1 This is the first CAMHS Training Service Line report. The aim of the report is to provide an overview of CAMHS training activity, our management structure, priorities, strengths and challenges.

2. CAMHS Training Activity

- 2.1 Eighteen of the Trust's 28 active validated MA and Professional Doctorate programmes are in the CAMHS portfolio; four of these programmes are also delivered in 15 associate centres, mainly in the UK, but also in two centres in Italy.
- 2.2 The recruitment profile (drawn from an analysis of 2010/11 recruitment) is primarily female, aged between 20-49, of which the 30-39 age group is the largest proportion, drawn largely from London and the South East and significantly self funding (66%). The identified discipline at the point of recruitment is diverse but education professionals represent the largest proportion at 18% followed by social work / care at 13%, the collection of health related disciplines accounts for 24% of our intake.
- 2.3 The CAMHS service line will have delivered 33 Continuous Personal and Professional Development (CPPD) programmes during 2010/11, with a forecast income of £135k, approximately £25k above Plan. This represents growth over three years and includes SHA funded places for commissioned CPPD. The recruitment profile, where comparative data is available, shows some similarities with our validated courses: primarily drawn from London and South East, 40% drawn from education related professions, 24% social work and child protection workers, and 27% health related disciplines. A significant difference is that 64% of the students obtain funding for CPPD.
- 2.4 Conference activity has decreased, reflecting the Trust-wide picture over the past three years. The diminishing number of conferences within CAMHS reflects a move to the more practice orientated and interactive format of workshops.
 - 2.4.1 Conference strategy and approval has now been allocated to the two Associate Deans and topic choice and the most suitable format is now discussed at the CAMHS Training Committee.

- 2.4.2 New streamlined and focused marketing strategy and, in particular, good database management, will be key to continuing conference success.
- 2.5 The Month 8 financial report indicates that the CAMHS service line is £34k above our budgeted surplus. So whilst projected income is £150k less than budgeted, this is been offset by a £220k underspend in expenditure. The target of a retained surplus of £2m for 2010/11 is on target.

3. Management Structure, Priorities and Opportunities

- 3.1 The Service Line is managed by the Associate Dean in close collaboration with the CAMHS Training Committee. The Training Committee membership consists of the Heads of Discipline, CAMHS Director, Assistant Director Education and Training, Librarian, Conference / Marketing Unit representative, and the Training Consultant for Race and Equity. This lively group embodies a strong commitment to training across the CAMHS disciplines. Strategy, financial position, course approvals, tenders and quality issues are all discussed and agreed within the committee and the Associate Dean CAMHS reports to the Education and Training Executive and the Dean, ensuring links with overall Education and Training strategy.
- 3.2 The Service line consults service users about education and training, and is involving employers where possible. This has included employer conferences in the past two years, and will include a wide dissemination of the results of the Trust's pilot audit / outcome data on the efficacy of training programmes and some single programme data on one cohort of students five years after completion.
- 3.3 Cluster groups in CAMHS education and training
- 3.3.1 The discipline approach to training within CAMHS is a real strength and the backbone of learning and development in the directorate. However, a strong professional base can militate against the development of multidisciplinary, coordinated approaches to contemporary child care and CAMHS practice in the children's workforce. To complement our uni-discipline trainings and to ensure a coordinated and multidisciplinary response to market need, we have developed within the service line a series of multidisciplinary clusters focusing on particular areas of training. Currently these include: education, child protection, management and early years / infant mental health. These clusters are expected to develop a coherent rolling programme of CPPD activity

with an allied marketing strategy. Clusters are accountable to the CAMHS Training Committee and can be expanded as policy develops and changes and new opportunities arise.

- 3.3.2 The cluster structure is currently undergoing some revision as part of our plan to develop a more aligned clinical and training strategy. The CAMHS Directorate has agreed to prioritise training and clinical activity in respect of education and vulnerable children. Our aim is to be responsive to the demands of the vulnerable children group in the context of diminishing Local Authority resources; we are mindful also of the need to respond to the Munro report on child protection.
- 3.3.3 Our aim is to develop an education service providing clinical and training services to the education workforce. The cluster groups will be reconfigured to form integrated training and clinical working groups tasked with developing a series of training and clinical products. The groups will also work closely with the Business Unit in terms of market analysis, strategy development and the marketing of products, which is a new and exciting opportunity in the training domain.

3.4 Other key areas of activity in 20011/12 will include:

- 3.4.1 Early Years: A key government priority and a field in which the Trust has lost ground. In this context Bidy Youell, Infant Mental Health Lead, is tasked with drafting a strategic plan for clinical and training intervention. Already in place is a partnership with Anna Freud Centre and Yale University to develop and jointly deliver competency based Infant Mental Health training. Within the Trust this is being led by Ellie Kavner with support from Louise Emmanuel. This is an innovative project in which the partnership will be seeking to create a market through the introduction of a competency approach. Whilst this approach carries some uncertainty, 'early years' is, as stated above, a government priority, and the competency approach to education and training is well established in the UK and likely to be attractive to employers.
- 3.4.2 Capacity Building: To continue developing the capacity of Tiers 1 and 2 of the children's workforce to work with mental health issues and in this context to develop and deliver clinical and training interventions congruent with a Children's IAPT service.
- 3.4.3 The creation of an e- and blended-learning unit will provide further opportunities for developing the CAMHS CPPD

portfolio into a nested and e- format. However, until the skills are learnt and internalised by staff, the developmental stage will require the specialist support of this proposed unit. The CAMHS Directorate is keen to make contact with the children's workforce in the earliest possible stages in their career to influence their professional development and establish a life-long professional relationship. Contributing to the public debate about mental health and well being via e- and viral technologies represents a potential opportunity to access younger generations of the children's workforce.

4. Challenges

- 4.1 A key challenge for 2011/12 is the productivity target of £371k. The CAMHS training service line strategic response includes:
 - 4.1.1 Exploring realistic productivities through some course closures, possible course mergers. Tactically some staff vacancies will not be filled, we will consider not filling current vacancies and the targeted use and/or redeployment of staff sessions.
 - 4.1.2 Increasing new business – ideas currently include a CPD 'triage clinic' to speed up the flow through of CPD and increase activity.
 - 4.1.3 Course mergers / closures may lead to individuals losing Organising Tutor roles with subsequent implications for their AfC banding.
 - 4.1.4 A more significant difficulty is the redeployment of staff sessions. Staff who are not fully utilising their training sessions and do not have the potential to take on new training tasks can only be redeployed if a role is identified elsewhere in the Trust. Thus whilst it is possible to identify solutions some may not be achievable.
- 4.2 Any future reduction in the Training Contract will pose further challenges.

5. Conclusion

- 5.1 The management of the service line is focussed on strong delivery of appropriate and needed learning and development opportunities for key health and social care partners. We have improved our governance processes and worked hard to ensure we manage the budget including both income and expenditure very well this year. The 2011/12 budget will prove even more challenging and is likely to require Trust wide commitment to see through.

Karen Tanner
Associate Dean CAMHS
January 2011

Board of Directors : January 2011

Item : 12

Title : Trust Chair's Objectives

Summary :

Attached are the 2010/11 objectives for the Trust Chair.

For : Approval

From : Trust Chair

Trust Chair's Objectives 2010/11

Overarching Aims

Strategy

- To ensure that the Board of Directors (BD) objectives 2010 / 2011 are met:
 - Initiating a BD review of mission / vision / values in accordance with Board Annual Review carried out in summer 2010
 - Keeping BD objectives under regular review in order to respond to the changing national and local health and social care environment and to changes in education and training.
- To ensure that the BD is kept abreast of national policy changes in order to ensure that the Trust is in a position to respond appropriately to the national policy environment.
- To ensure that the board is kept abreast of the local health and social care environment and potential changes over the year in order to ensure that the Trust can respond to local changes.
- To provide visible external leadership for the Trust participating in national and local groups / initiatives where these may be to the advantage of the Trust's profile and work.
- To provide leadership for the Board of Directors (BD) and Board of Governors (BG).
- To work closely with the Chief Executive in order to deliver aims and objectives.

Operations

- To ensure that the Annual Plan 2010/11 is reviewed regularly by the BD and that any necessary changes are put into effect, with appropriate action plans.
- To ensure that the Annual Plan 2011/12 is ready for submission to Monitor in the approved timescale, currently anticipated to be May 2011.
- Ensuring that the BD focuses on the quality of services and of education and training whilst achieving financial targets.
- To ensure that the Trust maintains regular contact with key commissioners, neighbouring providers and university partners and seeks to advance the interests of the Trust with a new and as yet barely defined group of commissioners.

Developing People and the Organisation

- Seek opportunities to meet and engage with staff so that their views may be taken into account in developing Trust strategy and services:
 - Seeking to support the staff group in the current uncertain and financially challenging circumstances
- Ensure the Trust's most valuable resource – its staff – are supported and encouraged to achieve their maximum potential at a time of considerable stress
- Ensure that the BD is enabled to function as effectively as possible by supporting training and development opportunities for Executive and Non-Executive Directors.

Governance

- As Chair of both the BD and the BG to take responsibility for promoting improvements in the working relationship between those bodies
- To ensure that the BG is consulted and involved fully in all aspects of the Trust's work as required by our regulators.
- To support the Governors to achieve better communications with the Trust's membership
- To seek improved Trust communications with the public and our patients and their families.

Performance and Finance

- In respect of the development of the Annual Plan 2011/12 to:
 - Ensure that there is a clear process for initiation and delivery of the Plan
 - Ensure that time is allotted for discussions by the Board of Directors
 - Ensure that consultation is conducted with the Board of Governors
 - Ensure that high quality is maintained whilst financial targets are met.
- Ensure that the Trust retains its unqualified registration with the Care Quality Commission
- Ensure that the Trust retains a Monitor Financial Risk Rating of 3 or above and a Governance Rating of Green.

Performance and Finance

- Manage the Trust's activity, development, organisation and economy over the next twelve months in line with the Annual Plan and in a manner that builds a secure platform for future development

Special Emphasis for the Year

Special Emphasis for the year	Aim	Objective	Review Date
Strategy	Meet BD objectives 2010 – 2011	Ensure review of mission / vision and values	Reviewed at Directors' Conference 9 th November 2010
		Review BD annual objectives	January 2011 BD
	Keep BD abreast of national policy	Ensure that the BD and BG receive regular reports on current policy changes in health & social care and in mental health policy	By reports from Chair, NEDs and CEO at BD and BG meetings
	External leadership for Trust	Attending regular meetings at SHA, NCL, UCLP, NHS Confederation (FT and MH networks) and others by invitation	Reports to BD
	Leadership of BD and BG	Keeping regular contact with Deputy Trust Chair, NEDs, and EDs.	Ongoing
		Keeping regular contact with Deputy Chair of the BG	Ongoing

Special Emphasis for the year	Aim	Objective	Review Date
Operations	Review of current Annual Plan	By BD	As set out in Board timetable
	Preparation of Annual Plan 2011 – 2012	Ensure BD follows timetable	Timetable agreed in October 2010
	Focus on quality	Ensure that the full BD discusses key issues raised by CQSG Committee.	Quarterly
		Ensure BD discusses progress on QIPP and Quality Account	Quarterly through Finance & Performance Reports to BD and CQSG Committee
		Ensure Governor involvement in developing the quality agenda	Spring (in line with AP timetable)
Maintain contact with key commissioners, providers and university	Trust Chair and CEO meeting, seeking opportunities to meet new commissioners as appropriate	Ongoing	
Developing People and the Organisation	Take more active measures to meet staff on a regular basis in order to become better known within the Trust, including occasional meetings with Union representatives	Trust Chair and CEO to hold at least six monthly meetings with staff	First held December 2010 (also met non-clinical staff representatives concerning staff concerns about national changes)

Special Emphasis for the year	Aim	Objective	Review Date
<p align="center">Developing People and the Organisation cont.</p>	<p>To gain a better understanding of and greater presence within the education and training area</p>	<p>Discuss with Dean</p>	<p>Early in 2011</p>
	<p>Supporting BD members to attend appropriate training courses and external events within a prudent financial limit</p>	<p>Using external organisations as well as any Trust based opportunities</p>	<p>Notifying BD of SHA, NHS Confederation and King's Fund opportunities as they arise.</p>
	<p>Support BD members to function effectively</p>	<p>Ensure that there is a Board annual review</p>	<p>To be held in Spring 2011</p>
		<p>Meet once a term with NEDs</p>	<p>Regular / ongoing</p>
		<p>To support the induction of the new NED</p>	<p>Review induction with new NED in February 2011</p>
<p>Review 'link' arrangements for NEDs with services</p>	<p>Discussion at a Board Lunch – possibly February 2011</p>		
<p align="center">Governance</p>	<p>Improving working relationships between BD and BG</p>	<p>To arrange one meeting providing an informal opportunity for Directors and Governors to meet, arrangements to involve Deputy Chair of the Board of Governors and Non-Executive Directors</p>	<p>TBC</p>

Special Emphasis for the year	Aim	Objective	Review Date
Governance cont.	Improving working relationships between BD and BG cont.	To encourage NEDs to attend BG and to encourage Governors to attend BD including improving Governor attendance at the AGM	Regular communication
		Work with newly appointed Senior Independent Director to agree any potential for development of relationship	Ongoing
	Reporting to / consultation with BG	As Chair, to agree agenda for BG meetings that will ensure matters requiring BG comment, consultation and agreement are presented	For agenda setting with CEO and Trust Secretary
	To support Governors' communication with Members	Agree practical ways in which the Trust can support Governors	Review held and reported to December BG. PPI & Comms Lead is putting in place additional channels of communication
			Regular communication with Members will always include information on Governors and how Members can make contact
Improve communications with public and patients and their families	To inform public and patients about the Trust and its work	Changes to communications and marketing team to be reported to BD when completed	

Special Emphasis for the year	Aim	Objective	Review Date
Performance & Finance	Develop Annual Plan 2011/12	Ensure AP is developed in a timely fashion	Follow timetable agreed by BD
		Review at BD regularly	At each meeting of BD
		Ensure consultation with BG	BG report in February 2011
	Registration with CQC	Ensure compliance	BD to receive regular reports on risk and on compliance
	Monitor Governance & Financial Risk Ratings	Financial Risk Rating of 3 Governance Rating of Green	Regular report to BD and top-line reports to BG

Board of Directors : January 2011

Item : 9

Title : Trust Policies: Safeguarding Children Policy

Summary :

Policy and Procedures for Safeguarding Children and the Management of Suspected Child Abuse.

For : Approval

From : Medical Director

Board of Directors

Agenda and papers
of a meeting to be held

2.30pm – 4.30pm
Tuesday 25th January 2011

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

Board of Directors
2.30pm – 4.30pm, Tuesday 25th January 2011

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 p.1
4. **Matters arising** (Report attached)
For noting p.7

Reports & Finance

5. **Chair and Non-Executive Directors' Report** For noting
6. **Chief Executive's Report** (Report attached)
Dr Matthew Patrick, Chief Executive For noting p.8
7. **Finance & Performance** (Report attached)
 - a. **Finance and Performance Report** For discussion p.14
 - b. **Q3 Monitor Governance Declarations** For approval p.23
Mr Simon Young, Finance Director

Corporate Governance

8. **Corporate Governance Report** (Report attached)
Miss Louise Carney, Trust Secretary For noting/approval p.26
9. **Trust Policies**
 - a. **Safeguarding Children Policy** (Report to follow)
Mr Rob Senior, Medical Director For approval

Quality & Development

10. **Estates and Facilities Report** (Report attached)
Ms Pat Key, Director of For discussion p.30
11. **Service Line Report – CAMHS Training** (Report attached)
Karen Tanner For discussion p.39
12. **Trust Chair Objectives** (Report to follow)
Ms Angela Greatley, Trust Chair For noting

Conclusion

13. Any other business

14. Notice of future meetings

Thursday 3rd February : Board of Governors
Tuesday 22nd February : Board of Directors
Tuesday 7th March : Directors' Conference (Research)
Tuesday 29th March : Board of Directors
Thursday 28th April : Board of Directors
Thursday 5th May : Board of Governors
Tuesday 24th May : Board of Directors
Tuesday 28th June : Board of Directors
Tuesday 26th July : Board of Directors
Thursday 15th September : Board of Governors
Tuesday 27th September : Board of Directors
Tuesday 25th October : Board of Directors
Tuesday 29th November : Board of Directors
Thursday 1st December : Board of Governors

Meetings of the Board of Directors are from 2.30pm until 5.30pm, 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 12.30pm until 5pm.

Board of Directors Part I

Meeting Minutes, 2.30pm – 4.10pm, Tuesday 30th November 2010

Present:			
Ms Angela Greatley Trust Chair	Mr Martin Bostock Non-Executive Director	Ms Lis Jones Nurse Director	Mr Altaf Kara Non-Executive Director
Ms Trudy Klauber Dean	Ms Louise Lyon Trust Clinical Director	Ms Joyce Moseley Non-Executive Director	Dr Matthew Patrick Chief Executive
Dr Ian McPherson Non-Executive Director	Dr Rob Senior Medical Director	Mr Richard Strang Non-Executive Director	Mr Simon Young Director of Finance
In Attendance:			
Mr Jonathan McKee Governance Project Lead (minutes)	Dr Rita Harris CAMHS Director (item)	Dr Sally Hodges PPI & Communications Lead (item)	Ms Susan Thomas Director of Human Resources (item)
Mr Namdi Ngoka Assistant Director of Human Resources (item)	Mr Andy Wiener Associate Director, Camden CAMHS (item)	Ms Sarah Miller Principal Consultant, TCS (item)	

Actions

AP	Item	Action to be taken	Resp	By
1	3	Miss Carney to amend minutes	LC	Immed
2	4	Mr Young to review process of approving contracts and report to Audit Committee	SY	
3	5	Miss Carney to schedule Board discussion on productivity	LC	Jan 11
4	7	Miss Carney to schedule Board discussion on financial planning	LC	Jan 11

Actions Agenda item

Future Agendas

1. Trust Chair's Opening Remarks

Ms Greatley welcomed everyone to the meeting, especially Dr Ian McPherson, new Non-Executive Director, and observers.

2. Apologies for absence

None.

3. Minutes of the previous meeting

AP1 The minutes were approved subject to some minor amendments:

4. Matters Arising

Student Feedback

A late paper had been circulated; questions are welcome by e-mail to the Dean.

Contracts Approval

AP2 Mr Young to review the process and report to the Audit Committee.

Honorary Contracts

Ms Lyon reported that a review of related procedures had been undertaken. The employment checks undertaken for paid staff are also undertaken for honorary staff; honorary staff are also required to undertake mandatory training. The Board of Directors noted that then Trust would expect CRB checks to identify criminal records for some applicants to some FDAC posts and that this risk was managed appropriately.

Information Governance

Mr Young confirmed that the Information Governance Declaration was the responsibility of management, not the Board of Directors.

5. Trust Chair and Non-Executive Directors' Reports

Voluntary Sector

The Board of Directors noted the generous contribution of Governors, a voluntary role. The Trust had on many occasions considered the possibility of involving potential volunteers in the Trusts work; however, there was no obvious role for volunteers in the Trust (unlike at acute trusts for example). This matter remains part of ongoing discussions at the PPI Committee.

Staff Meeting

This had been well attended: staff had asked many questions about the consequences of reductions in commissioning expenditure and the effects this would have on job security.

Health Economy in London

Underlying deficits in North Central London remain a concern. The Board of Directors was particularly concerned to note long standing problems in managing acute sector expenditure and the deleterious effects that this would have on the mental health sector.

The NHS Confederation

This may be reorganised, particularly in relation to the Foundation Trust Network.

Productivity

AP3 The King's Fund has published papers which may be of interest: the Board of Directors will discuss productivity in 2011. *Productivity*

The London Commercial Board

This is an advisory body that looks at procurement and commissioning; Mr Strang has recently joined as a Non-Executive Director.

6. Chief Executive's Report

Dr Patrick had previously circulated a paper; the following points were discussed:

- There had been much interest from GPs in developing commissioning

expertise. However, much detail on how this would work is still to be worked out;

- The Trust had been invited to submit proposals for a pilot *Big White Wall* for serving and former armed forces personnel.

The paper was noted.

7. Finance & Performance

Mr Young presented his previously circulated paper and advised the Board of Directors of the following amendments:

- On page 27, the reference to the short fall in training income is incorrect and should be disregarded
- On Page 30, training should be green rated and the £77k figure should read £124k
- On Page 31 – it was resolved that the Board would discuss CQUIN income in Part 2

Mr Young highlighted the following:

- The Trust is slightly ahead of target on income and expenditure
- The cash position is good
- The target for consultancy, previously revised down, will not be reached. There will be an adverse effect on the rest of the Trust in compensating for this reduction in income.

Board members made the following comments:

- AP4**
- The outlook for 2011/12 is uncertain and will require careful planning. This will be the subject of an informal discussion in the New Year
 - Underperformance at the Portman had been offset by reduced expenditure due to unfilled vacant posts; service quality was not affected. Whilst this position was sustainable in the short term, reduced capacity at senior level would result in an inability to develop future revenue streams.

*Financial
Planning*

The report was noted.

8. Clinical Quality, Safety, and Governance Committee Quarter Two Report

Dr Senior had presented his previously circulated report and highlighted the following points:

- The Patient Safety and Clinical Risk work stream was examined in detail on this occasion.
- The Board of Directors noted that the Committee was satisfied with the assurance that it had been given for green rated areas and that it had accepted the action plans to address amber and red rated areas. It was noted that risk was being managed appropriately.

Board members made the following comments:

- The format of the paper was thought to be very helpful in identifying issues that the Committee and the Board of Directors needed to address. Dr Senior had made it the Committee's business to consider its own performance; the development of the format of papers was an ongoing matter and suggestions for improvement were welcomed. One change already adopted was to indicate progress between meetings.
- The Board of Directors noted that the Committee had directed the Management Committee to approve and implement its paper on sanctions for those who had failed to attend mandatory training sessions.
- The Board of Directors noted that the development of the patient outcome work stream was a priority for the Trust as it was of particular interest for commissioners, and that failure to make progress would have adverse consequences for the Trust.
- The Audit Committee would be looking at the work of the CQSG, as it does with all Board Committees, on an annual basis.

The report was accepted as a record of the assurance of delivery and action plans to manage risk where assurance was not yet available.

9. Standing Financial Instructions

The proposed changes were approved.

10. Committee Terms of Reference

10a. Audit Committee Terms of Reference

The proposed amendments to the Terms of Reference were approved.

10b. Charitable Fund Committee Terms of Reference

The proposed amendments to the Terms of Reference were approved.

11. Consideration of nominations to fill interim vacancies to Trust Committee positions

Miss Carney had previously circulated a paper asking Non-Executive Directors to volunteer to temporarily fill internal link vacancies left by Ms Satyamurti's departure. The following links were approved:

- Committee for Clinical Excellence Awards: Mr Richard Strang
- Adult Department: Dr Ian McPherson
- Disability Issues: Dr Ian McPherson
- Equalities Issues: Dr Ian McPherson
- Human Rights: Dr Ian McPherson
- Legal Issues: Dr Ian McPherson
- Mental Health Act: Dr Ian McPherson

12. Membership Report

The Board of Directors was invited to consider the Membership plans listed under paragraph 3. The Board of Directors explored the following issues:

- The Board of Directors noted the continued trend in the decline of the proportion of non-student Members in the Public Constituency whilst the proportion of student and alumni members is increasing. This was attributed to the very successful recruitment of student Members each year.
- Using e-communication seemed to be a helpful way of managing Membership records though few Members took up the offer to adopt e-communications as their preferred option of communication.
- As a public benefit membership organisation, all matters affecting the Trust are Membership issues, and whilst the Trust was keen to explore other opportunities for communication, it was restricted by the Data Protection Act in some cases.

Board members with suggestions and comments should forward these to Dr Hodges.

13. Staff Survey Action Plan Update

The Board of Directors was pleased to note the following:

- The Trust had done extremely well overall

- The Trust had done extremely well in comparison to other trusts
- Action plans were in place for the areas that were highlighted as needing attention

14. Service Line Report – Camden CAMHS

Mr Wiener highlighted the following points:

- Commissioners were exploring possibilities of reducing the need for in-patient services by increasing intensive outreach services; this might be an opportunity for the Trust
- The staff in this service were highly committed and motivated
- notwithstanding staff enthusiasm and dedication, engaging staff in change and development is fraught with complexity

The Board of Directors noted the following:

- The Board of Directors was pleased to see the Trust was engaging with the Commissioners in developing commissioning options
- Interim and long term commissioning arrangements remain unclear

Board members were invited to put any additional questions to Mr Wiener directly.

15. Any other business

Promoting Tavistock Consultancy Service

Ms Miller attended and invited the members of the Board of Directors to promote its executive coaching service and its training programme for prospective executive coaches.

16. Notice of future meetings

Noted.

Outstanding Action Part 1

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date
1	Oct-10	8. Charitable Fund Annual Report & Accounts 2009/10	Mr Young to ask Independent Examiner to amend report	Simon Young	Oct-10
2	Oct-10	14b. Annual Safeguarding Vulnerable Adults Arrangements Review	Dr Senior to review role of Trust Advisor on Vulnerable Adults	Rob Senior	Nov-10
3	Oct-10	5. Trust Chair and Non-Executive Directors' Reports	Dr Senior to give consideration to conducting a survey of GP's knowledge of mental health commissioning	Rob Senior	Nov-10
4	Oct-10	7a. Finance & Performance Report	Mr Young to report on CQUIN targets	Simon Young	Nov-10
5	Oct-10	7a. Finance & Performance Report	Mr Young to report on Service Line reviews	Simon Young	Nov-10
6	Oct-10	14a. Annual Safeguarding Children Arrangements Review	Dr Senior to write to NHS Camden to explain that the Board of Directors has reviewed the role of Named Doctor	Rob Senior	Dec-10
7	Jul-10	10a. Safeguarding Children Policy	Policy to return with additional appendix	Rob Senior	Jan-11
8	Sep-10	7. Finance & Performance Report	Board discussion on CQUIN to be arranged	Louise Carney	Feb-11
9	Oct-10	11b. Chief Executive's Objectives	Ms Greatley to discuss timetable for objectives with appraisal committees of Board of Governors	Angela Greatley	Feb-11
10	Jan-09	22. Contingency for IT Failure	Internal Auditors to be asked to review policy to confirm it meets the Trust's requirements	Simon Young	TBC

Board of Directors : January 2011

Item : 6

Title : Chief Executive Report

Summary :

The report covers the following items:

1. Introduction
2. NHS Operating Framework
3. North Central London
4. White Paper Update
5. Mental Health Strategy
6. Rio Admin Go Live
7. And Finally...

For : Noting

From : Chief Executive

Chief Executive Report

1. Introduction

- 1.1 The period since the November Board of Directors meeting has, for us, perhaps been most dominated by concerns around finance across the public sector; concerns about the financial position of the North Central Sector in particular and the implications of this for all organisations within the local health economy; and the implementation of changes within commissioning organisations locally, including the delivery of a 46% saving on management costs before April 2011 and the planned reorganisation of the sector PCTs with the creation of a single executive committee.
- 1.2 As a Trust, we have been focused on the development of productivity plans including Cost Improvement Programmes and on the contracting round now underway in relation to both our clinical service commissioners and our training commissioners and partners. As expected, contracting will be particularly difficult this year in the light of real constraints on NHS and training and education budgets.
- 1.3 Clearly this is hard work for everyone across the sector and beyond. I know that our own staff welcomed a Christmas break, recognising, however, that the New Year was going to involve further challenge.

2. NHS Operating Framework

- 2.1 On 15th December, I attended the NHS CEO conference in Birmingham, where the details of the NHS operating framework were released. The operating framework sets out guidance on key NHS priorities for the coming year and the financial arrangements that will support these, including PCT allocations and tariff arrangements for providers.
- 2.2 For 2011/12, PCT allocation increases range from 2.9% to over 4%. These allocations include a component to support social care, however. It is also the case that across the country PCTs are aiming to implement their management savings (see 1.1, above) within this year, in order to release sufficient funds to support the development of GP consortia over the next two years.
- 2.3 In relation to tariff (the basis upon which providers are paid), the national efficiency requirement is 4%, with the uplift for pay and price inflation assessed at 2.5%. Consequently, the price for services outside the scope of national Payment by Results (PbR) tariffs should

reflect a reduction of 1.5% compared with those of 2010/11. This means, in effect, that the price that commissioners will expect to pay for mental health services will reduce by 1.5%.

- 2.4 The Mental Health Network has expressed significant concerns that the proposed changes to the tariff discriminate against mental health services, and that block contracts in mental health are now more vulnerable to further cuts. This is because of the fact that the majority of other health services in the acute sector are contracted on the basis of PbR, which can often mean that levels of activity (and therefore costs) are very difficult to control. Increasing demand for mental health services during a time of recession can compound these problems, as can significant reductions in social care provision.
- 2.5 The first NHS Outcomes Framework was published in December 2010. From 2012/13, this is the framework that will be used by the Secretary of State for Health to hold the NHS Commissioning Board to account for improving quality and delivering better health outcomes for people using the NHS.
- 2.6 From April 2011, patients should be offered greater choice of treatment and provider in some mental health services. Choice of any healthcare provider, meeting NHS standards, and within the tariff, will be introduced in a phased manner.
- 2.7 It will clearly not be easy for commissioners and providers to deliver on these objectives within a time of such tremendous financial and structural challenge.

3. North Central London

- 3.1 Caroline Taylor has been appointed as the new Chief Executive for the North Central London PCT executive. Caroline succeeds Rachel Tyndall who is taking up a new post working across London with responsibility for the implementation of the London cancer services model to improve cancer outcomes.
- 3.2 Caroline is currently the CEO of NHS Croydon. In addition she is in the CEO lead in London for specialist commissioning. She also has significant local knowledge as a former director of Camden and Islington Health Authority.
- 3.3 David Sloman has now been appointed to the substantive role of Chief Executive of the Royal Free Hospital, where he has been the interim CEO.

- 3.4 Finances with the sector remain very difficult, and Caroline Taylor will be leading the team with responsibility for balancing the budget and for supporting the development of local GP consortia and commissioning.

4. White Paper Update

- 4.1 In December 2010, 54 'pathfinder' GP Consortia were named. The Department of Health's plan is that these pathfinders will test different design concepts and identify issues and potential problem areas in the new commissioning structure.
- 4.2 The North West is the region with the largest number of pathfinder consortia with 12 and there are eight from both East of England and London.
- 4.3 The consortia range in size from one consisting of just two practices and covering around 23,000 patients in Fleetwood, North Lancashire and one single practice consortium, the Red House Group Hertfordshire with just 18,900 patients, to the WyvernHealth.com consortia in Somerset which covers 75 GP practices and a population of over half a million.
- 4.4 NHS London has contracted a KPMG-led partnership to support consortia development within London. It will also support development of London's pathfinder consortia. NHS London expects to announce further pathfinders in February.
- 4.5 Sir David Nicholson, the Chief Executive of the NHS, has been appointed to lead the new NHS commissioning board.
- 4.6 The original timetable envisaged the appointment of a shadow board next spring followed by the Chair and Chief Executive in autumn 2011.
- 4.7 The Department of Health Indicated that David Nicholson would fill both roles until 31st March 2012, when the role of Chief Executive of the NHS will cease to exist. A Chairman will be appointed during 2011/12.
- 4.8 More recently, however, very significant concern has been expressed about the scale and pace of structural reorganisation of the NHS at a time of such tremendous financial pressure by a number of organisations, including the British Medical Association and the King's Fund.

5. Mental Health Strategy

- 5.1 The Government's new Mental Health Strategy is due to be published towards the end of January 2011. The strategy will set out twin objectives of improving public mental health and well being while improving services through a focus on outcomes and patient experience.
- 5.2 There remains a strong focus on primary prevention, early years interventions, psychological therapies and the interdependences between physical and mental health.
- 5.3 The strategy retains a strong developmental flavour.
- 5.4 Clarity around expected outcomes will be crucial, however, if the strategy is to deliver, as will the delivery plan and support for implementation.
- 5.5 The operating framework also highlights the need for the NHS to pay greater attention to the needs of children, young people and families in commissioning and delivering services. NHS organisations are encouraged to pay particular attention to groups with specific needs including Child and Adolescent Mental Health service users.
- 5.6 The NHS is expected to continue the roll out of Improving Access to Psychological Therapy (IAPT) services in 2011/12 leading to full implementation by 2014/15. This includes training programmes to develop the workforce and a choice of NICE approved therapies. The Department of Health plans to extend talking therapies to children and young people, older people, people with severe mental illness and people with co-morbid mental and physical health long term conditions.
- 5.7 The expansion of the IAPT programme to cover children and young people was also a focus of the annual NHS Psychological Therapies Conference, where a number of Trust staff contributed as Chairs, speakers and from the floor in debate.

6. RiO Administrative Go Live

- 6.1 Although the initial migration from CareNotes to RiO was relatively smooth, a number of issues have come to light subsequently which are causing administrative staff considerable difficulties. I understand that the RiO team is now working closely with admin colleagues to assess the problems and the RiO Project Steering Group will then be meeting with the Departmental Administrative Managers with the aim of developing a plan of action to resolve

them. Longer term we will be putting a RiO User Group in place, with admin and clinical representatives from each Directorate, with the aim of managing any future problems and issues in a more structured way. I would, however, like to take the opportunity to thank all administrative staff for their efforts throughout this go-live period.

7. And Finally...

- 7.1 On 14th December 2010, I had the pleasure of attending the Launch of the Barnet Young People's Drug and Alcohol Service. The launch was very well attended by representatives from the Local Authority who commission the service and by service users and their relatives.
- 7.2 I was hugely impressed by the shared commitment of all of those involved in producing a genuinely inspiring service.

Dr Matthew Patrick
Chief Executive Officer
19th November 2010