Board of Directors

Agenda and papers
of a meeting to be held

2.30pm – 5pm
Tuesday 27th July 2010

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

Board of Directors
2.30pm– 5pm, Tuesday 27th July 2010

Agenda

Preliminaries

1. **Chair's opening remarks**
   Ms Angela Greatley, Trust Chair

2. **Apologies for absence**

3. **Minutes of the previous meeting**   *(Minutes attached)*
                                                           For approval

4. **Matters arising**   *(Report attached)*
                                                           For approval

Reports & Finance

5. **Chair and Non-Executive Directors' Report**   *For noting*

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

7. **Finance & Performance**

   a. **Finance & Performance Report**   *(Report attached)*
      Mr Simon Young, Director of Finance   *For discussion*

   b. **2010/11 Quarter 1 Monitor Governance Declaration** *(Declaration attached)*
      (Links to all outcomes)
      Ms Pat Key, Director of Corporate Governance & Facilities   *For approval*

   c. **2010/11 Quarter 1 Complaints Report**   *(Report attached)*
      (Links to outcome 17)
      Dr Matthew Patrick, Chief Executive   *For noting*

Corporate Governance

8. **Corporate Governance Report**   *(Report attached)*
   Miss Louise Carney, Trust Secretary   *For noting*

9. **Six Lives**   *(Report attached)*
   Dr Rob Senior, Medical Director   *For discussion*

10. **Trust Policies**

(Policies attached)
For approval

    a. **Safeguarding Children**
        Dr Rob Senior, Medical Director

    b. **Student Disabilities**
        Ms Trudy Klauber, Dean

Quality & Development

11. **Service Line Report – Developmental CAMHS**

(Report attached)

        (Links to outcomes 4, 6, & 16)
    Dr Sally Hodges, Associate Clinical Director, Developmental
    CAMHS

For discussion

12. **Training Services Report**
    Ms Trudy Klauber, Dean

(Report attached)
For discussion

13. **E-, Distance-, and Blended-Learning Report**
    Professor Stephen Briggs, Vice Dean, Adolescent Directorate

(Report attached)
For discussion

14. **Objectives**

(Objectives attached)
For approval

    a. **Board of Directors**
        Ms Angela Greatley, Trust Chair

    b. **Chief Executive**
        Ms Angela Greatley, Trust Chair

15. **Swine Flu Report**
    Dr Rob Senior, Medical Director

(Report attached)
For discussion

16. **RiO Project Report**
    Ms Julia Smith, Director of Service Development & Strategy

(Report attached)
For discussion

17. **Tavistock Clinic Foundation Report**
    Ms Louise Lyon, Trust Director

(Report attached)
For discussion

Conclusion

18. **Any other business**

19. **Notice of future meetings**

Thursday 9th September : Board of Governors
Tuesday 21st September: Directors' Conference (SLR)
Tuesday 28th September: Board of Directors
Tuesday 26th October: Board of Directors
Tuesday 9th November: Directors' Conference (Annual Plan)
Tuesday 30th November: Board of Directors
Thursday 9th 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 – 5pm, Tuesday 29th June 2009

Present:			
Mr Martin Bostock Non-Executive Director	Ms Angela Greatley Trust Chair	Mr Altaf Kara Non-Executive Director	Ms Trudy Klauber Dean of Postgraduate Ed.
Ms Louise Lyon Trust Clinical Director	Dr Matthew Patrick Chief Executive	Ms Emma Satyamurti Non-Executive Director	Dr Rob Senior Medical Director
Mr Simon Young Director of Finance			
In Attendance:			
Miss Louise Carney Trust Secretary	Ms Susan Thomas Director of HR (items 9a, 13 & 14)	Mr Gervase Cambell HR Manager (item 14)	Mr Namdi Ngoka Dep. Director of J+HR (items 9a & 13)
Ms Pat Key Director of Corporate Governance & Facilities (items 8, 9b & 15)	Dr Sally Hodges PPI & Communications Lead (item 11)	Mr Stan Ruszczynski Clinical Director, Portman Clinic (item 12)	
Apologies:			
Ms Joyce Moseley Non-Executive Director	Mr Richard Strang Non-Executive Director		

Actions

AP	Item	Action to be taken	By	Due
1	3a	Miss Carney to amend minutes	LC	Immed
2	5	Miss Carney to forward links to Andrew Lansley's speech at NHS Confederation annual conference	LC	Immed
3	8	Link to Clinical Quality, Safety & Governance Committee to be included in Audit Committee Terms of Reference	RSt	Jun 10
4	8	Terms of Reference to be amended as suggested	RSe	Immed
5	9b	Policy to be amended as suggested	PK	Immed
6	11	Future reports to contain summary chart and comparative data	SH	May 11
7	11	Ms Lyon to set up arrangements for monitoring occurrence of conversations around patient choice	LL	
8	11	Dr Patrick to investigate resourcing of PPI and report back	MP	
9	13	Human Resources Department to return with action plan	ST	
10	14	Human Resources Department to undertake audit of recruitment data	ST	
11	15	Ms Key to undertake analysis of fencing safety	PK	Immed
12	15	Ms Key to undertake investigation of unsafe behaviour in relation to roofs etc.	PK	Immed

Actions   **Agenda item**   **Future Agendas**

1. Chair's opening remarks

Ms Greatley welcomed everyone to the meeting, including members of the public, who were observing the meeting.

2.   Apologies for absence

As above.

3. Minutes of the previous meeting

3a. May 2010
The minutes were approved subject to minor amendments.

3b. May 2010 Extraordinary
The minutes were approved.

4. Matters Arising

Ms Moseley had arranged to meet with Dr Kennedy on 27th July 2010

Dr Patrick and Miss Carney had met and discussed the timetabling of Directors' Conferences

Dr Patrick and Mr Strang had met to discuss the position of the Business Development & Investment Committee in relation to the Board of Directors.

Miss Carney noted that in future scheduled actions would not appear on the Outstanding Action table.

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

Ms Angela Greatley, Trust Chair
Ms Greatley had attended the NHS Confederation's Annual Conference. Ms Greatley highlighted the main points of the Secretary of State's speech:

- There would be an emphasis outcomes, but targets would be removed

- There would be empowerment of clinical staff

- The health and wellbeing agenda would be prioritised

- Health and social care would be integrated, but not structurally

There had also been a discussion on GP consortia.

AP2   Miss Carney to forward summary of Mr Lansley's speech and a link to videos of the Conference.

Mr Martin Bostock
Mr Bostock noted that Non-Executive Director recruitment was underway. The Non-Executive Director Appointment Committee had shortlisted eight candidates from over 50 applicants, all of which had been of high-quality.

6. Chief Executive's Report

Dr Patrick noted that a white paper would be published on the health sector. Dr Patrick expected mental health to be highlighted, in particular psychological therapies, and child and adolescent mental health services (CAMHS).

7. Finance & Performance Report

Mr Young reported that the Trust was slightly behind the bottom line, as both income and expenditure were both down.

Ms Satyamurti queried the project income in 4.1.6. Mr Young explained that this was due to the deferral of projects.

Mr Kara noted that the variances in income were nearly 8%. Mr Young explained that this was made up of a number of smaller figures, and that most of the variances in income were matched by variances in expenditure. Mr Young noted that he did not feel that there was anything to be too concerned about at this stage, but that he would continue to keep a close eye on the Trust's budget.

Mr Young noted that a great deal of work has already been undertaken and further work will need to be undertaken to secure the Trust's position. Dr Patrick noted that the Trust was reasonably secure this year, but that the next two years were more uncertain. The Trust must be long-sighted in its strategic plans and take a structured approach to managing important relationships.

Ms Klauber noted that she had experienced some difficulty in getting a response from NHS London about how training would be commissioned in future years.

8. Implementation of Clinical Quality, Safety & Governance Committee Structure

Dr Senior clarified that the workstreams provide assurance to the Clinical Quality, Safety, and Governance Committee and to the Management Committee. The Clinical Quality, Safety, and Governance Committee was responsible for monitoring the activities of the workstreams, not to undertake the work themselves. Ms Key highlighted that the red dotted line in Appendix 1 highlighted the difference between management and the Board of Directors.

Ms Satyamurti queried where responsibility for safeguarding children and vulnerable adults fell. Dr Senior confirmed this was in the Patient Safety & Clinical Risk workstream.

The Board queried whether the new structure would have any affect on the population and reviewing of the Risk Register. Ms Key confirmed that the arrangements would remain the same.

AP3   Mr Kara queried the role of the Audit Committee in relation to the Clinical Quality, Safety, and Governance Committee. Dr Senior confirmed that the Audit Committee would receive assurance and an overview of the Clinical Quality, Safety, and Governance Committee in the same way as it previously received assurance and an overview from the Clinical Governance and Risk Management Committees. Mr Young noted that this should be included in the Audit Committee Terms of Reference.

AP4   Ms Satyamurti noted that paragraph 9.1 of the Terms of Reference should say "seek assurance". The Terms of Reference were approved subject to the above amendment.

Mr Bostock and Ms Moseley were confirmed as members of the Clinical Quality, Safety, and Governance Committee. Mr Bostock agreed to review his membership once the Board had appointed a new Non-Executive Director in November. Dr Senior noted that Mr Bostock provided a good link between the Clinical Quality, Safety, and Governance Committee and the Patient and Public Involvement Committee.

9. Trust Policies

9a. Grievance Policy
Approved.

9b. Health & Safety Policy
AP5   It was agreed to amend paragraph 6.2 to say "to continue to receive".

The policy was approved, subject to the above amendment.

Ms Satyamurti noted that the first aid room was also used as a room for religious prayer. Ms Key noted that it was a possibility that the room may need to be used for both purposes at the same time, but that this had not occurred thus far.

9c. Infection Control Policy
Dr Senior noted that the amended policy had been brought into line with the new arrangements for the Trust's Clinical Quality, Safety, and Governance Committee. The policy was approved.

10. Committee Reports & Minutes
Noted.

11. Patient & Public Involvement Committee Annual Report
Dr Hodges noted that the PPI Committee was trying to find ways to strength patient and public involvement throughout the Trust, developing a

AP6

range of ways to get in touch. Dr Hodges noted that responses to surveys were often low, and the Trust needs to give thought to different methods of engagement. It was noted, however, that over 70% of feedback on the Trust's services was positive. It was also noted that response rates were higher for smaller surveys on particular topics. Mr Kara requested that future reports have a summary chart and have comparative data with previous year's surveys.

AP7

The Board discussed the issue of patient choice, noting that patient choice at the Trust was not so obvious. However, the importance of having conversations with patients about choice at the front end of their treatment was noted. Ms Lyon suggested that the Trust monitor whether clinicians are having these conversations with patients.

Dr Patrick noted the importance of responding to comments and criticism received by the Trust, highlighting that it is frustrating for people to feel that their comments have no effect on the Trust. The Trust must be responding to the needs of its service users. Dr Patrick suggested highlighting a small list of priority areas to address each year and publicising activity on these. Board members agreed that tackling specific areas was more effective than trying to address every issue raised.

AP8

It was noted that the emphasis on PPI work and the patient voice is not unanimous throughout the organisation. Board members highlighted that patient experience was the most important aspect of the Trust's work. Board members agreed that there needed to be Board-level ownership of PPI work and a focussed centrality to the PPI Committee's work. Dr Patrick to consider how PPI work links across the work of the Trust. Dr Patrick to investigate resourcing of PPI and report back to Board of Directors.

12. Service Line Report – Portman Clinic

The Board noted the links between young people, criminal justice and mental health. Mr Ruszczynski highlighted that the Portman Clinic has some involvement in prison services. Dr Senior noted that were likely to be opportunities in the justice system for the Clinic. Mr Kara queried whether the Clinic had a market share of appropriate services. Mr Ruszczynski noted that it did not. Dr Patrick noted the importance of looking out for strategic opportunities.

Ms Moseley had sent a comment on the ratio of administrative to clinical staff. Mr Young noted that it was important to ensure the Clinic has appropriate staff to undertake all work, noting the importance of having administrative staff to undertake administrative work.

Ms Moseley had sent a comment about the relationships between the Portman Clinic and the Trust's Education and Training and Consultancy services. Mr Ruszczynski noted the importance of improving communications and relationships with all the Trust's services. Mr Young noted that training accounted for 10% of the Clinic's income.

Mr Ruszczynski made mention of the clinics robust clinical governance and staff support system. As the Clinic has a difficult patient group, this support system is vital.

Dr Patrick and Mr Ruszczynski noted that Julia Smith, Director of Service Development & Strategy, was developing a marketing strategy for the Clinic, and that a Clinic brochure would soon be produced. Mr Young noted the importance of ensuring there are adequate resources to fund the marketing strategy.

13. Staff Survey Report

Mr Ngoka noted that the Trust had recently changed its training requirements so that staff were now required to attend training once every two years, rather than annually, so the results were naturally lower in the 2009 Annual Staff Survey.

Ms Satyamurti commented on the positive results, and queried how these were fed back to staff. Ms Thomas noted that these would be summarised and published, perhaps in the Staff Newsletter.

AP9   Human Resources Department to return to Board of Directors with action plan.

14. Workforce Statistics

Mr Campbell noted that the Trust's turnover was still low, but that the Trust had changed its reporting method, so it does not appear as good as in previous years' reports.

The Board discussed the ethnicity of staff at higher bands. Ms Thomas noted that the Trust was very aware of its ethnic make up but that turnover within the Executive was very low so it was difficult to do much about this in the short-term.

AP10   Mr Bostock noted that Table 12 highlighted the disparity between applications received and candidates appointed for categories L, M, and N. Ms Greatley suggested the Trust undertake frequent audits on its recruitment data and update the Board of Directors. Ms Klauber suggested that the way in which advertisements are worded may influence the high number of applications. Ms Thomas noted that the Trust was receiving an exceptionally high number of applications for all jobs, many from candidates highly unqualified for the role. It was noted that NHS Jobs made applying for jobs very easy and the high number of applications may be an indication of the current employment market.

15. Tavistock Centre Roof Project Proposal

Ms Key noted that a detailed risk assessment had been carried out for the

project, and teat planning permission had been granted, with slightly amended drawings.

Ms Moseley had sent a comment about letting out the Trust's conference space. Ms Key reported that the Trust could let this space out, but access to the space would be via swipe card and that one of the Trust's staff would need to be present for access security.

Ms Satyamurti queried whether the roof space would have any impact on the possibility of providing catering to patients. Ms Key noted that it would certainly free up space for staff and students, which may have an impact on patient catering.

AP11

AP12

Ms Greatley noted that it looked strange for a mental health organisation to have roof-top space. Ms Key noted that access to the roof would be limited to staff and students, via a swipe card, but also noted that the fencing was as fool-proof as it could be, and was frequently used for sports stadia, schools carparks etc. It was noted that the fencing was 1.7m high. Dr Patrick requested an analysis of the fencing's safety. Mr Bostock stated that he did not tolerate risk 2 – "patients could access the area with the intention of behaving in an unsafe way". Ms Lyon noted that roof space presents an attraction to patients intending to behave in an unsafe way, and queried at what level this risk would be tolerated. Mr Kara requested information on unsafe behaviour in relation to roofs and bridges. Ms Key to undertake. Board members deferred approval of the project pending further investigation by Ms Key. It was noted that work on the project would have to begin in advance of the July meeting of the Board of Directors, and so approval would be sought via e-mail and the use of emergency powers.

Ms Greatley clarified that the money to fund this project could not be used for patient services, but rather had to be used for capital expenditure.

16. Any other business
None.

17. Notice of future meetings
Noted.

The Tavistock and Portman **NHS**
NHS Foundation Trust

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date
1	Oct-09	14. Committee Minutes	Ms Lyon to present report on honorary appointments to Board of Directors	Louise Lyon	Jun-10
2	Apr-10	10b. Care Quality Commission Reporting 2010/11	Ms Lyon to investigate McKinsey workshops on quality	Louise Lyon	Jun-10
3	Jan-10	7b. Complaints Report	Student Complaints to be presented annually to Board of Directors	Trudy Klauber	Jul-10
4	Feb-10	14. RiO Project Update	RiO Project to return to the Board of Directors	Julia Smith	Jul-10
5	Mar-10	10. Tavistock Clinic Foundation Constitution Update	Tavistock Clinic Foundation to report to Board of Directors with brief of work	Louise Lyon	Jul-10
6	Apr-10	9. Corporate Governance Report	Ms Smith to prepare note on the process of approving contracts	Julia Smith	Jul-10
7	Sep-09	12. Student Feedback Report	Ms Klauber to undertake cross-organisational benchmarking	Trudy Klauber	Sep-10
9	Mar-10	8. Corporate Governance Report	Dr Patrick and Miss Carney to consider what matters for the Board of Directors can be delegated down to Committees of the Board	Matthew Patrick / Louise Carney	Sep-10
11	Oct-09	5. Trust Chair's and Non-Executive Directors' Reports	Miss Carney to arrange session on the responsibilities and operation of the Board of Directors for the next layer of Management	Louise Carney	Oct-10
12	Oct-09	12. Health & Safety Guidance	Briefing on Health and Safety systems to be presented to Board of Directors	Pat Key	Oct-10
13	Mar-10	8. Corporate Governance Report	Mr Strang and Miss Carney to review Audit Committee Terms of Reference	Richard Strang / Louise Carney	Oct-10
14	May-10	10. Corporate Governance Report	Miss Carney to add evidence of assurance for each pledge / right in NHS Constitution	Louise Carney	Oct-10
17	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	Jan-11
20	May-10	8b. Risk Management Committee Review of Terms of Reference	Dr Patrick to investigate benchmarking for Day Unit incidents	Matthew Patrick	May-11
21	Feb-10	6. Chief Executive's Report	Ms Moseley to update the Board of Directors on Catch 22's discussions with Big White Wall	Joyce Moseley	As appropriate
22	Feb-10	13. Website Analysis	Communications Department to consider the objectives and priorities of the Trust's website, when data becomes available	Sally Hodges	As appropriate
23	Feb-10	11. Annual Training Services Report	Miss Carney to schedule discussion on Trust branding in relation to training	Louise Carney	September

Board of Directors : July 2010

Item : 4

Title : Matters Arising

Summary:

This paper reports on the following items:

1. Amendment of 2010/11 Capital Budget
2. Sealing of Lease for City & Hackney Service
3. Minor amendment to the Clinical Quality, Safety, & Governance Committee Terms of Reference

For : Approval

From : Trust Chair
Chief Executive

Matters Arising

1.   Amendment of 2010/11 Capital Budget

1.1   Introduction

1.1.1   At the Board of Directors' meeting in June 2010, there was discussion about the proposal for a roof terrace at the Tavistock Centre. Members of the Board requested further patient safety data and an additional staff survey in order to be able to make a final decision regarding the proposal.

1.1.2   It was subsequently decided to commission an options appraisal about a number of physical improvements that might be made to the building to assess which is likely to bring the greatest benefit to staff, students and patients. It was proposed that the outside area of the roof terrace project be considered as part of this appraisal.

1.2   Capital budget 2010/11

1.2.1   In March 2010, the Board of Directors agreed a capital budget of £90k to renew the boilers, and £60k to continue the toilet redesign programme. In addition, £350k was allocated to the roof terrace project subject to formal approval of the project at the June 2010 meeting of the Board of Directors.

1.2.2   It is proposed to take forward those elements of the roof terrace project which will improve the current 5th floor facilities. These elements are the redesign and increased capacity to the toilet provision and the addition of dedicated coat storage areas. These are both particularly important to enhance the facilities the Trust offers to conference delegates.

1.2.3   The budget cost obtained for the items in 2.2 is £60k inclusive.

1.2.4   This is separate from the £60k already budgeted (as above) for toilet redesign. The latter is being used for the gentlemen's lavatories on the 3rd floor and the ladies lavatories on the 1st floor.

1.3 Action

1.3.1 Members of the Board were contacted with the above proposal to amend the Capital Budget and were asked to send their views to the Trust Chair and Chief Executive. As the plan is due to be implemented during the summer of 2010, approval was required prior to the July meeting of the Board of Directors, and it was necessary to use emergency powers.

1.3.2 According to the Trust's Constitution, Annex 4 (Board of Directors' Standing Orders), paragraph 3.2 the powers of the Board of Directors "*may in emergency be exercised by the Chief Executive and the Trust Chair after having consulted at least two Non-Executive Directors*".

1.3.3 Four (of five) Non-Executive Directors and two (of four) Executive Directors responded with approval of the proposal to amend the Capital Budget. No Directors (Executive or Non-Executive) responded to block the proposal.

1.3.4 In accordance with the Trust Constitution, Annex 4, paragraph 11.2.11, the Board of Directors are asked to ratify the decision taken by the Chief Executive and Trust Chair.

2. Sealing of City & Hackney Lease

2.1 Introduction

2.1.1 At the Board of Directors' meeting in April 2010, Board members were asked to approve the sealing of a *contract* for clinical services for the City & Hackney services. Unfortunately, this was a misunderstanding, and the Board should have been asked to approve the *lease* for the service.

2.2 City & Hackney Lease

2.2.1 This lease agreement is for the City and Hackney service, which is located in 210 Kingsland Road London E2 8EB. This office is owned by the PCT provider arm and is being leased to us for the duration of our contract with the PCT for the clinical services (which is a separate contract). The lease document has been checked by our lawyer and by Pat Key. It describes the amount of office space we will have and the services delivered to us as part of the lease, including security. This office space is used for our employees only – no patients are seen on site. We have occupied this office since October 2009. It has been re-decorated and kitted out for our use.

2.2.2 The amount of the lease is paid for by the Trust (for all years) from the City & Hackney budget, using the initial under-spend in staffing during year 1, which arose due to the late starting of the service, this has been negotiated and agreed with the commissioner. We will be invoiced directly by the PCT provider arm and our finance team are aware of the arrangements, as is the Commissioner. The lease timeline ties in exactly with that of the clinical contract.

2.3 Action

2.3.1 Members of the Board were contacted with the above information and the proposal to seal the lease using emergency powers, and asked to send their views to the Trust Secretary (for forwarding to the Chief Executive and Trust Chair).

2.3.2 According to the Trust's Constitution, Annex 4 (Board of Directors' Standing Orders), paragraph 3.2 the powers of the Board of Directors "*may in emergency be exercised by the Chief Executive and the Trust Chair after having consulted at least two Non-Executive Directors*".

2.3.3   Three (of five) Non-Executive Directors and four (of four) Executive Directors responded with approval of the proposal to amend the Capital Budget. No Directors (Executive or Non-Executive) responded to block the proposal

2.3.4   The lease was sealed by the Chief Executive and the Director of Finance, in the presence of the Governance Project Manager on Friday 16th July 2010.

2.3.5   In accordance with the Trust Constitution, Annex 4, paragraph 11.2.11, the Board of Directors are asked to ratify the decision taken by the Chief Executive and Trust Chair.

3. **Amendment to the Clinical Quality, Safety, & Governance Committee Terms of Reference**

3.1 **Introduction**

   3.1.1   At the Board of Directors' meeting in June 2010, the Terms of Reference for the Clinical Quality, Safety, & Governance Committee were approved. A minor amendment has since been proposed, which requires the approval of the Board of Directors.

3.2 **Terms of Reference Amendment Proposal**

   3.2.1   It is proposed that the title of section 9.5, which is the title of the work stream "Quality Accounts and Contracting Informatics" be amended to "Quality Standards and Reports". None of the duties for this work stream have been amended.

   3.2.2   It is proposed that the Director of Service Development and Strategy be added to the list of staff in attendance in section 3.

3.3 **Action**

   3.3.1   Members of the Board are asked to approve these minor amendments.

Board of Directors : May 2009

Item : 6

Title : Chief Executive's Report

Summary :

The report covers the following items:

1. "Equity and excellence: liberating the NHS"; the coalition Government's white paper on Health
2. Commissioning
3. Local Democracy
4. Providers
5. Mental Health
6. Transition
7. Finances
8. And finally…

For : Discussion

From : Chief Executive

Chief Executive's Report

1. "Equity and excellence: liberating the NHS"

1.1 "Equity and excellence: liberating the NHS", the coalition Government's white paper on Health, was published on 12 July 2010. Within it the Government sets out its plans for the NHS.

1.2 It has at its heart three key principles:

1.2.1 Placing patients at the centre of the NHS

1.2.2 Changing the emphasis from targets to clinical outcomes

1.2.3 Empowering health professionals, in particular GPs

1.3 In a way the paper can be read at two levels. On one it signals significant continuity with a direction of travel focused on quality, improved access to information and developing partnerships between health and Local Authorities (LAs). At the same time, there is little doubt the white paper signals the biggest reorganisation of the NHS in its history and, as expected, almost every part of the NHS will see significant change if the proposals are fully implemented.

1.4 The proposals are built around an ambitious timetable. By April 2012 it proposes establishing the Independent NHS Commissioning Board. The new GP led commissioning system is expected to be in place by April 2013. Much of the content has been signalled in advance, and has been referred to in previous of my reports to the Board. I will focus in this report, therefore, on significant departures or developments contained within the White Paper.

2. Commissioning

2.1 As you will all be aware, commissioning responsibilities will move from PCTs to GP consortia. The size and number of consortia is not prescribed (it could be as many as 500 to replace the present 150 PCTs), but each will have an Accountable Officer. It is proposed that GP consortia should be established in shadow form by 2011.

2.2 The White paper now contains a definite proposal that PCTs should be abolished by April 2013.

3. Local Democracy

3.1 Public Health responsibilities, now framed as Health and Wellbeing, will move to Local Government. It is as yet uncertain within London what the balance of responsibilities will be between the Mayor and LAs.

3.2 Local Health and Wellbeing Boards will be established within each Local Authority to strengthen democratic legitimacy and join up the commissioning of NHS services with social care and health improvement. These Boards will take on the responsibilities of Health Scrutiny Committees. There will, in addition, be a network of Health Watch organisations set up by Local Government. These will deal with Complaints, function as advocates on behalf of patient and more generally represent patient interests, liaising also with the CQC.

4. Providers

4.1 The White paper confirms the Foundation Trust model, with all service provision to be through FTs by 2013. This will force decisions regarding aspirant FTs and their likely future.

4.2 In addition the White paper contains proposals for reforming the Foundation Trust model by removing restrictions and facilitating acquisitions and mergers. The aim of this is to facilitate the move of services towards FT provision.

4.3 Monitor will take on the role of economic regulator for all providers by 2013. It is proposed that the economic regulator should have significant powers including the power to require providers to contribute to a risk pool.

4.4 The White Paper also contains a suggestion regarding the abolition of the private patients cap.

5. Mental Health

5.1 A number of proposals within the White Paper relate to Mental Health. These have been summarised by the NHS Confederation as follows:

    5.1.1 Choice of both treatment and provider will be extended into some mental health services from April 2011

    5.1.2 A set of Payment by Results 'currencies' for adult mental health services will be introduced from 2012/13. There are also active plans and commitment to develop currencies for child and adolescent mental health services

5.1.3   Payment mechanisms to support the commissioning of talking therapies will be formulated

5.1.4   An assurance is made that the criteria utilised within the NHS Outcomes Framework will ensure that mental health outcomes are included

5.1.5   The NHS Commissioning Board (NHSCB) will take responsibility for commissioning some specialist mental health services

6.   Transition

6.1   In response to the White Paper, The NHS Chief Executive, David Nicholson, has acted to set up a 'bridge' or 'transition' team. This has involved a number of key appointments:

6.1.1   Deputy CEO (responsible for delivery and performance) – David Flory

6.1.2   Director of Commissioning – Barbara Hakin

6.1.3   A provider Directorate led by Ian Dalton (responsible for FT transitions)

6.1.4   And a Director of HR – Neil McKay

7.   Finances

7.1   At the present time financial projections remain unaltered: "The NHS will release up to £20 billion of efficiency savings by 2014, which will be reinvested to support improvements in quality and outcomes." £20bn over four years is equivalent to 5% per annum in terms of required productivity across the whole NHS.

8.   And finally…

8.1   As the summer is upon us I wanted to take the opportunity of thanking all Board members for their contributions, and indeed all staff within the organisation for their tremendous dedication and passion.

Dr Matthew Patrick
Chief Executive
20 July 2010

EQUITY AND EXCELLENCE: LIBERATING THE NHS
BRIEFING FOR MEMBERS
13 JULY 2010

Equity and excellence: liberating the NHS, the coalition Government's white paper, was published on 12 July 2010. It has at its heart three key principles:
- patients at the centre of the NHS
- changing the emphasis to clinical outcomes
- empowering health professionals, in particular GPs.

There is no doubt the white paper signals the biggest reorganisation of the NHS in its history and, as expected, almost every part of the NHS will see significant change if the proposals are fully implemented.

The white paper is structured as follows:

Chapter 1. **Liberating the NHS** – covers the Government's vision for health, and sets it in context alongside its approach to public health and social care.

Chapter 2. **Putting patients and the public first** – covers shared decision making between clinicians and patients, an information revolution for patients, increased choice and control for patients and carers, and HealthWatch that will strengthen the voice of patients and the public.

Chapter 3. **Improving healthcare outcomes** – covers a new NHS Outcomes Framework, new quality standards to support progress on outcomes, and financial incentives for quality improvement.

Chapter 4. **Autonomy, accountability and democratic legitimacy** – covers GP commissioning consortia, an NHS Commissioning Board, a new relationship between the NHS and Government, local democratic legitimacy, freedom for existing NHS providers, changing roles for the Care Quality Commission and Monitor, and NHS pay and pensions.

Chapter 5. **Cutting bureaucracy and improving efficiency** – covers cutting bureaucracy and administrative costs, increasing NHS productivity and quality, enhanced financial controls, and making savings during the transition.

Chapter 6. **Conclusion: making it happen** – covers proposals for legislation, the transition to the new systems, and a timetable for action.

This briefing sets out the key points from the white paper. For ease of reference we have structured it along the following themes:
- Commissioning
- Financial controls
- Risk pooling
- Future of providers
- Regulation and inspection
- Efficiency and bureaucracy
- Quality and outcomes
- Choice and control
- Public health
- Social care
- Workforce
- Mental health
- Information revolution
- Patient and public engagement.

The white paper sets out an ambitious timetable. By April 2012 it proposes establishing the Independent NHS Commissioning Board and new local authority health and wellbeing boards, and developing Monitor as an economic regulator. The new commissioning system is expected to be in place by April 2013 by which time SHAs and PCTs will be abolished.

The Department of Health (DH) will be consulting on the white paper proposals until 5 October 2010. The NHS Confederation will set in place a number of opportunities for members to inform our work to influence the debate, including an event for members in September and our response to the consultation on the white paper itself. Please send any comments to sam.hunt@nhsconfed.org.

Commissioning
- GP commissioning will be changed so it operates on a statutory basis, with commissioners' powers and duties enshrined in legislation.
- All GP practices are to become part of a consortium. Consortia will need to have sufficient geographical focus. They will also assume responsibility for commissioning services for those people not currently registered with a GP and for commissioning a comprehensive urgent care service.
- Consortia will have a "maximum management allowance", although the limit is not specified.
- A comprehensive system of GP consortia in shadow form is expected to be in place by 2011/12. The consortia will then begin to assume commissioning responsibility in the following year before taking full responsibility from 2013/14.
- NHS Commissioning Board (NHSCB) will commission GPs and family health services (dentistry, pharmacy and primary ophthalmic services). The NHSCB

will have a duty to establish a comprehensive system of GP consortia and the power to assign practices to consortia.

- The NHSCB will be in shadow form from April 2011 as a special health authority before becoming a statutory body in April 2012. The Secretary of State will determine the board's 'formal mandate' (covers three years, updated annually) and holds the board to account for delivery against those objectives. The Government may intervene in-year, but would have to lay a report in Parliament to explain why.
- Both Monitor and the NHSCB will ensure that competing to provide services is a fair and transparent process.

Financial controls

- NHS Commissioning Board will be accountable to the DH for managing within an annual revenue limit and will allocate resources to GP consortia on basis of need.
- GP consortia will be accountable to the NHSCB for managing public funds and will have an accountable officer.
- Commissioners will be free to buy services from any willing provider.
- Monitor will be able to allow transparent subsidies where these are "objectively justified and agreed by commissioners."

Risk pooling

- The white paper stipulates that current risk pooling arrangements will migrate away from SHAs.
- Monitor will be able to authorise special funding arrangements to ensure that essential services can be maintained in circumstances where they would usually have become unviable. Providers may be asked for contributions towards a risk pool by Monitor.
- GP consortia will be required to take part in risk pooling arrangements, overseen by the NHSCB.

Future of providers

- All NHS trusts will be part of or become foundation trusts (FTs) by 2013, with the abolition of the NHS trust model
- New FT models with staff-only membership (social enterprise) are intended for community FTs but not limited to them.
- The white paper contains a clear commitment that FTs "will not be privatised."
- Consultation proposed on increasing FT freedoms including:
  - abolition of the cap on income that can be earned from other sources
  - enabling FTs to merge more easily
  - enabling FTs to tailor their governance to local needs.
- DH will assume responsibility for provider development.
- Community services will operate under the Any Willing Provider ethos.
- Monitor takes over responsibility for regulating all NHS providers from April 2013, irrespective of status.
- Commissioning will be separate from provision by April 2011.

- Special arrangements will be made for three high secure psychiatric hospitals to benefit from FT status.

Regulation and inspection
- The white paper stipulates a stable, transparent and rules based system of regulation
- The Care Quality Commission (CQC) will have "a clearer focus on the essential levels of safety and quality of providers." It will inspect providers with a "targeted and risk-based" approach in accordance with those levels.
- CQC and Monitor will deliver a joint licensing regime, to cover essential levels of safety and quality and ensure continuity of essential services.
- Monitor as economic regulator for both health and social care will:
  - promote competition and concurrent powers with OFT to apply competition law. Powers apply to privately and publicly funded health and social care services
  - regulate pricing but only "where necessary" and with flexibility between 'efficient' and/or 'maximum' price. Monitor's powers to regulate pricing only relate to publicly funded health services
  - have responsibility for FT continuity of service – "continued access to key services in some cases"
  - authorise "special funding arrangements for essential services that would otherwise be unviable" (with agreement of NHSCB and subject to rules on state aid)
  - have powers to intervene directly in the event of failure.
- There is reference made to enforcing competition law. Monitor will be able to undertake market studies and refer structural problems to the Competition Commission.

Efficiency and bureaucracy
- The Government acknowledges that the cuts in administrative costs represent an "important but modest contribution" to the overall NHS efficiency drive.
- NHS management costs will be reduced by more than 45 per cent over the next four years.
- Strategic health authorities will be abolished by 2012/2013.
- Tight cost reduction will apply to centrally managed DH programmes.
- Other potential cost cutting solutions include: the forthcoming review of arms-length bodies; NHS services increasingly empowered to be "customers of a more plural system of IT and other suppliers"; a reduction in the regulatory burden; and energy efficiency and sustainability.
- Existing providers will be freed from central and regional management and they will be supported by a system of economic regulation, overseen by Monitor.
- GP consortia will align clinical decisions in general practice with the financial consequences of those decisions.
- There is a commitment that the QIPP programme "will continue with even greater urgency" and it is hoped that SHAs and PCTs will devolve leadership of this agenda to GP consortia and local authorities as soon as practicable.

- The DH will place requirement on SHAs and PCTs to ensure rigorous financial control over the transition period, supported in this task by Monitor.
- Best practice pricing, increased use of quality incentives and a move away from average cost prices, will be an important feature of the new system.

Quality and outcomes
- The document reaffirms the Government's commitment to hold the NHS to account "against clinically credible and evidence-based outcome measures."
- The new NHS Outcomes Framework will include national outcome goals, chosen by the Secretary of State (following consultation), with the NHSCB held accountable for attainment. The first framework will be available in April 2011, with full implementation expected a year later. It encompasses the domains of quality, safety and patient experience.
- GP consortia will have a commissioning outcomes framework, which should "create powerful incentives for effective commissioning."
- The National Institute for Health and Clinical Excellence (NICE) will develop quality standards for the NHSCB, with 150 different standards ultimately expected. The library of standards should be "reflected in commissioning contracts and financial incentives."
- The NHSCB will be responsible for a payment system structure, with the economic regulator looking after pricing.
- Current Payment by Results tariffs will be refined, with the introduction of best practice tariffs to be accelerated. The DH will evaluate the scope for a benchmarking approach.
- Commissioners will be able to pay a quality increment if providers deliver excellent patient care in line with commissioner priorities.
- CQUIN will be extended to support local quality improvement goals.
- Commissioners will be enabled to impose penalties on providers delivering substandard care.
- A "single contractual and funding model to promote quality improvement" will be developed.
- The Cancer Drug Fund will come into operation from April 2011. Value-based pricing for NHS medication will be introduced once the current scheme expires.

Choice and control
- From April 2011, patients will be able to choose their consultant-led team for elective care where clinically appropriate.
- Choice will be extended to include mental health providers from April 2011, and for diagnostic testing and choice post-diagnosis from 2011 onwards.
- Patients will be able to choose a GP practice (with an open list), not limited to where they live.
- A consultation on choice of treatment is expected later in 2010, including "potential introduction of new requirements on providers, and collecting and publishing information on whether this is happening to support patients."

- Patients will have choice of treatment and provider for most NHS-funded services no later than 2013/14.
- A single number for all types of urgent and social care will be established and technology developed to help people communicate with their clinicians.
- A further tranche of Personal Health Budget (PHB) pilots will be encouraged with general roll out informed by evaluation in 2012.This includes the potential for introducing PHBs for NHS continuing care.
- The Government has confirmed there will be no bail-outs for organisations that overspend public budgets.

Public health
- A Public Health Service will be established, encompassing the existing health improvement and protection bodies and responsibilities.
- Local authorities will assume the responsibilities for local health improvement currently held by primary care trusts. While the Public Health Service will set national objectives for improving population health, local authorities will have the freedom to determine the means by which these are achieved.
- Directors of Public Health (DPHs) will be jointly appointed by the Public Health Service and local authorities. They will be given control over ring-fenced public health budgets in their local area.
- A 'health premium' will be introduced, aimed at alleviating health inequalities.
- A separate Public Health White Paper is due for publication later this year.
- Health and Wellbeing Boards will be created within local government in an attempt to coordinate commissioning of NHS services, social care and health improvement.

Social care
- The Department of Health will establish a commission on the funding of long term care and support to report within one year. A white paper is then expected in 2011, with the aim of introducing legislation in the second session of this Parliament.

Workforce
- The Government advocates allowing all employers the right to determine their own pay levels. However it acknowledges that many providers will wish to utilise national remuneration contracts.
- The DH will take more of a back seat role in relation to education and training. The Government wishes to see employers agreeing plans and resources for workforce development with their staff. Healthcare professions at both a local and national level will assume leadership for education commissioning.
- The review of public sector pensions chaired by Lord Hutton will examine issues including labour market mobility and the potential impact upon plurality of provision, alongside affordability and sustainability.

Mental health
- Choice of both treatment and provider will be extended into some mental health services from April 2011.

- The importance of decision aids to enable effective patient choice is particularly acknowledged for mental health and community services.
- A set of Payment by Results 'currencies' for adult mental health services will be introduced from 2012/13. There are also plans to develop currencies for child and adolescent services.
- Payment mechanisms to support the commissioning of talking therapies will be formulated.
- An assurance is made that the criteria utilised within the NHS Outcomes Framework will ensure that mental health outcomes are included.
- The NHSCB will take responsibility for commissioning some specialist mental health services.

Information revolution
- The white paper includes a focus on the publication of "comprehensive, trustworthy and easy to understand information" from a range of sources.
- Patient Reported Outcome Measures (PROMs), patient experience data and real-time feedback are all expected to be utilised more frequently in the future. Patients will have the opportunity to rate services and specific clinical departments.
- National clinical audit will be broadened out across a larger range of treatments and conditions.
- Quality Accounts will be revised in an attempt to enhance local accountability. The White Paper also states all providers of NHS care will have to publish accounts from 2011, subject to evaluation.
- Hospitals will be required to be open about mistakes and to always inform patients of errors made with their care.
- A consultation on health records will be held later in 2010 to determine the appropriate confidentiality safeguards. Records will be made available in a standardised format, with patients enabled to provide access to third parties if they wish to.
- The virtues of a voluntary accreditation system will be examined, which would allow organisations to apply for a quality standards kitemark.
- The Information Centre will have an enhanced role, with centralised data returns and the responsibility for reviewing existing data collections.
- Clear contractual obligations around accuracy and timeliness of data will be placed on providers. Compatibility of data among both providers and commissioners is paramount.
- There will be a consultation on the information strategy in autumn 2010.

Patient and public engagement
- The NHSCB is to act as a champion for patient and carer involvement.
- HealthWatch England will sit inside the Care Quality Commission. LINKs will become the local arms of HealthWatch and will be both funded by and accountable to local authorities.
- Local HealthWatch and HealthWatch England will play crucial roles in providing advocacy and support and within the complaints procedure.

- Local HealthWatch will also be empowered to recommend investigating services deemed to be inadequate.

Further documentation

NHS chief executive Sir David Nicholson wrote to NHS leaders on 13 July about managing the transition and we expect a number of detailed documents to be published in the near future on:

- commissioning
- local democratic legitimacy in health
- freeing providers and economic regulation
- NHS outcomes framework
- ALB review
- social care
- information strategy
- patient choice
- education
- data returns.

Viewpoint

The plans laid out in *Equity and Excellence: Liberating the NHS* indicate the most significant restructuring of the NHS in its history. The paper sets out a very major shift in where power and accountability lie in the health service, and in where responsibility for public health will lie in future.

A large number of unanswered questions remain which we hope will be addressed over the summer as detailed policy documents are published but it is clear that some solutions will have to be determined locally. Key questions about the proposed approach include the nature of accountability for GP consortia, how the areas of commissioning that fall outside the scope of consortia will be dealt with, and how the large scale change needed to move responsibility from PCTs to GP consortia will be accomplished. For providers, the implications of new freedoms and the development of a new economic regulator are just as significant. For example, Monitor will have the power to require providers to grant access to their facilities to third parties. For patients, there is a strong emphasis on increased choice and control, but previous white papers have had similar ambitions and the difficulty of converting rhetoric into reality has been considerable. For GPs, there are new challenges and the difficult task of balancing patient centred and population viewpoints.

The new system will look very different to the current NHS. It is clear that GP consortia will not be mini-PCTs, and the driver of change in this new system seems to be individual choices by GPs rather than traditional planning approaches. Accountability will be for outcomes rather than process measures or targets. The system will be rules based, subject to competition law, and governed by standards for commissioning that will create a more explicit statement of what patients can expect. It is clear that there will be fewer policy initiatives from the centre.

The end point of these reforms will be a radical shift from where we are now, but there are risks and uncertainties about the journey that mean adjustments will be made as the policy is implemented. The transition risks are significant, and David Nicholson's letter on transition sets out the extensive programme of change, restructuring, capacity building and policy development that will be required.

It is unfortunate that the way the reforms have been portrayed has failed to acknowledge the progress that has been made in commissioning and PCTs over the past few years, and keeping SHA and PCT staff motivated during the transition period will be important. Staff working within SHAs and PCTs will be asked to continue to manage performance and finances tightly; it will not be seen as politically acceptable for performance or financial management to slip over the next few years because the NHS budget is being protected relative to other public sector services.

The NHS Confederation and its networks will be working with the Department of Health to influence the policy as it develops and to help members to make sense of what is an emerging picture. As ever, we are keen to hear your views to inform our response to the white paper consultation. Please send any comments to sam.hunt@nhsconfed.org.

Board of Directors : July 2010

Item : 7a

Title : Finance and Performance Report

Summary:

After three months, a surplus of £61k is reported, £39k below the planned surplus of £100k. Income shortfalls on Consultancy, Training and Clinical offset under spends across the organisation are the main reason for the surplus. These variances are being investigated, but no major variances for the year are forecast at this early stage.

An update on service line reporting is to be provided separately.

The cash balance at 30 June was £3,556k, slightly below plan. Cash is expected to remain close to plan for the rest of the year, subject to achievement of planned income and expenditure.

For : Discussion

From : Director of Finance

Finance and Performance Report

1. External Assessments

1.1 Monitor

1.1.1 The Annual Plan, as approved by the Board, was submitted to Monitor in May. Following their review, a response is now expected in August. The Plan should lead to a Financial Risk Rating of 3.

1.1.2 The first quarter's results should also give a rating of 3. It is currently expected that the actual rating for the year will also be a 3. As in previous years, it would only fall below this if (a) a small deficit led to the return on assets falling below 3%; and/or (b) cash and working capital balances (including our borrowing facility) were £1.4m less than Plan, leading to less than 15 days liquidity. Neither of these is expected to occur. The current borrowing facility expires on 31 October, so negotiations for a new facility are in progress.

1.1.3 The Board is therefore asked to approve the following declaration, to be included in the quarterly return to Monitor:

> *The Board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.*

1.1.4 The quarter 1 governance declaration is presented in a separate paper; our rating should remain at green. We are not affected by recent changes to the rating thresholds in the Compliance Framework, as a result of some targets being withdrawn.

2. Finance

2.1 Income and Expenditure 2010/11

2.1.1 After three months, income is £465k below budget, and expenditure £426k below budget. The surplus is £39k below budget. Some of these variances are due to timing, and the forecast for the year remains in line with budget at present.

2.1.2 The income shortfall includes £129k for training which is mainly due to CWDC income being £66k lower than expected, this also reflected expenditure. Fee and conference income are also below target. Consultancy income is £140k under budget, with TCS under target by £24k and departmental consultancy under by £116k. There are also shortfalls in clinical income. In all of these cases, the shortfalls are partly or mainly due to timing, and should be recovered in future months. These main income sources and their variances are discussed in sections 3, 4 and 5 below. There is also a shortfall on research income, which may continue for the year; this will be reviewed in a later report.

2.1.3 The expenditure under spend of £426k is due to both Training £219k and Clinical £196k. Training includes £66k CWDC mentioned above as well as vacant posts in training and under spends on marketing and conferences. The majority of the Clinical under spend can be attributed to Child & Family £126k whilst Portman £42k and Adult £39k also have vacancies. The Child & Family underspend is partially due to the new Barnet Young Persons D&A Service £25k. These under spends have been offset an over spend in TCS of £51k due to delayed 2009/10 payments for associate consultants. The forecast outturn for expenditure is likely to be around £360k favourable; a more robust forecast will be possible in future months.

2.1.4 Income for the year is forecast at £144k below budget in Appendices A and B. However, if there are larger shortfalls than this, they should be covered firstly by the under spending discussed above; and then by the budgeted contingency reserve.

2.2 Cash Flow (Appendix C)

2.2.1 The actual cash balance at 30 June was £3,556k, compared to the Plan of £3,521k. Receipts from General Debtors were below Plan as are payments to suppliers which reflects the shortfall on planned income and expenditure mentioned in 2.1 above.

2.2.2 However, student debt has grown, with £120k outstanding for the 2009/10 academic year, of which £90k still has no repayment plans. A meeting on 20 July between Finance and DET will review the credit control process. The target is to reduce the 2009/10 and earlier debt to £50k by 1 October 2010.

	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)	2,739	2,848	(109)
General debtors (incl LAs)	1,685	2,135	(450)
SHA for Training	2,743	2,703	40
Students and sponsors	465	600	(135)
Other	88	54	34
	7,719	8,340	(621)
Operational expenditure payments			
Salaries (net)	(3,595)	(3,741)	146
Tax, NI and Pension	(2,643)	(2,701)	58
Suppliers	(1,571)	(1,937)	366
	(7,810)	(8,379)	569
Capital Expenditure	0	0	0
Interest Income	1	5	(4)
Payments from provisions	0	(90)	90
PDC Dividend Payments	0	0	0
Closing cash balance	3,556	3,521	35

2.2.3   In the first quarter, 90% of suppliers' bills were paid within 30 days, compared to the target of 95%. By value, 95% was paid within 30 days, confirming the pattern that it tends to be the smaller bills which are delayed in being authorised or for other reasons.

3.   <mark>Training</mark>

3.1   Training income is £129k below budget in total after 3 months, with the main shortfall as mentioned above in 2.1.2 CWDC at £66k. Also Fee income is £25k; £34k on conferences (expected to be recovered in future months); and £57k on Child Psychotherapy Trainees (offset by lower costs).

3.2   Income from university partners remains under negotiation. Apart from this, the other key area of uncertainty is, as always, fee income from students and sponsors for the academic year starting in October.

4.   Patient Services

4.1   <mark>Activity and Income</mark>

4.1.1   All contract values have now been agreed. Total contracted income for the year is in line with budget. After three months, there is a small favourable variance on cost and volume activity. Part of the budgeted income for the year is dependent on meeting our CQUIN[†] targets agreed with commissioners.

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

4.1.3   After three months named patient agreements (NPAs) actual income is £19k below budget, with £13k of this shortfall in the Portman. If extrapolated for the full year, this would give an adverse variance of £74k, but improvement on this is expected.

4.1.4   Court report income was £8k above budget after three months. The majority of the over performance was from CAMHS.

4.1.5   Monroe income is slightly above budget after 3 months. The annual budget was reduced from £810k to £780k this year

4.1.6   Day Unit is currently over performing by £59k cumulatively due to high student numbers.

4.1.7   Project income is forecast to be £25k below budget for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.
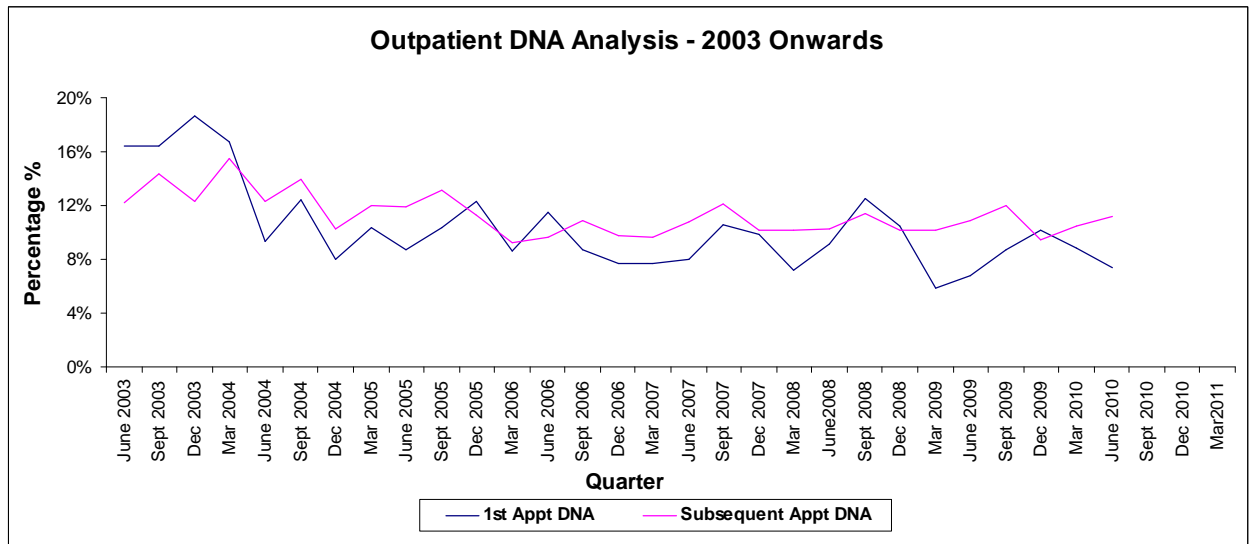

[†] Commissioning for Quality and Innovation

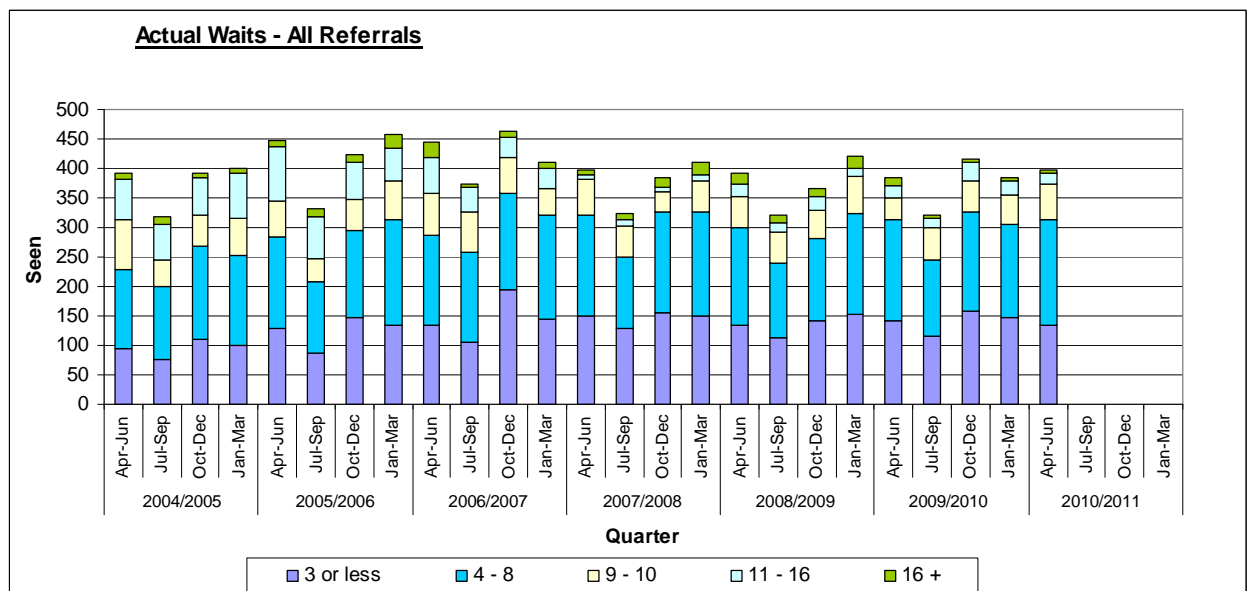|	Budget £000	Actual £000	Variance %	Full year		Comments
				Variance based on y-t-d	Predicted variance	
Contracts - base values	2,236	2,231	-0.2%	-20	-20	East London SLA expected to be £20k below budget
Cost and vol variances	3	13		43	43	
NPAs	60	41	-31.1%	-74	-30	Activity expected to rise
Projects and other	771	603		–	-25	Income matched to costs, so variance is largely offset.
Day Unit	253	312	23.3%	236	100	Gain may not be sustained. Lower pupil numbers expected in autumn.
Monroe	176	182	3.3%	26	0	
FDAC	83	90	8.9%	30	0	
Court report	38	45	20.9%	31	0	
Total	3,620	3,518		272	68	

4.2 Clinical performance (quarter 1, 2010/11)

4.2.1 This section has been provided by the Head of Informatics and the Director of Service Development.

4.2.2 DNA rates for the Trust continue to be below national averages which run at around 15-20% for MH Trusts. DNAs on first appointments have been fairly consistent over the last six months; the percentage fell to 7.4% in the latest quarter, but remains significantly lower than in previous years. Fluctuation is due to the relatively small population

Outpatient DNA Analysis - 2003 Onwards

4.2.3 For the larger number of subsequent appointments, the percentage rose slightly to 11.1% though not significantly.

4.2.4 The Trust is no longer required to report externally on waiting times; but we continue to monitor our lists with the aim of keeping to the 11 week waiting limit from referral, regardless of the source of the referral. The chart below shows the actual waits (in weeks) for all patients with a first attendance appointment in each quarter.

Actual Waits - All Referrals

4.2.5 In this quarter, 25 patients (6%) waited 11+ weeks for their first appointment, a reduction from 7% in the previous period; within this, the numbers waiting 16+ weeks remained at 5.

4.2.6 The breakdown of reasons is given below

External causes: 9

More information from referrer required. (2)
Complex case, local liaison required. (1)
Authorisation for inclusion in SLA and NPA (3)
Patient request/delay (3)

Clerical Error: 5
Appointments offered within 11 weeks but turned down by patient and date note entered on Carenotes by administrator hence waiting time clock not re-set (3)
Calculation error of last possible appointment date before breach (1)
Clinician double booked (1)

Cancellation by Trust: 2
Due to volcanic ash and unexpected hospital admission (2)

Lack of clinical availability: 3
2 of these were in a newly developing service where clinical capacity not yet established. This is a temporary situation.

Patient requested taxi fare – process extended the waiting time by 1 week (1)

Difficulty engaging patient: 1
Patient initially only engaged with clinician via letters and phone calls before feeling able to attend in person

Unknown: 4

4.2.7   Excluding those cases with external causes and those where the cause is unknown, action to prevent recurrence has been identified for 8 cases and the remaining 7 will be investigate and processes checked

5.   <mark>Consultancy</mark>

5.1   TCS income was £95k in June compared to the budget of £77k. After three months, income of £168k is £24k behind budget. Our forecast for the year assumes at present that budget is achieved for the remaining nine months.

5.2   Departmental consultancy is £116k below budget after three months, but this is partly due to timing of work, and is not expected to be continued.

Simon Young
Director of Finance
19 July 2010

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST

INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2010-11

	Jun-10			CUMULATIVE					
	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	1,208	1,189	(19)	3,595	3,518	(77)	14,455	14,523	68
2 TRAINING	1,337	1,328	(9)	3,932	3,803	(129)	16,065	16,042	(24)
3 CONSULTANCY	154	133	(21)	424	284	(140)	1,658	1,616	(42)
4 RESEARCH	27	13	(14)	82	40	(41)	327	247	(80)
5 OTHER	62	50	(11)	185	108	(77)	678	612	(66)
TOTAL INCOME	**2,788**	**2,714**	**(74)**	**8,218**	**7,753**	**(465)**	**33,183**	**33,040**	**(144)**
OPERATING EXPENDITURE (EXCL. DEPRECIATION)									
6 CLINICAL DIRECTORATES	1,527	1,522	4	4,592	4,396	196	18,391	18,053	338
7 OTHER TRAINING COSTS	547	497	50	1,560	1,340	219	6,470	6,395	75
8 OTHER CONSULTANCY COSTS	51	63	(12)	158	208	(50)	630	679	(49)
9 CENTRAL FUNCTIONS	538	507	31	1,575	1,514	61	6,187	6,192	(5)
10 TOTAL RESERVES	0	0	0	0	0	0	420	635	(215)
TOTAL EXPENDITURE	**2,663**	**2,589**	**74**	**7,884**	**7,458**	**426**	**32,099**	**31,954**	**145**
EBITDA	**125**	**125**	**(0)**	**334**	**295**	**(38)**	**1,085**	**1,086**	**1**
ADD:-									
12 BANK INTEREST RECEIVED	2	4	(2)	5	4	1	20	19	(1)
LESS:-									
11 DEPRECIATION	42	42	0	127	127	0	509	509	0
13 FINANCE COSTS	0	0	0	0	0	0	0	0	0
14 DIVIDEND	37	37	0	112	112	0	446	446	0
RETAINED SURPLUS	**47**	**49**	**(2)**	**100**	**61**	**(37)**	**150**	**150**	**0**
EBITDA AS % OF INCOME	4.5%	4.6%		4.1%	3.8%		3.3%	3.3%	

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

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APPENDIX B

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	Jun-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	660	37	1,870	1,906	37	7,479	7,479	0
TRAINING FEES & OTHER ACA INC	466	416	(51)	1,320	1,187	(133)	5,616	5,591	(25)
POSTGRADUATE MED & DENT'L EDUC	6	6	0	17	19	1	70	71	1
JUNIOR MEDICAL STAFF	86	122	36	259	282	22	1,037	1,037	0
CHILD PSYCHOTHERAPY TRAINEES	155	124	(31)	466	409	(57)	1,863	1,863	0
R&D	27	13	(14)	82	40	(41)	327	247	(80)
CLINICAL INCOME	1,015	961	(54)	3,045	2,888	(157)	12,179	12,147	(32)
DAY UNIT	84	95	11	253	312	59	1,014	1,114	100
MONROE	68	74	6	176	182	6	780	780	0
FDAC	28	35	7	83	90	7	332	332	0
TCS INCOME	77	95	18	192	168	(24)	730	688	(42)
DEPT CONSULTANCY INCOME	77	38	(39)	232	116	(116)	928	928	0
COURT REPORT INCOME	13	24	11	38	45	8	150	150	0
EXCELLENCE AWARDS	10	10	(0)	29	29	(0)	118	118	(0)
RENTAL INCOME	0	0	0	0	0	0	0	0	0
OTHER INCOME	52	41	(11)	155	78	(77)	561	495	(66)
TOTAL INCOME	**2,788**	**2,714**	**(74)**	**8,218**	**7,753**	**(465)**	**33,183**	**33,040**	**(144)**
EXPENDITURE									
EDUCATION & TRAINING	365	341	24	1,015	877	137	4,290	4,230	60
PORTMAN CLINIC	129	125	4	403	362	42	1,614	1,544	70
ADULT DEPT	260	248	12	779	739	39	3,118	3,040	78
MEDNET	18	11	7	55	48	7	221	221	0
ADOLESCENT DEPT	132	135	(3)	396	389	7	1,584	1,544	40
ADOLESCENT PROJECTS	2	18	(17)	18	26	(8)	72	72	0
C & F CENTRAL	610	613	(3)	1,831	1,775	55	7,341	7,191	150
C&F PROJECTS	162	149	13	487	429	58	1,948	1,948	0
MONROE & FDAC	82	77	5	245	232	13	979	979	0
DAY UNIT	64	75	(11)	192	193	(1)	768	768	0
SPECIALIST SERVICES	60	59	1	179	179	0	716	715	0
COURT REPORT EXPENDITURE	8	12	(4)	8	23	(15)	30	30	0
TRUST BOARD	10	12	(2)	29	29	0	115	115	0
CHIEF EXECUTIVE OFFICE	27	23	5	81	78	4	325	325	0
PERFORMANCE & INFORMATICS	77	71	7	225	205	20	897	897	0
FINANCE & ICT	91	105	(14)	273	280	(7)	1,092	1,092	0
CENTRAL SERVICES DEPT	196	177	19	559	566	(7)	2,189	2,214	(25)
HUMAN RESOURCES	65	60	4	195	182	13	719	719	0
CLINICAL GOVERNANCE	24	21	3	68	57	12	268	268	0
TRUST DIRECTOR	16	14	3	49	43	6	197	197	0
PPI	11	11	1	34	36	(2)	135	135	0
SWP & R+D & PERU	31	22	9	93	67	25	371	351	20
R+D PROJECTS	0	0	0	0	(0)	0	0	(0)	0
PGMDE	9	(2)	11	27	1	27	109	89	20
NHS LONDON FUNDED CP TRAINEES	155	137	18	466	409	57	1,863	1,863	0
TAVISTOCK SESSIONAL CP TRAINEES	9	8	1	28	24	4	110	110	0
FLEXIBLE TRAINEE DOCTORS	8	12	(4)	24	29	(5)	97	102	(5)
TCS	49	61	(12)	147	198	(51)	587	637	(50)
DEPARTMENTAL CONSULTANCY	2	2	(0)	11	9	1	43	42	1
DEPRECIATION	42	42	0	127	127	0	509	509	0
PROJECTS CONTRIBUTION	(10)	(8)	(2)	(30)	(28)	(2)	(121)	(121)	0
IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	0	0	0	0	0
CENTRAL RESERVES	0	0	0	0	0	0	420	635	(215)
TOTAL EXPENDITURE	**2,705**	**2,632**	**74**	**8,011**	**7,585**	**426**	**32,608**	**32,463**	**145**
OPERATING SURPLUS/(DEFICIT)	**82**	**82**	**(0)**	**206**	**168**	**(38)**	**576**	**577**	**1**
INTEREST RECEIVABLE	2	4	2	5	4	(1)	20	19	1
UNWINDING OF DISCOUNT ON PROVISION	0	0	0	0	0	0	0	0	0
DIVIDEND ON PDC	(37)	(37)	0	(112)	(112)	0	(446)	(446)	0
SURPLUS/(DEFICIT)	**47**	**49**	**2**	**100**	**61**	**(39)**	**150**	**150**	**2**

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	3,556	3,265	2,886	2,333	2,519	2,436	2,063	2,428	2,312	3,645
Operational income received													
NHS (excl SHA)	892	1,017	829	1,005	1,038	917	904	1,038	917	905	1,036	917	11,416
General debtors (incl LAs)	709	387	588	550	402	379	556	474	423	783	591	458	6,301
SHA for Training	874	854	1,015	894	914	894	895	914	894	894	915	894	10,851
Students and sponsors	277	102	86	100	0	200	650	250	100	500	100	100	2,465
Other	24	35	29	18	18	18	18	18	18	18	18	18	250
	2,776	2,396	2,547	2,567	2,372	2,408	3,023	2,694	2,352	3,100	2,660	2,387	31,282
Operational expenditure payments													
Salaries (net)	(1,206)	(1,192)	(1,198)	(1,220)	(1,220)	(1,220)	(1,220)	(1,247)	(1,247)	(1,246)	(1,247)	(1,247)	(14,709)
Tax, NI and Pension	(859)	(889)	(895)	(910)	(910)	(910)	(910)	(921)	(921)	(921)	(921)	(921)	(10,888)
Suppliers	(570)	(615)	(386)	(697)	(622)	(510)	(509)	(510)	(509)	(510)	(509)	(510)	(6,457)
	(2,635)	(2,695)	(2,480)	(2,827)	(2,752)	(2,640)	(2,639)	(2,678)	(2,677)	(2,677)	(2,677)	(2,678)	(32,055)
Capital Expenditure	0	0	0	(20)	0	(100)	(200)	(100)	(50)	(60)	(100)	(90)	(720)
Interest Income	1	0	1	2	1	2	2	1	2	2	1	2	16
Payments from provisions	0	0	0	(13)	0	0	0	0	0	0	0	0	(13)
PDC Dividend Payments	0	0	0	0	0	(223)	0	0	0	0	0	(223)	(446)
Closing cash balance	3,787	3,488	3,556	3,265	2,886	2,333	2,519	2,436	2,063	2,428	2,312	1,710	1,710

Board of Directors : July 2010

Item : 7b

Title : 2010/11 Monitor's Quarter 1 Governance Declaration

Summary:

The Trust remains compliant with the CQC registration requirements and with all healthcare targets and indicators, with one exception: as agreed when the 2010 Annual Plan was approved in May, the Trust is not currently achieving 99% completeness on collection of some of the patient data identifiers required by the Compliance Framework.

The Board is therefore 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.

Notes:
- The wording of Declaration 1 is "The Board confirms that all healthcare targets and indicators have been met."
- On the "Targets and Indicators" worksheet, the only indicator marked "Failed to Meet" and the overall score will be 0.5, resulting in a Green rating for governance.

For : Approval

From : Director of Corporate Governance and Facilities

Board of Directors : July 2010

Item : 7c

Title : Quarter 1 Complaints Report 2010/11

Summary:

At July 2010, the Trust had a total of 5 open complaints

One complaint for 2009/10, received in July 2009, remains open following a number of meeting s between the complainant and Trust staff, a further meeting has been offered.

In 2010/11, we have received 4 new complaints, three have been investigated and the complainant has received a response, one is under investigation. All remain open pending further contact from or a meeting with the complainants.

A more detailed summary is presented to the Board of Directors in closed session.

For : Noting

From : Chief Executive

Board of Directors : July 2010

Item : 8

Title : Corporate Governance Report

Summary:

This paper reports on the following items:

1.   Use of Trust's Seal

2.   Mid-Staffordshire NHS Foundation Trust Public Inquiry

3.   Monitor 2009/10 review of foundation trusts

4.   Annual Report & Accounts 2009/10

5.   Foundation Trust Governors' Association Policy Line on Board Meetings

6.   CQC Annual Healthcheck 2009/10

For : Noting

From : Trust Secretary

Corporate Governance Report

1. **Use of Trust's Seal**

1.1 On 16th July 2009, the Trust sealed the underlease for 210 Kingland Road for the Trust's City & Hackney Service. The underlease was sealed by Dr Matthew Patrick, Chief Executive, and Mr Simon Young, Director of Finance, and witnessed by Mr Jonathan McKee, Governance Project Manager.

2. **Mid-Staffordshire NHS Foundation Trust Public Inquiry**

2.1 The Secretary of State has announced a full public inquiry into the operation of the commissioning, supervisory and regulatory bodies in relation to their monitoring role at Mid-Staffordshire NHS Foundation Trust. The focus will be on the lessons to be learned from the wider NHS system. The inquiry will be chaired by Robert Francis QC, and will be conducted under the Inquiries Act 2005.

www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_116650

3. **Monitor 2009/10 review of foundation trusts**

3.1 Monitor have published *NHS foundation trusts: review of 12 months to 31 March 2010*. There were 129 foundation trusts at the end of 2009/10. Monitor's report is based on the data submitted by FTs on a quarterly basis.

3.2 Below are the 2009/10 statistics on foundation trusts. Categories where the Tavistock & Portman NHS Foundation Trust fits are highlighted in red.

Table 1: NHS Foundation Trust Statistics at 31 March 2010

Type of FTs		
Total	129	
Acute	73	56.6%
Mental Health	40	31%
Specialist	16	12.4%
FTs by Strategic Health Authority		
North West	27	20.9%
South West	16	12.4%
Yorkshire & The Humber	15	11.6%
London	15	11.6%
East of England	14	10.9%
West Midlands	12	9.3%
North East	10	7.8%
South Central	7	5.4%
South East Coast	7	5.4%
East Midlands	6	4.7%
Governance Risk Ratings		
Green	80	62%
Amber	28	21.7%
Red	21	16.2%
Financial Risk Ratings		
5 (lowest risk)	6	4.7%
4	75	58%
3	41	31.8%
2	5	3.9%
1	2	1.6%
FTs in significant breach of terms of authorisation		
Total	13	10.1%
Combined actual net surplus 2009/10		
Total	£365m	
EBITDA margin		
Total	7%	

3.3 Monitor's document can be found at http://www.monitor-nhsft.gov.uk/sites/default/files/Q4%20final%20version%2025%20June.pdf

4. Annual Report & Accounts 2009/10

4.1 The Trust submitted it's Annual Report & Accounts for 2009/10 to Monitor by the deadline of 8th June.

4.2 In line with requirements, the Trust wrote to Stephen Hay, the Chief Operating Officer at Monitor, on 23rd June to confirm there had been no post-balance sheet activity.

4.3 On 7th July, the Annual Report & Accounts were submitted to the Parliamentary Clerk's Office at the Department of Health, for laying before Parliament.

4.4 On 20th July, the laid Report & Accounts were sent to Monitor. Monitor will notify the Trust when the Report is published. Until that date, the Trust is not at liberty to publish its Report & Accounts, in whole or in part.

5. Foundation Trust Governors' Association Policy Line on Board Meetings

5.1 The Foundation Trust Governors' Association (FTGA) has published a policy line on how Boards of Directors conduct their meetings, noting that public access to Board meetings has been brought into sharper focus by the Francis Report[1]. The report notes:

> *The need for public accountability puts a special obligation on NHS Boards to conduct themselves and their business in an open and transparent way that commands public confidence. For that reason, Board meetings are open to the public and should operate in a way that makes their business understandable to the public... It follows from this commitment to open debate that the use of the confidential part of the Board meeting should be restricted to those areas generally concerning named individuals or commercially sensitive information, where there is an overriding need for confidentiality."[2]*

5.2 The FTGA have set out their policy line:

5.2.1 Board of Directors' meetings should be open to the public

5.2.2 There may be instances of commercial sensitivity or issues of confidentiality that mean some business needs to be conducted in private. The arrangements for this should be decided by each Trust

5.2.3 A part 1 and part 2 of Board meetings may be necessary but the items restricted to the closed part of the meeting should be clearly defined under the headings of commercial sensitivity or confidentiality only

5.2.4 The Chair, as Chair of both Boards, has the central role to play in ensuring that all items that can be heard in public are

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[1] reference
[2] Department of Health, *Governing the NHS – A Guide for NHS Boards*, June 2003, p.14, in Francis Inquiry, Part 1, p.301

5.2.5 Although Governors are the elected representatives of the membership, they are still members of the public and so where a Board meeting is open, it should be open to all members of the public

5.2.6 Where part or all of a Board meeting is closed, individual FTs may wish to offer enhanced access to Governors as long as confidentiality is observed

5.2.7 Meetings should be publicised regularly and as widely as possible to ensure the public is able to attend

5.3 This Trust holds its Board meetings in two parts, with Part 1 open to the public, and Part 2 held in camera and reserved for commercially sensitive or confidential information. Authors are encouraged to discuss their papers in Part 1, where possible.

5.4 Whilst any Governors are welcome to attend Board of Directors' meetings, the Board of Governors has a rota for attendance, to ensure that at least one Governor is present for all Board of Directors' meetings. Public Governors may stay for Part 2 meetings, on the proviso that confidentiality is maintained.

5.5 Dates for Board meetings are published on the website, and a notification is placed in the main foyer publicising the meeting on that day. The Trust often has members of the public observing its meetings.

6. CQC Annual Healthcheck

6.1 The CQC will not be producing its "Annual Healthcheck" for 2009/10, but will instead be publishing benchmarking data on the indicators set out in the NHS Operating Framework. This means removing the "excellent", "good", "fair", "poor" grading for the quality of services and use of resources.

Board of Directors : July 2010

Item : 9

Title : Six Lives: The Provision of Public Services to People with Learning Difficulties

Summary :

An independent report, "Six Lives: the provision of public services to people with learning disabilities", was published on 24th March by the Health Service and Local Government Ombudsmen. Focusing on investigations into the deaths of the six individuals in previous reports, it calls for an urgent review of health and social care for people with learning disabilities.

One recommendation of particular relevance to the Tavistock and Portman NHS FT indicates that all NHS and social care organisations in England should review urgently and report accordingly to those responsible for the governance of those organisations within 12 months for**:**

- the effectiveness of the systems they have in place to enable them to understand and plan to meet the full range of needs of people with learning disabilities in their areas; and

- the capacity and capability of the services they provide and/or commission for their local populations to meet the additional and often complex needs of people with learning disabilities;

This paper considers the relevance of this and other associated reports for the Trust.

For : Information

From : Medical Director

Six Lives: The Provision of Public Services to People with Learning Difficulties

1.   Introduction

1.1   An Independent Inquiry into Access to Healthcare for People with Learning Disabilities, led by Sir Jonathan Michael, published its findings 'Healthcare for all' on 29th July 2008.

1.2   The inquiry was ordered following Mencap's 'Death by indifference' report, which told the stories of the six people with a learning disability who died while in NHS care. The Inquiry sought to identify the action needed to ensure adults and children with learning disabilities receive appropriate treatment in acute and primary healthcare in England.

1.3   Central to the development of these performance indicators is adherence to the Human Rights Act 1998 and the Disability Discrimination Act 1995, to ensure equality of access and equity for all people with learning disabilities and that a human rights approach is adopted by the NHS and that 'reasonable adjustments' are made in the delivery of services to reduce health inequalities.

1.4   A further independent report, 'Six Lives: the provision of public services to people with learning disabilities', was published on 24th March by the Health Service and Local Government Ombudsmen. Focusing on investigations into the deaths of the six individuals in previous reports, it calls for an urgent review of health and social care for people with learning disabilities. The report revealed:

   1.4.1   Significant and distressing failures in service across health and social care;

   1.4.2   One person died as a consequence of public service failure. It is likely the death of another individual could have been avoided, had the care and treatment provided not fallen so far below the relevant standards;

   1.4.3   People with learning disabilities experienced prolonged suffering and poor care, and some of these failures were for disability related reasons;

   1.4.4   Some public bodies failed to live up to human rights principles, especially those of dignity and equality; and

   1.4.5   Many organisations responded inadequately to the complaints made against them which left family members feeling drained and demoralised.

1.5   The Ombudsmen make three key recommendations. Two recommendations concern the role of the regulators of Health and Social Care organisations in relation to the provision of services to people with learning disabilities and the role of the Department of Health in promoting and supporting the implementation of the report.

1.6   The third recommendation and the one of particular relevance to the Tavistock and Portman NHS FT indicates that all NHS and social care organisations in England should review urgently and report accordingly to those responsible for the governance of those organisations within 12 months for:

   1.6.1   the effectiveness of the systems they have in place to enable them to understand and plan to meet the full range of needs of people with learning disabilities in their areas; and

   1.6.2   the capacity and capability of the services they provide and/or commission for their local populations to meet the additional and often complex needs of people with learning disabilities.

2.   Findings

2.1   Clearly the Tavistock and Portman does not provide acute medical care or in-patient or residential care for individuals with a learning disability but we will be judged on the evidence of our commitment to equity and access to services for people with disabilities; on evidence of the effectiveness and capacity of our services indicated above and on our ability to engage users and carers in the provision and development of services.

2.2   The CQC performance assessment criteria followed on from the 'healthcare for all' report and this indicator sought information from providers about access to healthcare for people with learning disability. It specifically sought evidence around the collection of data and information necessary to allow people with a learning disability to be identified and the arrangements trusts have in place to ensure that the views and interests of people with learning disabilities and their carers are included in the planning and development of services. The additional recommendations from the Ombudsmen's report are unlikely to change substantially our reporting requirements.

3.   Conclusion

3.1   The Board can be assured that the recommendations of the Ombudsmen's report in so far as they apply to the Tavistock and

Portman are covered by our existing performance assessment and report to the Board and to the CQC on Access to Healthcare for People with Learning Disability.   We will be monitoring quality of care to this group of patients, i.e. through the Patient Safety and Risk Work stream reporting to the CQSG, which has within its proposed terms of reference monitoring performance for safeguarding adults and child protection.

3.2   Please see Appendix 1 outlining our action plans and progress report.

Links to Reports referred to above:

http://www.ombudsman.org.uk/improving-public-service/reports-and-consultations/reports/health/six-lives-the-provision-of-public-services-to-people-with-learning-disabilities/11

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_099255

Dr Rob Senior
Medical Director
July 2010

Appendix 1

Performance Assessment 2009/10

Access to healthcare for people with a learning disability

Rationale

Equality in access to healthcare is central to the delivery of healthcare. The Independent Inquiry into Access to Healthcare for People with learning Disabilities, led by Sir Jonathan Michael, published its findings 'Healthcare for all' on 29th July 2008.

The inquiry was ordered following Mencap's 'Death by indifference' report, which told the stories of six people with a learning disability who died while in NHS care. The Inquiry sought to identify the action needed to ensure adults and children with learning disabilities receive appropriate treatment in acute and primary healthcare in England.
Central to the development of these performance indicators is adherence to the Human Rights Act 1998 and the Disability Discrimination Act 1995, to ensure equality of access and equity for all people with learning disabilities and that a human rights approach is adopted by the NHS and that 'reasonable adjustments' are made in the delivery of services to reduce health inequalities.

This indicator will seek to respond to the recommendations made in the Inquiry report for providers, specifically around the collection of data and information necessary to allow people with a leaning disability to be identified and the arrangements trusts have in place to ensure the views and interests of people with learning disabilities and their carers are included in the planning and development of services.

Indicator

Trusts will be assessed on their responses to the following six questions, based on the recommendations set out in 'Healthcare for all' (2008) – the Independent Inquiry into Access to Healthcare for People with learning Disabilities.

For each question, a response of 1 to 4 is required depending upon the extent to which plans and protocols are in place and are fully implemented for all aspects of each question.

Note : *This indicator will not be included in the scored assessment for 2009/10. However, trusts will be expected to collect the requisite information and report on it separately and we will publish this along side the results of the review to ensure visibility.*

The scoring guide for question 1, 3-6 is as follows:

(1) = Protocols/mechanisms are not in place.
(2) = Protocols/mechanisms are in place but have not yet been implemented.
(3) = Protocols/mechanisms are in place but are only partially implemented.
(4) = Protocols/mechanisms are in place and are fully implemented.

Scoring guide for question 2 is as follows:

1. Accessible information not provided
2. Accessible information provided for one of the criteria
3. Accessible information provided for two of the criteria
4. Accessible information provided for all three of the criteria.

Action plan and progress report Dec 2009 following meetings between Governance and LD leads

Criteria for Asses to healthcare for people with a learning disability	Score (1-4)	Evidence	Assurance
1. Does the trust have a mechanism in place to identify and flag patients with learning disabilities* and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	4	o We operate a specialist LD service for both adults and children, and receive direct referrals to the service , referrals will contain some LD information ,see referral pathway diagram o Learning Disability information is collected routinely for all CAMHS patients from Nov 09, this is as part of the assessment process conducted by clinicians with patients and parent/carer o We receive direct referrals to the LCDS service where LD information is provided as port of the referral, we reassess this at the assessment phase of contact for all patients accepted for assessment o In November 2008 the LCDS held a conference on the theme of what limits access to adequate services for people with learning and complex disabilities. This conference was well attended, including staff and trainees from the	o Referral administrators can confirm that direct referrals to the services are received and reviewed by clinical teams, see diagram referral pathway.doc o Case note review would show that LD information is recorded when relevant o Referral letters and assessment documentation within the patient record o Contact Maxine Dennis and Lynda Miller re raising LD issues in adult and adolescent services respectively. o Elisa Reyes-Simpson can provide details of the Nov 2009 conference

		Trust directorates, and examined ways in which access for this patient group could be facilitated o The LCDS runs a twice monthly clinical workshop which is open to all clinical staff in the Trust. The workshop offers the opportunity to examine and explore issues pertinent to patients who have learning/ complex disability o LCDS offer consultation to clinicians from all directorates o MOSAIC team presented their work to the Child & Family directorate	o Elisa Reyes Simpson can provide details of clinical workshops o Nancy Sheppard can provide details of MOSIAC team presentations o Elisa Reyes Simpson can provide confirmation of advisory service to clinicians
2. In accordance with the Disability Equality Duty of the Disability Discrimination Act (2005), does the trust provide readily available and comprehensible information** (jointly designed and agreed with people with	3	o The Trust commissioned some advisory work from People First to help us improve our literature and other arrangements for patients with LD, as a result of this work new documents have been produced and there is an ongoing piece of work arising from the consultation with the reception and front of house staff, see attached documents. 📄 Complaints leaflet.doc 📄 Information for Patients.doc 📄 Tavistock leaflet.doc	o Recommendations from the People First review group have been put into practice 📄 recommendations from consultation2.do 📄 Response from Estates Team.doc

learning disabilities, representative local bodies and/or local advocacy organisations) to patients with learning disabilities about the following criteria: • treatment options (including health promotion) • complaints procedures, and • appointments			

3. Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities, including the provision of information regarding learning disabilities, relevant legislation*** and carers' rights?	3	o Learning Disabilities team have agreed mechanisms to support families, it is integral to the way that the service is delivered.	o A review of records will show this to be the way that the service operates. The trust does not have a written procedure describing how this is to be carried out in practice as this will be according to the specific needs of the patient
4. Does the trust have protocols in place to routinely include training on learning	3	o Mandatory inset training days (every staff member has to attend at least one every 2 years) includes Disability Awareness Training including presentation about vulnerable Adults by a member of the Learning Disability	o INSET and Clinical Audit INDUCTION programmes o Elisa Reyes Simpson can provide details of other training conducted throughout the year o The Mandatory training matrix included Vulnerable Adults training and this includes persons with a LD, within the staff

disability awareness, relevant legislation***, human rights, communication techniques for working with people with learning disabilities and person centred approaches in their staff development and/or induction programmes for all staff?		Team o During the Induction Day presentation, Elisa Reyes-Simpson makes a presentation, not solely as a member of LCDS, but as the Trust Advisor on Vulnerable Adults o Training for team managers, on annual basis, on Disability Awareness o Regular one-to-one consultations for front-line staff from senior Learning Disability team members regarding specific L D patients as necessary	training policy (most up to date policy attached) o Recommendation from People First will prompt the |trust to purchase a specific training video for INSET in 2010/11 vulnerable adults July 2008 final.doc vulnerable adults July 2008 final.doc Clinical Induction Day Programme 2009 FIN. INSET prog Oct 2009.doc
5. Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups and other	2	o The Trust invites all patients (Including LD patients) to be members of the trust o in 2009-10 there was no LD representative on the PPI committee but as a result of the People First project there will be a representative from April 2010 o we have a voluntary sector rep as a Trust Governor	o Application to Trust membership available to all (but currently we do not have information written in a simple format in relation to membership) o Our PALS service was directly involved with People First who are helping us to improve our access

relevant forums, which seek to incorporate their views and interests in the planning and development of health services?			
6. Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? (1-4)	3	o The LD have a team meeting weekly during which cases are audited and reviewed, it is core to the way the department works o The Trust seeks feedback from patients including patients with LD and these are reported in our annual PPI report which is available via the trust website o	o Elisa Reyes Simpson an provide details of the Friday clinical meetings o PPI information on Trust website: http://128.86.238.87/sites/default/files/PPI%20recent%20activity.pdf o http://128.86.238.87/Patient%20and%20public/involvement-strategy o

Definitions

* Learning disabilities (Valuing People, 2001) include the presence of:

1. A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
2. A reduced ability to cope independently (impaired social functioning);
3. which started before adulthood, with a lasting effect on development.

**As described in the Mental Capacity Act (2007), organisations should take 'all practicable steps' to present information in a way that is appropriate to the person's circumstances.*

****To include the Mental Capacity Act (2007), the Disability Discrimination Act (1995) and the Carers Act (1995)*

Data source and period
Care Quality Commission special data collection (as at 31st March 2010)

Board of Directors : July 2010

Item : 10a

Title : Safeguarding Children Policy

Summary :

The Safeguarding Policy and Procedure has been reviewed and updated to ensure that it is in line with current legalisation and practice.

The basic principles within the policy have not changed however further explanation and detail has been added to the earlier version.

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 *(unless external requirement to update earlier)*

Contents

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.
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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** (aged13 – 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 Disciple 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

<table>
<tr><td colspan="2">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:</td></tr>
<tr><td>1. concern about missing a treatable disorder</td><td>7. uncertainty about when to mention suspicion, what to say to parent(s) or carer(s) and what to write in the clinical file</td></tr>
<tr><td>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</td><td>8. losing control over the child protection process and doubts about its benefits</td></tr>
<tr><td>3. discomfort of disbelieving, thinking ill of, suspecting or wrongly blaming a parent or carer</td><td>9. child protection processes can be stressful for professionals and time-consuming</td></tr>
<tr><td>4. divided duties to adult and child patients and breaching confidentiality</td><td>10. personal safety</td></tr>
<tr><td>5. understanding the background and reasons why the maltreatment might have occurred,
especially when there is no perceived intention to harm the child</td><td>11. fear of complaints, litigation and dealings with professional bodies</td></tr>
<tr><td>6. difficulty in saying that a presentation is unclear and there is uncertainty about whether the presentation really indicates significant harm</td><td>12. fear of seeking support from colleagues</td></tr>
<tr><td colspan="2">(See When to Suspect Child Maltreatment, July 2009, page 16)</td></tr>
</table>

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.

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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 Confidential information 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

(See London Child Protection Procedures, 2006).

6.2   Tasks Usually Undertaken by Children's Services

6.2.1   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.

6.3   Tasks for Trust Professionals

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

6.3.2   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.

6.3.3   Prepare reports for Child Protection Initial and Review Conferences.

6.3.4   Requests or Court Directions for court reports should always be discussed with Case Co-ordinators and Team Leaders

6.3.5. 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.

6.3.6   To assist and participate in any Serious Case Review or Child Death Review processes conducted under the auspices of a Local Safeguarding Children Board.

6.4   Out of Hours Advice

6.4.1   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.

6.4.2   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.

6.4.3   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.

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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 criminal 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).

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

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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 has 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 portering 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.

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. 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.

15.1   Review of Training as Part of Annual Performance Review

15.1.1 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.

15.2   Transfer of Previous Training

15.2.1 Staff who have previously worked in health and social services 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 CP concerns to ensure that the 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 E**.

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://www.londonscb.gov.uk/files/2010/procedures/london_cp_procedures_v.3__15.02.10.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, 2007
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)   24
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)

2.98 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.

2.99 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 (see Chapter 4).

2.100 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.

2.101 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

2.102 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.

2.103 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*[45] and *Child Abuse and Neglect: the Role of Mental Health Services*[46] and SCIE Guide 30[47].

2.104 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.

2.105 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 on CAMHS who would need to be involved in decisions about accommodation, care and facilities for education in hospital.

APPENDIX B

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 C

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

- Behavioural, emotional and social difficulty

C

- 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

- MAPPA (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 D

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 follwoed 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 <u>is</u> 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 completed …………………reviewed and updated 20.6.10

Signed …………………………………………………..

Print name ………………E Jane Chapman

The Tavistock and Portman NHS

NHS Foundation Trust

Draft Student Disabilities Policy

Version:	Five
Approved by:	Management Committee
Date Approved:	July 2010
Name of originator/author:	Obi Maduako / Carolyn Cousins
Name of responsible committee/individual:	Trudy Klauber
Date issued:	July 2010
Review date:	*Usually 2 years from issue, may be annual if a 'fast moving area'*

Note ratification is for the Board of Directors Management Committee can approve documents, Board of Directors Advice on approval process available from the Governance Team (PatKey/Jane Chapman)

Contents

Section		Page
1	Introduction (*reasons for the document, may refer to requirement, legislation and Trust commitment to address the issues of the document*)	1
2	Purpose *(what risk/objectives does this policy procedure seek to address)*	1
3	Scope (to whom does this policy/procedure apply)	1
4	Definitions (provide a table of core definitions/acronyms that are used the document)	1
5	Policy statements (if relevant)	
6	Duties and responsibilities (by job title)	
7	Procedures *(detail procedures relevant to the document (this may also refer to detailed procedures, flow charts etc that can form appendices to the document)*	
*8	Training Requirements *(training not relevant to all polices and procedures)*	
9*	Process for Monitoring Compliance with the Policy (**Note** this section MUST be completed for all policies and procedures)	
10	Equality Impact Statement *(summarise the position and refer to form in the appendix)*	
11	References *(to include core list of references to support the policy/procedure)*	
12*	Associated documents *(list all related policies and procedures)*	
*	Appendices *(remember many policies and procedures can be made simpler for use by inclusion of flow charts etc.)*	

1	Introduction

The Tavistock and Portman is committed to promoting full participation of disabled students in all aspects of the academic and social life of the Trust. We aim of implement a process of ongoing review and development of this policy in a manner which promotes full inclusion of students and staff with disabilities.

The Trust recognizes its obligations under the Disability Discrimination Act 1995 (DDA) as amended by the Disability Discrimination Act 2005 and is committed to making anticipatory and reasonable adjustments in the provision and delivery of education and training.

The Trust is currently in the process of developing a Single equalities scheme which will include and action plan to promote equality for all students with a disability.

2	Purpose

This policy articulates and outlines Trust policy for managing the needs of students with disabilities in order to ensure they receive and achieve a positive learning experience throughout the duration of their stay at the Trust.

This policy is intended to meet our obligations under the equality legislation and to ensure we provide a safe, effective and positive working and learning environment for the delivery and receipt of education and training.

3	Scope

This policy applies to all applicants and existing students attending the Tavistock and Portman NHS Foundation Trust on Trust premises. It does not apply to applicants or students attending programmes of study in outlying centres. The Trust will seek to encourage outlying centres to implement a Disability policy.

4	Definitions

The Trust adopts the definition of disability in the Disability Discrimination Act 1995 as a 'physical or mental impairment which has a substantial and long-term adverse effect on the ability of carryout normal day-day activities'.

5	Duties and responsibilities

5.1 Student Lead Disability Officer

The Trust has appointed a Student Lead Disability Officer (SLDO) who has operational responsibility leading on issues relating to student disability across the Trust. This lead is accountable to the Assistant director

education and training and the Dean of postgraduate studies who has strategic responsibility for Student Disability issues across the Trust. The Trust seeks to encourage students with disabilities to declare them and to contact SLDO for support.

The SLDO will be responsible for communicating and ensuring appropriate staff particularly OTs and CAs will receive information about particular requirements of disabled students in a clear and timely manner.

The SLDO has responsibility ensuring the Trust Library and Course Organising Tutors are routinely notified within 28 days of the arrival of a disabled student.

5.2   Assistant Director Education and Training
The Assistant Director Education and Training will monitor this policy on an annual basis. Information about the effectiveness of this policy will be gathered and monitored through the Trust student feedback process.

The Assistant Director Education and Training has a duty to report outcome of monitoring and evaluation of this policy to the Dean of postgraduate studies who will communicate outcomes to appropriate Trust committees.

6	**Procedures**

6.1   This policy aims to address the needs of all students with visible and invisible disabilities whether declared or not.

6.2   Environment
The Trust is committed to the systematic review and improvement of physical access to our premises. The Trust system of ongoing review and maintenance will be communicated widely and will seek not to create new barriers. This will include consultation with disabled users. Where facilities are not accessible we will endeavour to make appropriate arrangements which meet the needs of the user.

6.3   Access to facilities and support
Students with disabilities will have access to the same range of support services as are available to their non-disabled peers. We will ensure that there is a designated member of staff to provide advice and support to disabled applicants, students and to staff who work with them.

Although the Trust endeavours to make all its buildings accessible to wheelchair users, there remain facilities which are inaccessible.

The SLDO and Assistant Director will undertake annually a review and identification of barriers to academic support services including consultation of disabled students on their access requirements for education and training services.

6.4   Information for applicants, students and staff

All publicity, course details and general information will be offered in accessible formats with sufficient time to allow for modification into alternative formats where necessary for familiarisation by students.

All publicity, programme details and general information will describe the opportunities available for disabled people to participate in the activities offered and the support available to enable maximum inclusion in these activities. This will include a review and revision of all course materials and texts to ensure course information is clearly included and Organising tutors are advised of alternative delivery of courses where necessary.

6.5   Taster Events

The Trust will meet its statutory and legal obligations to members of the public and potential applicants attending taster events and promotional learning activities. Members of the public and potential applicants are encouraged to inform staff in the Department of Education and Training or the lead contact for the event or interview of any individual requirements prior to the event. This allows staff to make suitable/appropriate arrangements to address the access needs of the individual.

6.6   Admission Criteria

The Trust offers a range of postgraduate course and Continuous Professional Development activities. It will seek to make explicit and transparent the process and criteria for admitting students on its programmes. The Trust will endeavour to ensure that such criteria and processes for admitting students do not create unnecessary barriers to disabled applicants and students.

6.7   Selection of students

Offers of a place of study at the Trust are made on academic merit. The Trust will ensure equitable consideration of all applicants in selection and admission of students.

Applicants are encouraged to disclose their disability on application to the Trust. This disability information will be removed from application forms prior to interview. This is in order to ensure student disability information does not inform admission decisions.

Where an applicant has declared a visible disability on the course application form, the student will be contacted by the Course Administrator (CA) to ascertain what reasonable adjustments can be made before interview. Students will be asked to communicate any access requirements to the CA or SDLO.

Trust Organising Tutors (OT) are required to communicate the outcome of all interviews directly to the CA and not directly to the Student. All interview decisions will be communicated to the student in writing by the CA, authorised by the OT.

6.8   Admission of Students

After interview but prior to communication of admission decisions to the applicant, the disabled applicant study support requirements (where disability is disclosed) should be discussed with the Organising Tutor (OT). This is in order to identify any factors that may impact on our ability to meet the disabled student needs or ensure course completion and the student's ability to access the required support in time for the desired course start date. CAs are required to inform the SLDO where a disabled student has been admitted.

Appropriate training and information about systems and sources of support will be distributed to all OTs, CAs and tutors by the SLDO. In doing so, disabled applicant's support needs will be identified and assessed in an effective and timely manner, taking into account their needs.

Where the Trust has made all endeavours and is unable to make reasonable adjustments, it may very exceptionally reject an application on the grounds of disability on a number of grounds including the nature of the courses delivered by the Trust.

6.8   Enrolment, Registration and Induction

Processes, systems and structures for enrolment, registration and induction of new students (including students APELED) will accommodate the needs of disabled students.

The Trust will enable individual students to disclose their disability and offer them a professional assessment (via our collaborative partners) of their study support requirements, and seek to meet those requirements within a reasonable time period. We aim to undertake a full assessment of study support requirements as soon as possible. Study support requirements identified at this assessment will be met within a reasonable time.

A representative from the Library will be available prior to disabled student admission or at enrolment days to discuss students' library needs with them.

6.9   Learning and Teaching

Students are encouraged to discuss their learning support needs with their personal and organising tutor where possible or directly with the SLDO.

Course specifications will be reviewed to ensure they are inclusive, responsive to student needs, offer maximum flexibility and free of unnecessary barriers to access. All academic support services and guidance will be accessible and appropriate to the needs of disabled students.

Course delivery will take into account the needs of disabled students and as far as is reasonably possible be adapted to accommodate their individual requirements. This will include a review of course specifications to ensure they are responsive to student needs, offer maximum flexibility and are free of unnecessary barriers.

The Trust will ensure that wherever possible, disabled students will have access to academic materials and placements that adequately support their learning and support needs.

Additional curricular materials will be provided to disabled students on request or where already noted by the tutor. In terms of providing lecture notes, these will be provided where deemed appropriate.

6.10 Assessments and Vivas
Assessments policies, practices and procedures will provide disabled students with opportunities equal to those of their peers to demonstrate the achievement of learning outcomes. Where study or assessment is negatively affected as a direct result of a disability-related cause, we will make reasonable adjustments to ensure the academic progress of the student is not unjustifiably impeded.

Where the disabled student is attending a Viva, arrangements to accommodate the needs of student will be made by the CA in consultation with the particular student.

6.12 Quality assurance and course validation and review
All quality assurance procedures will require evidence of provision made in all courses to ensure full participation in all aspects of teaching and learning for students with disabilities, and the annual monitoring of this provision.

6.13 Associate centres
Providers in associate centres will be advised to provide their own policy which should be consistent with the Tavistock and Portman policy in relation to all students and applicants enrolled on courses franchised to Tavistock and Portman.

6.14 Overseas students and applicants
Applicants declaring a disability will be invited and enabled in consultation with staff to assess and identify their study support requirements.

Prior to offering a place to the student, we will endeavour to advise the student of an estimate of the cost of the support required, possible sources and procedures for securing this support, the contribution we may make to the cost and alternative sources of funding.

6.15 Promotion of Disability
It is the duty of the SLDO to ensure the needs of disabled students are met from the point of admission to completion of their programme at the

Trust. This duty will also include actively promoting disabled support to students through a range of communication mediums including 'Moodle'. The SLDO will also have a duty to ensure all staff in the Trust is made aware of their statutory obligations to disabled students through a range of communication mediums including the Trust intranet and newsletter.

6.15 Library and learning resources

The Special needs librarian has responsibility for supporting the needs of disabled user from admission and throughout their stay at the Trust.

The Library has a duty to provide equitable access to resources and a range of services for disabled users. Details of library services must be made available to disabled students on enrolment.

All students with a declared disability must enter into an agreement with the library following which a *Library support certificate for disabled students* will be issued. This agreement will set out details of disabled student access to library services.

The Library encourages early notification of student support needs to ensure such additional aids or adaptations are in place.

The Library will canvass disabled students' views through annual surveys as well as less formal channels so as to enable improvement of the service it delivers to disabled students services.

6.17 Emergency Evacuation
`   Trust policy for emergency evacuation will be distributed to all staff and students and offered in accessible formats. The policy for emergency evacuation will be revised in light of systematic and regular practice, monitoring and review of the procedures identified in the policy.

7.	**Training requirements**

Trust wide induction and other relevant training will include disability awareness/equality and training in specific services and support.

All staff including Course Administrators (CAs) and Organising tutors (OTs) will be required to undertake appropriate disability awareness/equality training. This will include regular awareness training.

8.	**Process for monitoring compliance with this policy/procedure**

8.1 Monitoring and evaluation

We will monitor student applications, admission, academic progress, and patterns of impairment presented by disabled students.

We will monitor the effectiveness of our provision for students with disabilities, identify opportunities for enhancement and ensure modification of practice including complaints on an annual basis. Outcomes will be

communicated Trust wide and to students on our electronic communication systems including our website and Moodle.

8.2 Student Feedback

The Trust is committed to considering feedback from students with disabilities in implementation of mechanisms which enable a positive learning environment and experience for disabled students.

8.3 Data management

In order to maintain accuracy of data and information on disabled students, the library has a duty to exchange of details of disabled students who declare themselves to the library within 7 days of this information being made available to them. Similarly DET will provide the library with details of all students who declare a disability within 28 days of the student accepting a place on the Trust course or as soon as it is made known to the SLDO or the CA.

8.4 Data Protection Act

Appropriate records will be kept on all students with disabilities in line with Data protection Act. All matters relating to disabled students will be managed confidentially by the SLDO, CAs and all staff who come into contact with this information.

8.5 Annual Review

This policy will be reviewed annually and action plans developed to improve it.

9.	**Equality impact statement**

This policy has been screened using the Trust's Equality Impact Tool and has been found not to discriminate against any group of persons. The EQIS is shown at Appendix 1

10.	**References**

This policy is informed by the Disability Policy of our collaborative partners, University of East London and University of Essex.

11.	**Associated documents**

The Tavistock and Portman NHS Foundation Trust

EQUALITY IMPACT ASSESSMENT

FORM ONE – INITIAL SCREENING

Name of policy

Policy, function, or service development being assessed: Draft Student Disabilities Policy

Name of person carrying out the assessment: Carolyn Cousins

Please describe the purpose of the policy, function or service development. This policy articulates and outlines Trust policy for managing the needs of students with disabilities in order to ensure they receive and achieve a positive learning experience throughout the duration of their stay at the Trust. This policy is intended to meet our obligations under the equality legislation and to ensure we provide a safe, effective and positive working and learning environment for the delivery and receipt of education and training.

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

YES (*go to Section 5.*)

NO 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:

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

NO – specifically designed to overcome adverse impacts and outline our responsibilities to do so

If YES, which groups may be disadvantaged or experience adverse impact?

Age – especially younger and older people YES / NO

Disability – people with impairments YES / NO

Gender – women, men, transgender people YES / NO

Race – people of different ethnic groups YES / NO

Religion and belief – people of different faiths and beliefs YES / NO

Sexuality – especially lesbian, gay, and bisexual people YES / NO

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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)

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: Low

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 some 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

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

Medium......... (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)

N.B. A rating of 'High' negative / adverse impact' means that a Full Equality Impact Assessment should be carried out (see Form Two)

A rating of 'Medium negative' or 'Low' positive impact may mean that further work has to take place, especially where the policy, function, service development is designed to promote equality of opportunity

Date completed 1st April 2010

Signed ....

Print name Carolyn Cousins ....

Board of Directors : July 2010

Item : 11

Title : Service Line Report – Developmental CAMHS

Summary:

This paper describes the activity, areas of growth and potential areas of risk for the developmental service line in the child and family department.

For : Discussion

From : Associate Clinical Director, CAMHS Developmental
            Service Line

Service Line Report – CAMHS Developmental

1.   **Executive Summary**

1.1   The service line consists of five teams that between them provide a generic CAMH service for up to 24 contracts, specialist autism and learning and complex disabilities work, the parents and carers consultation service and a community based drug and alcohol service for young people in Barnet.

1.2   **Areas of risk / concern**

    1.2.1   In the current financial climate all contracts are at risk. However, there are contracts within this service line which are more imminently at risk, for example the Commissioner for the London contract has already stated that this contract is likely to be cut by 20% over the next three years. Many of the smaller contracts have increasingly rigorous gate keeping procedures in place, which in some cases has led us to under perform on these contracts, putting them at further risk.

    1.2.2   The need to improve productivity whilst reducing costs is a key driver for the teams in the service line. The Trust is in uncertain times financially and adapting to new ways of working, whilst retaining the aspects of our services that set us apart from other CAMH services, will be paramount to our survival.

    1.2.3   The need to ensure that we meet the CQUIN targets, as this puts the uplift as risk as well as the main contract.

1.3   **Proposed action plan**

    1.3.1   The teams are working (with the other teams in the Directorate) on developing more efficient and therefore cost effective procedures for managing clinical care. This work has included looking at referral criteria, care plans, developing systematic review procedures and staff work plans. This work also includes developing effective systems for gathering data required for the CQIN targets.

    1.3.2   The working group has also involved representatives from the currency project and RiO to ensure that any changes implemented are consistent with other current developments and drivers.

1.3.3 It is envisaged that through the work above, clinical time will be freed up within the service line. Any time generated will be used for the following:

    1.3.3.1 Working with Commissioners and local providers to ensure contracts are maintained and that the services we provide are complementary and supportive to local services within each contract area

    1.3.3.2 Seizing new opportunities such as working on developing services where new funding streams are possible. This will primarily be on developing the cross-Trust autism assessment and treatment services, psychotherapy / training within schools service and the children's emotional well-being website.

2. Overview of the Service

2.1 The Developmental service line consists of five clinical teams; two generic CAMHS teams, the learning and complex disabilities service, Barnet young peoples drug and alcohol service and the Parents and Carers Consultation Service. This service line does the majority of work on our main contracts in C&F (excluding Camden) such as Haringey, Barnet, Islington, Enfield as well as other smaller contracts.

2.2 Team two is a multidisciplinary team that takes its referrals primarily from Barnet. It has 3.6 WTE staff (with additional resources from trainees). Referrals come into the team through the central intake system in the department. Barnet is in the process of developing a single point of entry system. Fortunately owing to the experience gathered through developing the SPE in Camden and the good working relationship the CAMHS director has established with the CAMHS commissioner in Barnet, we have been asked to take a central role in developing this SPE.

2.3 Team three is a multidisciplinary team that takes its referrals primarily from Haringey. It has 4.2 WTE (with additional resources from trainees) and also houses the department's autism service for children. Haringey now has a single point of entry, so Haringey referrals go straight into the team from this single point. Haringey struggles to meet the need for CAMHS within borough so we typically over perform on this contract.

2.4 The Learning and Complex Disabilities Service is a multidisciplinary team that takes its referrals directly and is funded through the

London Contract for specialist services (a contract shared with the Portman Clinic). It consists of 2.9 WTE (with additional resources from trainees) and its services are unusual in that they span the full age range.

2.5 Barnet young peoples drug and alcohol service is a specialist community service that has been commissioned to provide universal, targeted and specialist drug and alcohol education and treatment services in Barnet. It has been commissioned by the LA, and given the likelihood that all children's services will eventually be LA commissioned; this is a key development for the service line.

2.6 The Parents and Carers Consultation Service. This is a trust wide service (but with currently no resources from the Adult Department). It is a very small team with 0.4 WTE and the team struggle to taken on any developmental work alongside clinical work.

2.7 There are a number of smaller service development areas in the service line such as the New Rush Hall project (which is a commissioned child psychotherapy clinical and training service) in a school and the link with the Royal National Orthopaedic hospital, where we employ then second three sessions of psychiatry and five of psychology.

3. **Activity Data**

3.1 The activity data is from 1st April 2009 to 1st April 2010. During this time the following numbers of cases were seen:

	No. of new cases	No. of appointments		Referrals received 1st April 2009 – 1st April 2010
		ATT	DNA	
Autism	8	974	33	10
Team 2	54	1569	155	58
Team 3	43	2072	128	67
LCDS	35	862	74	46
PCCS	11	52	4	13

3.2 The Barnet service is commissioned via a contract, and it only came into effect on 1st April 2010. The commissioning will be dependent on numbers of specialist treatment cases, which poses interesting difficulties, as young people are difficult to engage in the standardised treatment that the NTA (national treatment agency) requires. However, we have been working hard to develop local referral pathways and key relationships with local stakeholders and the referral numbers have started to increase.

4. DNA Statistics

4.1 These statistics cover the period 01.01.09 - 31.12.09 (i.e. the last year).

	Team Two	Team Three	LCDS	Autism
DNAs	138	125	96	22
DNA Rate	9.2%	6%	11.6%	2.6%

4.2 In 2009 there were 9 cases that breached the 11 weeks target.

5. Financial Situation

5.1 The service line income is around £1.7m. All the contracts have now been signed and the majority of the contact income is secure for the year (with the CQUIN funding being dependent on achieving specific targets). The service line has additional targets for court work and autism diagnosis training.

6. Clinical Quality

6.1 High quality supervision of case work is embedded in the culture of the Trust, where reflective practice is a given. The team leaders are members of the service redesign group where systems to ensure the quality indicators are met, are being developed.

6.2 The service line has also been working on ensuring that the systems for obtaining the outcome measures are in place across all of the teams.

6.3 The Trust PPI Lead manages this service line, and therefore patient experience data is regularly reviewed across the service line, for example data from the children's survey is fed into the service redesign work. The PPI Committee is in the process of developing the range of methods for obtaining feedback from service users, such as extending the work of the adolescent department in getting the ESQ's completed over the telephone.

7. Complaints, Compliments and Patient Feedback

7.1 There have been no complaints relating to work undertaken in the service line. The team leaders have reviewed the feedback from the patient's survey and the children's survey to ensure that clinicians are aware of the concerns patients have raised generally about clinical practice, so that this can be acted on accordingly.

8. Clinical Governance and Audit

8.1 The annual case file audit was conducted across the department, and the service lines teams participated in this. The concerns raised in the audit have been fed into the service redesign workgroup and are been addressed within the systematic review of clinical work processes.

9. Patient Safety Incidents

9.1 There were no recorded patient safety incidents within this service line over the last year.

10. Service Developments and proposed work plan

10.1 Improving relationships with commissioners and local service providers.

    10.1.1 Our core contracts are dependent on commissioners seeing the value in continuing to commission our services, and on the local services who gate keep referrals seeing a value in working in partnership with our services. This requires ensuring these relationships are given attention and that we are responsive to meeting the gaps in local service provision where appropriate.

10.2 The Trust Wide Autism Service

    10.2.1 Owing to a change in legislation last year (the Autism Bill, 2009) there is a requirement for health providers to provide diagnostic services for adults where there is a suspected social-communication disorder that affects their capacity to access services. Several trusts and organisations have responded by developing autism assessment clinics. We have now trained a range of professionals in autism diagnostic assessment tools, and alongside this are developing a more comprehensive assessment service that not only looks at diagnostic issues, but assesses a range of related issues including a person's mental health. The service is able to provide recommendations for treatment, a range of appropriate treatments and consultation to local services where needed. We are developing information on this service and have started to market it with Commissioners.

10.3 The Schools Based Psychotherapy and training service

    10.3.1 We have a contract with New Rush Hall school (which is an EBD school) in Redbridge to provide training consultation and psychotherapy within the school. This is funded from the school budget. Several other schools have approached us to ask for a similar service, and we are in the process of developing a business plan to extend and promote this work.

10.4 The Children's Emotional Well-being website

    10.4.1 The Trust was given £50k last year to develop an emotional well-being site for primary school children. This fits well with the current drivers (e.g. Public Service Agreements) for promoting emotional health in children and other PCT's have expressed an interesting in commissioning a similar site for their own population. We are in the process of developing a business plan and strategy for promoting and selling this site onwards.

10.5 The parents and carers consultation service (PCCS)

    10.5.1 This is a very small team consisting of three sessions from C&F and one from the Adolescent Directorate. It was originally envisaged that this service would also included adult trained workers, to be able to respond to the growing number of referrals of adult families and families where the parent has a complex mental health concern. However the Adult Department are no longer in a position to contribute to this service, and now much of its work is subsumed into the already active parent services within C&F and the Adolescent Department.

11. **Any risk issues not mentioned above (e.g. significant additions to the Risk Register)**

11.1 As mentioned the Barnet drug and alcohol service for young people's funding (and the Trust's reputation) is dependent on improving numbers of young people from a range of referral sources (including health) and this has required intensive work to develop relationships and partnerships locally, but whilst referral numbers are improving, we are have not yet achieved the level the LA requires. In order to mitigate this risk, we have been working very closely with the Drug & Alcohol commissioner and performance lead so that we can identify issues and develop appropriate action plans in response.

11.2 The current financial context is very uncertain, particularly in relation to contracting arrangements. We will need to be ready to seize opportunities in changes to service delivery and commissioning as and when they occur across all contracts.

Board of Directors : July 2010

Item : 12

Title : Training Services Report

Summary :

This paper sets out:

- Financial position

- Protecting contracts, recruitment indicators and other risks

- Development of the training strategy to date

For : Discussion

From : Dean

Training Services Report

1   Introduction

1.1   The NHS White Paper published on 12th July 2010 involves major restructuring with a reduced role for PCTs and, specifically in relation to education commissioning cuts in the budgets of SHAs. It is not clear, for the long term, whether SHAs will retain responsibility for education commissioning or what options will be considered.

1.2   The Trust has always ensured good relationships with all its commissioners, and, with each restructuring, has succeeded in establishing links with new commissioners in changed-structures. There is always a risk with large-scale re-organisation, that our national contract could be divided amongst regions (currently SHAs) or that there will be fewer people in strategic health authorities who understand the specialist, high quality services we deliver.

1.3   Public sector cuts, specifically in local authority budgets will be likely to have an adverse effect on funding for training and unemployment will rise in the short-term. Local authorities have in the recent past commissioned small training projects in social services and education, and such funding is likely to disappear in the short to medium term.

1.4   The Trust is in a relatively secure financial position for the current year, but we shall need to work hard to protect contracts and current levels of fee and commission income alongside making detailed contingency plans for the prospect of cuts and reduced fee income in the following year. We are also looking at new markets and new products as set out later in the paper's section on training strategy.

2   The Financial Position

2.1   All four contracts with NHS London have confirmed values for the current financial year as set out in the Finance and Business report in June 2010. (Income: £10.436m, includes London (Continuing Personal and Professional development –CPPD)

2.2   There are small positive changes in the child psychotherapy contract, NHS London CPPD funded training and tuition fee income forecast, including some more overseas students (double UK fee).

2.3   Commissioned training is broadly on a par with 2009/10, as is CPD course income, excluding commissions from NHS London now

reported separately. The Trust has carried over unused management charge income from the CWDC for the Educational Psychology doctorate to fund a half time management accountant and two month handover to the new course director and chair of the consortium delivering the courses in, South and East of England and London (SEEL).

2.4 The impact of the year on year decrease in HEFCE funding (Equivalent and Lower Qualifications fixed reduction) does not affect the overall position for 2010/11 (figures already agreed in Annual Plan). A negotiated increase per student negotiated with UEL, up to £450 per student from £350, when finalised, will compensate the Trust for the cut, as will £115k professional doctorate HEFCE (Research doctorate student numbers paid at £970 per student). The overall figure is £100k down on 2009/10 and we shall need to budget for a further cut in the coming year.

2.5 Preliminary forecasts became forecast actuals in the Annual Plan and are set out below.

2.6 Non-contract training and academic income

Fees			
Academic Year 2009/10 £000		**Academic Year 2010/11 £000**	
Plan	£1,937	Plan	£2,299
Forecast actual	£2.080	Forecast	£2,301
Variance	£0.071	Variance	£ 0.002

Variance in agreed Plan very slightly differs from original forecast

HEFCE		
Academic Year 2009/10		**Notes**
Plan	£586k	
Forecast actual	£602k	
Variance	£16k	Subject to confirmation of final settlement with UEL and Essex

CPD	
Financial Year to date 2010/11 tentative	
Plan	£304k
Forecast actual	£310.5k
Variance	£6.5k

2.7 Non-contract training and academic income

2.8   Recruitment

2.8.1   The forecast for 2010/11 is looking satisfactory. Some courses are traditionally late in recruiting. In CAMHS the Observational Studies course, Psychoanalytic Studies and Applied Systemic Theory are over target, and the new combined pathway Emotional Wellbeing in Children and Families: Interprofessional Practice currently has 32 applications – already over target. The Adult Department is having particular success with Introduction to counselling and Psychotherapy and increased interest in the advanced psychoanalytic Psychotherapy clinical training has led to even more enrolments on the Foundations in Psychoanalytic Psychotherapy. The intercultural psychotherapy stream is also over target. The adolescent Department is on target and also reports satisfactory figures for Consultation and the Organisation.

3   Protecting and Maintaining Contracts

3.1   This is a key strategic objective for the Trust. The SHA has been asked to reduce costs by 50% in a year.

3.2   We are brokering meetings with contract managers to discuss the final academic year figures sent in relation to the national contract and have regular contact with others concerned with CPPD, medical and child psychotherapy contracts.

3.3   The coming year will require full contract performance management reports (Red Amber and Green ratings) on a list of indicators and discussion with the SHA. Local intelligence indicates that the Education Commissioning side of the SHA feels somewhat more protected because there are no different plans for commissioning Multi Professional Education and Training (MPET) currently. Contracts for medical and child psychotherapy trainees (and probably clinical psychology trainees) are likely to be linked much more closely to workforce intelligence on service needs. There could be cuts in medical trainee funding as other trainings demand funding for placement support.

3.4   The Trust's reputation for engagement and quality are both high in NHS London and the Contract totals are relatively small both of which are potential mitigating factors against large cuts in 2011/12.

4   Developing a Trust Training Strategy

4.1   Development of a Trust-wide strategy began with the Annual Plan, has been discussed in the Clinics' Committee, and is being developed in CAMHS and SAMHS with Associate Deans and Directors.

4.2   We have developed an internal structure – appointed two Associate Deans responsible for operational management and delivery, and constituted an Education and Training Executive which meets weekly to replace the Trust Training Committee. Key staff will be invited to these meetings, in addition to which, Associate Deans are working within their own domains with Clinical Directors, CAMHS Director, Heads of Discipline and Course organisers.

4.3   The Education and Training Executive is working at both an operational and a strategic level, and beginning to find structures within which both kinds of work can be done. The New Assistant Director of Education and Training is now feeling more firmly established.

4.4   SWOT

    4.4.1   Strengths

        4.4.1.1   Many strands of a respected Brand

        4.4.1.2   Reputation and quality (Inc. NHS London)

        4.4.1.3   Excellent Feedback

        4.4.1.4   Few competitors

        4.4.1.5   Multiple income sources

        4.4.1.6   Flexible and ready for new opportunities

        4.4.1.7   Loyalty of past students

        4.4.1.8   Confidence in product

    4.4.2   Weaknesses

        4.4.2.1   Perhaps too much reliance on historical products and reputation

        4.4.2.2   Low margin business

4.4.2.3   Business Development responsiveness not built-in specifically for training yet

4.4.2.4   Cross-directorate collaboration is important for shared ideas and coordination in a small trust

4.4.2.5   Relatively weak marketing

4.4.2.6   IT system

4.4.2.7   Don't speak language of outside world

4.4.2.8   Internal / resource capacity

4.4.2.9   Relatively undeveloped evidence base

4.4.2.10   It is difficult for Trust staff, across and within service lines to debate and conclude most urgent priorities and how best to pursue them. The novelty of service line structures has meant more work within, rather than across lines, countered now by CAMHS Education and Training Group and the cross-directorate work of the Associate Dean SAMHS

4.4.3   Opportunities

4.4.3.1   E- and Blended learning

4.4.3.2   Management, organisation and group functioning, coaching, supervision

4.4.3.3   Social care agenda

4.4.3.4   Evidence-based psychological therapies training in partnership

4.4.3.5   To become leaders in BME

4.4.3.6   New Applications of proven model to support and skill a competency-focused workforce

4.4.3.7   International links, Internships as a marketed opportunity

4.4.4   Threats / Risks

4.4.4.1   Reduction of training contract/s – a greater threat for 2011-12 along with reduced funding for medical and child psychotherapy contracts and overall risk

4.4.4.2   Lower recruitment as employer funding reduces and day release is more difficult

4.4.4.3   Accommodation within the Trust

4.4.4.4   How to invest in capacity-building, e.g. e-learning; training trainers in psychological therapies

4.4.4.5   Internal rivalries

4.4.4.6   Financial, quality and value-driven agendas pull in different directions

4.4.4.7   "Sound like" imitation courses could affect our market especially if web-based

4.4.5   Key elements of Tavistock and Portman Training Brand

4.4.5.1   Working within a reliable and close relationship – students and clients

4.4.5.2   Understanding the emotional content of complex task with which people are engaged (use of self) promotes resilience and capacity to reflect in difficult contexts

4.4.5.3   Maintain depth – a theme of developed applications needs to be renewed in areas of experience and knowledge as we focus on continuing to create applications

4.4.5.4   Learning from experience

4.4.5.5   Excellence of brand with the Trust and teaching is gathering evidence/outcome

4.4.5.6   Developmental perspective and attention to the social context

5   Developing the strategy

5.1   Developing new products for existing markets and new markets for existing and new products is clearly a key part of the strategy, the latter suited particularly to e- and blended learning. Applications of clinical expertise are also key as well as maintaining quality and market where possible for existing courses. We need also to look at very small recruitment numbers and agree where to discontinue – a difficult decision across the directorates – where broad ranging products for niche markets have been part of implicit strategy without consideration of margins.

5.2   E- Learning, distance and blended learning strategy is reported separately and is led by Stephen Briggs, Associate Dean SAMHS.

5.3   Evidence-based psychological therapies and training possibilities arising from new clinical services – FDAC, City and Hackney, Monroe, ADOS (Autism diagnosis), are all examples along with our partnership with the Anna Freud Centre (linking with UCL) led by Alessandra Lemma for IPT, DIT and BDT (Brief Dynamic Psychotherapy), and in planning for a School of Infant Mental Health.

5.4   CAMHS is leading on an inter-professional programme which has at least four pathways including one to train CAMHS practitioners.

5.5   The four non CAMHS directorates are using working with the new Associate Dean to look at synergies especially on personality disorder between the Adult Department and Portman who are also creating a forensic training post for the advanced psychoanalytic psychotherapy training (M1).

6   University Partnerships

6.1   There is a commitment to two of our three existing training partnerships, but proportional development of new ideas will potentially involve new ventures with Essex University. UEL Connect is currently offering favourable terms for partnership in e-learning. Our Middlesex University link is for one advanced diploma course where validation, and other administrative fees have risen excessively. However, we have joint appointments in CAMHS for nurses. The original link was important when nurse training was within sectors in London. Our CAMHS nurses hold lectureships at Middlesex where they are valued and contribute high quality teaching.

6.2 AHSC and HIEC will be linked through the mental health stream of UCL Partners and we shall see what training possibilities emerge along with the significance of potential research partnerships and research posts. Some of the psychological therapies joint courses will be validated by UCL

7 Streamlining course administration and organisation

7.1 We are appointing a consultant for three months to look at more developments linked to our new better configured Student Database, QLS. Online applications and and new reporting facilities have already obviated a great deal of manual entering. When online payments come in for CPD and conferences in the autumn further streamlining as well as an impetus to recruitment will be in place.

7.2 We shall use the consultancy to find further efficiencies in administrative practice amongst course administrators and we shall, for the first time, try to look at course organisation and more efficient use of course organisers' time. There are possibilities here for re-directing administrative and organiser time to the development of new projects, the support of new e-learning as it comes on stream and we hope to reduce administrative costs within two years to divert resources to responsive project managers.

7.3 Marketing is under review, and proposals will be ready for widespread consultation in the autumn.

8 Conclusion

8.1 There is much to do in ensuring new structures are established and new working relationships are supported at a time of anxiety about sustaining income from contracts, HEFCE and tuition.

8.2 It is difficult to predict what will happen to our big national contract or to medical or child psychotherapy contracts in 2011-12 but we should seriously consider a cut which could amount to 10% as a planning assumption for contingency planning which will need to begin in September 2010.

8.3 We shall continue to work hard with NHS London and hope that some familiar structures and good working relationships will remain for commissioning and reporting in the coming two years.

8.4 Our strategy needs to be supported by agreed decision-making and authorisation frameworks with clinical directorates. Work is in hand but can be slower than we would wish.

8.5 Overall the new structures are good in terms of responsiveness to the market, but there is less understanding of certain academic and quality requirements.

Appendix 1

CPD Update July 2010

INCOME			
Department	2007/08	2008/09	2009/10
CAMHS SL	£100,731	£208,456	£168,187
Adolescent	£117,977	£122,154	£135,724
Adult	£88,664	£11,481	£24,961
Portman	£6,068	£20,847	£23,427
Total	£313,440	£362,938	£352,299

STUDENT NOs.			
Department	2007/08	2008/09	2009/10
C&F	314	666	464
Adolescent	182	252	344
Adult	197	124	212
Portman	43	102	111
TOTAL	736	1144	1131

NOTES

- C&F income – 2008/09 includes income of c. £40k (c. 80 students) for Under Fives Short Course: which only runs every two years – next is 2011

- 2009/10 figures up-to-date as of 6/7/10, some income still expected for CPD65 and CPD61

- Adolescent and Adult - S5 (approx £70k per year) mainly commissioned as LCPPD from NHSL not included in figures above for 2008/09 and 2009/10

- (Mainly commissioned by NHS London as LCPPD to teams and services created in consultation with managers)

Board of Directors : July 2010

Item : 13

Title : Distance-, E-, and Blended-Learning

Summary :

This paper sets out:

- Context and market assessment for the development of e-learning in the Trust

- Overall strategic considerations and three year strategic plan (2010 – 2013)

- Questions for discussion

For : Discussion

From : Dean
Associate Dean, SAMHS

Distance-, E-, and Blended-Learning

1 The Current Context

1.1 E-learning is developing rapidly across the university / professional training sector, using all the new and developing technologies.

1.2 NHS trusts and local authorities are more reluctant to release staff and pay for backfill which has also encouraged the development of brief modules of online training and education.

1.3 Students and employers expect that they will be able to access training globally and nationally rather than locally and this creates opportunities in the marketplace for organisations with strong reputations in education and training.

2 Trust Level Strategy

2.1 We believe that we can develop new markets with new models of teaching and learning linked to our core values, in addition to ensuring a global reach for video links and our more traditional one-to-one and group teaching model.

3 Market assessment

3.1 Strengths:

3.1.1 Contacts with a global market, and a strong international reputation.

3.1.2 Alumni, nationally and internationally as well as locally are eager to take up CPD and further training opportunities.

3.1.3 Our core training methods can be delivered effectively in both traditional and new ways. This would include in real time (synchronous) and non-real time (asynchronous) methods of delivery. This includes, as key examples, clinical supervision, work discussion / supervision groups, observation seminars, theory seminars, research methods.

3.1.4 Our creative staff group, given time and opportunity, will learn quickly and develop a range of new methods congruent with our brand and mission.

3.2 Weaknesses

3.2.1 The Trust is not known for e-learning and face marketing challenges to establish us in this domain

3.2.2 We are starting from a low baseline in terms of staff skills and knowledge of e-learning and infrastructure needed and strategies for developing these are essential available staff with relevant skills and interest and capacity to be released to train and to develop materials in collaboration with technical experts

3.2.3 It is important to ensure the Trust's IT capacity to support the most up to date and reliable infrastructures for e-learning

3.2.4 We are in the process of developing a business case which will demonstrate the investment required and the margins for delivery of e-learning using the strategy outlined in this paper. We need to examine the robustness of this business case.

3.3 Opportunities:

3.3.1 There are major opportunities for the Trust in delivering an effective e-learning strategy. The key opportunity is opening up new markets, introducing new groups students and potential students to the Trust's training, globally. We need to develop new ways of E-learning that are consistent with our values, aims and quality, enabling the trust to broaden ways in which training can be delivered (in hybrid, blended and alongside more traditional methods).

3.3.2 We are aware currently – and paradoxically – that as public sector is reducing, of some opportunities in the UK and internationally for developing e-learning on a substantial scale.

3.3.3 We can influence thinking about the significance of early developmental experiences and the social context for emotional health and well-being.

3.3.4 We can produce conferences for teaching, research and public health debate online.

3.4 Threats:

3.4.1 Other universities and specialist e-learning providers are geared up to further development, specifically to offset

reductions in HEFCE grant and tuition fee caps by reaching global markets.

3.4.2   Existing markets are threatened for longer courses, and possibly CPD if training budgets and staff release opportunities reduce.

3.4.3   Existing markets are threatened by competition from new providers, even if quality is not yet tested.

4   Strategy

4.1   The Training Executive has already commissioned a project to scope existing resources, skills and staff attitudes, as well as looking at specific needs and timeframe for successful development of e-, distance- and blended-learning in all interested Directorates. The report has been considered in the Training Executive and we have subsequently undertaken further discussions with staff and potential partners (including UEL Connect) in order to develop a three year strategic plan.

4.2   Overall strategic considerations:

4.2.1   The key to success is to aim to develop e-learning from a strong, central core team which will be well informed on the issues and which will follow the detailed 3 year strategic plan outlined below. This base will provide leadership for the organic development of e-learning in the Trust and will work closely with technical expertise in developing products.

4.2.2   The preferred partner initially is UEL Connect, as this will provide the quickest and most efficient starting point. This partnership has many advantages at this point in time: there is already a working relationship in place, discussions to date show compatibility of aims and capacity, and the partnership provides a range of additional benefits including access to staff development courses and other resources with no charge. Longer term partnerships need to be explored in the course of delivering the strategy (see below)

4.2.3   Development should involve cascading expertise and transferable skills from staff working on early and pilot experiences to staff becoming engaged in subsequent phases. Pilots are essential to build a sense of confidence that Trust staff will succeed in this new training world.

4.2.4 Development should be based on continuing evaluation and refinement, through designated e-learning management group reporting to Training Executive, Management Committee and Board if required. The aim will be to authorise a core group to deliver quickly and effectively.

4.3 Specific actions for three years (2010 – 2013):

4.3.1 2010/11

4.3.1.1 Clinical supervision and consultation can be delivered widely through:

4.3.1.1.1 Providing appropriate broadband technologies on Trust computers

4.3.1.1.2 Providing written guidance on ethical and professional provisions of live supervision

4.3.1.1.3 Provision of agreed fees for private individuals, organisationally funded supervision, and small group supervision costs (currently groups are charged around £100 per hour which might be too low)

4.3.1.1.4 Current extent of this in the Trust to be mapped and new projects to begin as soon as possible in September / October 2010.

4.3.1.2 Identify and pilot 2 selected CPD courses (e.g. 10 weeks) to develop in conjunction with UEL Connect for synchronous and asynchronous delivery. These will be entirely new in terms of method of delivery – written and audio-visual materials, including podcasts, video-casts with exercises to be self marked, tutor marked and include both synchronous and asynchronous meetings with tutors.

4.3.1.3 Identify some current, existing main courses for which modules will be developed for delivery by e-learning; undertake developments of such modules and establish / undertake necessary validation processes.

4.3.1.4   Identify and develop potential delivery of some new main courses, establish market potential for these, developing training materials and methods for e-delivery. These can include delivery of theory and research lectures/seminars and discussions, video- / pod-casted delivery of lecture series etc.

4.3.1.5   Identify new projects through scoping potential training commissions – e.g. Government departments, Social care services, Children's and Adult services. Collaborate with Business Development Council on tendering, development and delivery.

4.3.1.6   Establish an e-learning workshop with academic staff (staff joining in line with their involvement) and technology staff presence to ensure staff development and the effective use of time on projects.

4.3.1.7   Explore further partnership links in connection with specific e-learning training as they are developed. There is scope to explore university links to see how these may further our project and provide additional energy and status, e.g. Essex, OU

4.3.2   2011/12

4.3.2.1   Continue to expand delivery of clinical supervision/ groups and small seminars supporting clinicians and researchers.

4.3.2.2   Develop new CPD courses through e learning to expand this market.

4.3.2.3   Begin delivery of selected pilot new main courses and modules on existing main courses.

4.3.2.4   Further develop delivery to new markets internationally.

4.3.2.5   Marketing through international forum / sites linked to training opportunities for qualified clinicians at the Trust – online procedures, application forms, podcast former or existing overseas clinicians training at the Trust.

4.3.3   2012/13

    4.3.3.1   Continue as above.

    4.3.3.2   Begin wider delivery of main courses.

    4.3.3.3   Ensure learning from experience leading to informed decision making, staff and infrastructural developmental processes.

4.4   Supporting strategy

4.4.1   The key development is to ensure that the core e-learning team delivers effective e-learning packages following the strategy outlined above. There needs to be within the core team coordinated, joined up development between teaching/training staff and technological experts. Good links with marketing and effective marketing strategy needs development.

4.4.2   A realistic business case is essential and is being developed within the Trust and include advice from partners e.g. UEL Connect who have experience and can advise on best use of time.

4.4.3   Investment is needed to support the staff and infrastructural development needed to implement this strategy. Income from clinical supervision will be generated more quickly, offsetting the expenses of the wider development which is on a longer time frame.

4.4.4   Supporting structures will need to take account of blips that will occur enabling us to learn from experience in this domain which is new for the Trust.

5   Conclusions and questions

5.1   We are presenting the strategy for e-learning in the knowledge that this is new, we are starting at the beginning and we wish to seek help in refining and developing the strategy. We need help in thinking about a realistic business case.

5.1.1   Are we on the right lines?

5.1.2   Are there aspects we have missed out?

5.1.3   What additional avenues could be explored?

Board of Directors : July 2010

Item : 14a

Title : Board of Directors' Objectives

Summary :

Attached are the 2010/11 objectives for the Board of Directors.

For : Approval

From : Trust Chair

Board of Directors Objectives

Board of Directors Objectives 2010/11

Requirements

Strategy

- Develop the values and vision in order to create an inspiring strategy that reflects the changing environment in health and social care. This will support the delivery and ongoing review of the Annual Plan, which in turn needs to take into account the Trust's scheme of accountability, patient and pubic needs, quality and growth

- Ensure that the Trust continues to focus on the quality of all its services, on the QIPP (quality, innovation, performance and productivity) agenda more broadly, and reflects this in its quality accounts. Our aim is to measure, communicate and develop the quality of the Trust's services; locating outcomes, customer experience and safety at the heart of our work

- Develop our understanding of the potential impact on the Trust of changes in local, regional and national health, social care and education markets; specifically to ensure we work alongside local developments and reconfigurations including strong engagement with the development of UCL Partners and participation in its mental health board

- Build on the annual review of the Board's own functioning to ensure its maximum performance as a unitary body

Operations

- Be aware of and develop the skills of the Trust's staff and Governors in support of the Trust's clinical, training, research and consultancy services

- Promote close working with the Trust's customers, purchasers, commissioners, and university partners with the aim of developing and delivering relevant, high quality services that respond to emerging business opportunities

- Assist the Trust in maintaining, developing and publicising the quality and distinctive contribution of its services

Developing People and the Organisation

- Actively seek and engage with the views of staff and ensure these

views contribute to the shaping and future development of the organisation and its services

- Support the Trust in renewing its approach to succession planning, including the identification and development of talent within the organisation, whilst promoting a high functioning and motivated executive team capable of managing the Trust effectively

Governance

- Develop the relationship between the Board of Governors and Board of Directors, to ensure that they work well together and are both following objectives that complement each other's work

- Support the Governors in developing their accountability to Members and work with the Board to improve patient and public engagement

- Actively seek and engage with the views of stakeholders and Members and ensure they acted upon where ever possible

Performance and Finance

- Ensure that the Trust retains unqualified registration with the Care Quality Commission (CQC)

- Ensure that the Trust retains a Monitor Financial Risk Rating of 3 or above, and a green rating for governance

- Ensure the Trust delivers its accountability obligations to Parliament through Monitor and to Members through the Board of Governors

Special Emphasis for the year

- Performance within year - Ensure that the Trust delivers on the objectives contained within the annual plan according to the timetable set out.

- Productivity – Ensure that the Trust develops and agrees action plans to deliver on the challenging productivity targets for 2011/12 and subsequent years contained within the annual plan, and any additional targets required in relation to changes in the external environment. Ensure that these action plans will deliver productivity in a way that supports and develops quality and safety.

- Customer Relations - Maintain an awareness of the impact on the Trust of changes in the NHS both nationally and locally, and in the Trust's markets more specifically. Ensure that staff work alongside local reconfigurations to the sector's best advantage.

- Developing a Patient, Student and Customer Centred culture - Ensure that the Trust continues to focus on the quality of all its services, locating patient, student and customer experience and need at the centre of all of our work and developments. As a part of this work, ensure that we measure, develop and communicate the quality and outcomes of the Trust's services.

- Members and Governors - Develop the relationship between the Board of Governors and Board of Directors, to ensure that they work well together and are both following objectives that complement each other's work. Ensure that the views of stakeholders and Members are sought, engaged with, and acted upon where possible and appropriate.

Board of Directors : July 2010

Item : 14b

Title : Chief Executive's Objectives

Summary :

Attached are the 2010/11 objectives for the Chief Executive.

For : Approval

From : Trust Chair

Chief Executive's Objectives 2010/11

Overarching Aims

Strategy

- Create an inspiring strategic vision through the delivery and ongoing review of the Annual Plan. This should encompass the Trust's scheme of accountability as a membership organisation, patient and public needs, quality, and growth

- Ensure that the Trust makes appropriate steps to continue developing within what is a very difficult public sector funding environment

- Ensure that the impact of growth and development on the core values and quality of the organisation's services are monitored, and use feedback to guide further development

Leadership

- Lead continued change within the organisation promoting a more outward-looking and responsive attitude, greater customer focus, and a greater sense of commercial awareness

- Develop and lead effective communication within the organisation around key areas of the Annual Plan to ensure that all staff understand the direction of travel and the thinking behind it

- Continue contributing to the development of mental health policy at a local and national level, representing the Trust's perspective and contribution in these areas and supporting the Trust's national profile

Developing People and the Organisation

- Support, motivate and continue developing a high-functioning and motivated executive team capable of managing the Trust effectively, and delivering on key organisational objectives as set out in the Annual Plan

- Create an environment that fosters talent and innovation through personal leadership, development of staff training, and effective communication. In particular:

  o Build on strong and open communications with all staff, encouraging engagement with both vision and strategy

  o Support the development and implementation of the

communications strategy linking PPI, communications, and membership and marketing

- Ensure the Trust's most valuable resource, its staff, are supported and encouraged to achieve their maximum potential at a time of considerable stress

Interpreting and Influencing the Healthcare Landscape

- Ensure that the Trust is in touch with the rapidly changing external environment, and with associated opportunities and potential threats

- Position the Trust within the wider Mental Health context (e.g. other MH Trusts and providers; NHS London; DH) such that its reputation and brand supports its continued development

- Continue partnership work with key all stakeholders, including commissioners and providers to manage risks and develop opportunities for new services development

Developing Effective Partnerships

- Further develop the organisation's local and public accountability through the Board of Governors and Membership, promoting a more active Membership and a greater dialogue between Governors and Members

- Ensure that our relationships with NHS London and with our University Partners are aligned in support of our training and education activity

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

Specific Objectives for the year

Developing People and the Organisation

- Develop the relationship between the CEO and the Chair of the Trust, to the maximum benefit of the organisation and its stakeholders

- Ensure the development and implementation of the new Clinical Quality, Safety and Governance Framework. Gain approval for new structure (**June 2010**); ensure first meeting of CQSG Committee held by **July 2010**. Appoint a Quality Reports lead for the Trust, to support the Trust Clinical Director in her leadership of this area (**September 2010**). Quality to report quarterly to the Board of Directors

- Support the role and use of Patient Experience within the Trust though increasing the establishment of PPI staff and integration of workstream with CQSGC. New member of staff to be appointed by **October 2010**

- Support effective communication between Governors and Members. New staff member with dedicated sessions to be appointed by **October 2010**. Improved solutions in place by **December 2010**

- Undertake review of communications and marketing infrastructure with a view to establishing an integrated marketing department by **Dec 2010**

Interpreting and Influencing the Healthcare Landscape

- Ensure that the Trust engage fully in the NHS London led review of the North Central Sector, influencing outcomes appropriately

Developing Effective Partnerships

- Pursue and develop our involvement with UCL Partners, establishing the Trust as a key contributor to the mental health theme.Trust lead to be appointed by **July 2010** to sit on mental health executive of UCLP

Performance & Finance

- Ensure that action plans to deliver the Annual Plan productivity targets are developed and agreed, contributing to 2011/12 **Annual Plan** without compromising service quality

- Retain unqualified CQC registration

- Retain a financial risk rating of at least 3 and green ratings for governance from Monitor

Board of Directors : July 2010

Item : 15

Title : Swine Flu Update

Summary :

On 1st July 2010, Sir David Nicholson, the NHS Chief Executive, wrote to the CEOs of all NHS trusts asking them to consider the lessons learned from the H1N1 (swine flu) pandemic. Boards were particularly asked to take action now to ensure that the recommendations from a number of reports into aspects of last winter's pandemic were incorporated into their organisations plans.

This paper considers briefly the relevance for this Trust.

For : Noting

From : Medical Director

Swine flu Update

1 Introduction

1.1 The H1N1 pandemic which emerged in 2009 turned out to be a relatively mild illness for most of those affected, though it must not be forgotten that for some people its effects were very serious. Sadly, 457 people are known to have died during the pandemic in the UK as of 18 March 2010. In an independent review of the UK swine flu response, Dame Deidre Hine considered that the overall response from government and the NHS had been proportionate and effective. Considerable uncertainty remains about the nature and severity of next year's influenza outbreak and the possibility of a far more serious pandemic has not gone away.

2 Invitation to NHS Boards from the NHS Chief Executive

2.1 On 1st July 2010, Sir David Nicholson, the NHS Chief Executive, wrote to the CEOs of all NHS trusts asking them to consider the lessons learned from the H1N1 (swine flu) pandemic. Boards of Directors were particularly asked to take action now to ensure that the recommendations from a number of reports into aspects of last winter's pandemic were incorporated into their organisations plans.

2.2 The independent review of the UK swine flu response referred to above was led by Dame Deidre Hine and focused on the UK wide strategy used to manage the consequences of the pandemic, but not the operational aspects of the NHS response.

2.3 Two NHS operational reports have also been produced by the NHS Resilience team and published at the same time as the UK-wide strategic review. These are:

  2.3.1 Report of the swine flu Critical Care clinical group

  2.3.2 Learning the lessons from the H1N1 vaccination campaign for Health Care Workers.

2.4 Implications for this Trust are modest and considered below.

3 Critical Care report

3.1 As David Nicholson indicates in his letter, the Critical Care report builds on the work done during the flu pandemic to increase critical care capacity. The report incorporates key learning points for future surge planning. Most important is the recommended work for

critical care networks, which must be robust and well prepared as the essential foundation of any response to surge in demand. Clearly critical care is not part of the work of this Trust. However we took an active part in supporting our neighbouring acute Trusts including Great Ormond Street in planning meetings during last winter's pandemic and would expect to do so again.

4   Vaccination report

4.1   The Vaccination report includes areas of good practice in encouraging uptake of vaccination by healthcare workers during swine flu.

4.2   The Key Learning Points identified were:

   4.2.1   Flexible and accessible delivery approaches

   4.2.2   Visible leadership

   4.2.3   Effective communications

   4.2.4   The basics of planning, governance and project management

4.3   The Tavistock and Portman was dependent on colleagues in Occupational Health at the Royal Free for arrangements to deliver the vaccine and it was not possible for staff to be vaccinated at the Tavistock Centre. However, uptake of H1N1 and seasonal flu vaccination by Tavistock and Portman Staff showed a substantial increase compared to normal years and was close to the average for Mental Health Trusts. When more details about next winter's arrangement are published, the Medical Director will inform staff of the current advice and arrangements for administering vaccine.

Dr Rob Senior
Medical Director
July 2010

Board of Directors : July 2010

Item : 16

Title : RiO Project Update

Summary :

The RiO project has progressed very well in many areas and we will still endeavour to go live on 1ˢᵗ November 2010. At present, however, the project is one month behind schedule.

An interim assessment of the feasibility of this timetable will be made at the RiO Project board on 20ᵗʰ July. There is a risk that all elements of the project will not be in place by the 1ˢᵗ November. The Management Committee will review feasibility again on 16ᵗʰ September, where final decisions will be made.

The Management Committee is currently prioritising three issues:

- Confidentiality
- Assurance that robust measures are in place so that data quality and good practice do not diminish
- Ensuring full ownership at senior level, across the organisation

It is recommended that the Board of Directors receives a further report on RiO at the September meeting.

For : Noting

From : Medical Director

RiO Project Update

1 Introduction

1.1 From November 2010, RiO will be used for our clinical records, with only supplementary paper files (e.g. to hold longer external reports, children's drawings etc.) being maintained. It will also be the means by which we manage patient administration, support clinical functions such as risk management and safeguarding and provide information for contracting and other internal and external reporting purposes.

1.2 The exceptions are:

1.2.1 The Portman Clinic, who will for a period at least only use RiO as a patient administrative system (e.g. basic patient details, appointments and information required for external reporting requirements)

1.2.2 Stand-alone services, away from our primary sites, which are closely integrated with local health or council systems and hence use local information systems e.g. City and Hackney Primary Care Service use EMIS

2 RiO Progress

2.1 The RiO project has progressed very well in many areas:

2.1.1 There has been good engagement with staff

2.1.2 The Management Committee has agreed proposals for the scope of the RiO implementation and how it will be used

2.1.3 Our approach to training has been finalised and most staff have been booked onto one days training

2.1.4 RiO has nearly been fully configured for our use and data from CareNotes have been mapped to RiO

2.1.5 Plans for IM&T helpdesk and post go live support have been agreed, with a Management Committee decision on additional resources made by the July Board of Directors

2.2 Key elements of the project (primarily defining how we will use RiO) are, however, one month behind schedule. There are several reasons for this:

2.2.1 Staff sickness, with CAMHS clinical lead off for three months and possibly not returning until September

2.2.2 The failure of the model of BT transformation to produce a detailed enough vision and description of RiO use

2.2.3 The lack of an accurate staff list which indicates whether or not staff are involved in clinical work

2.2.4 The difficulties of delivering a very complex, large project in a short timescale with limited resources

2.3 To get the project back on track senior staff involved in the RiO project have had to dedicate significant time to the project over the last month and a half. In the longer term this is not viewed as a sustainable approach.

2.4 The project will still endeavour to go live on 1st November 2010, by very clear articulation and delegation of the remaining, ensuring resources within the team are maximised and enlisting the help and support of other staff within the Trust where appropriate. An interim assessment of the 1st November go live date will be made at the RiO Project Board on 20th July. There is a risk, though, that all elements of the project will not be in place by the 1st November. The Management Committee will review feasibility again on 16th September, where final decisions will be made. The implications of delay will be:

2.4.1 additional resources (to extend the contracts of existing staff)

2.4.2 staff disruption because training will need to be rebooked

2.4.3 Director-level staff involved in the project and Head of Informatics will not be able to fully return to 'day jobs' for longer

2.5 If the entire project cannot go live on 1st November, our task will be to ascertain which elements are critical and ensure that these are completed to a sufficiently high standard.

2.6 The management of the teams work will need to be very tight and there will be no room for slippage on critical path tasks. We will also need full cooperation and engagement with other teams within the Trust e.g. clinical governance and governance.

3   Current Issues

3.1   The Management Committee is currently prioritising three issues:

    3.1.1   Proposals regarding confidentiality need to be agreed at CEO level, taking into account views of the Caldicott Guardian and others.

    3.1.2   The Management Committee needs to be assured that robust measures are in place to ensure data quality / good practice does not diminish (e.g. to identify when data is not entered, or not entered correctly / to an adequate standard and that effective ongoing support and training is in place for staff).

    3.1.3   Ensuring that there is full ownership of the RiO project and related issues at a senior level.

4   Recommendation

4.1   The RiO project reports to the Board of Directors in September.

Board of Directors : July 2010

Item : 17

Title : Tavistock Clinic Foundation Report

Summary:

The Tavistock Clinic Foundation has made changes to its Deeds specifically in the area of Governance.

The Foundation is now in a position to be re-launched as a charity independent of the Trust but working to support the aims of the Trust.

For : Discussion

From : Trust Director

Tavistock Clinic Foundation Report

1.   History

1.1   The Tavistock Clinic Foundation (TCF) was set up in June 1982 with the aim of raising funds towards the prevention and treatment of mental ill health and in particular supporting the aims of the Tavistock Clinic in terms of its roles in clinical work, research, training and consultancy. Once the Tavistock Clinic and the Portman Clinic became incorporated as an NHS Trust, TCF support in principle was not confined to the Tavistock Clinic alone.

1.2   TCF has had a strong and successful record in these fulfilling these aims for example through supporting the creation of the Chair of Child Psychotherapy, supporting various research projects and fundraising for example for the innovative children's website.

2.   Current position

2.1   Over recent years the TCF has moved towards greater independence from the Trust. Changes in TCF deeds were reported to the Board of Directors in March 2010 and the TCF now no longer has a formal relationship to the Board of Directors. To recapitulate the changes:

2.1.1   Chair of the TCF: the Trust Director is no longer ex-officio the Chair of the TCF but is a Trustee

2.1.2   Two trustees to be proposed by the Trust Clinics Committee from the staff[1] of the Trust, although not necessarily members of the Committee

2.1.3   Additional Trustees (up to four) not Trust staff and proposed by current Trustees

2.1.4   Non-voting guests can be invited

2.1.5   Trustees' terms are now for three years renewable

2.2   As at March 2009, the balance of funds was £87,718. Of these £18,135 was held for the Chair of Child Psychotherapy. Examined accounts for March 2010 are not yet available. TCF's policy has been not to hold significant general reserves since the commitment to projects do not exceed funds specifically held for those projects.

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[1] Staff may include those working within the Tavistock and Portman NHS Foundation Trust on secondment from their organisations

3.   Future directions

3.1   TCF is at a point where it could be relaunched as a charity independent of the Trust but working to support the aims of the Trust. There are many areas of our work which could benefit from charitable funding; new initiatives have started in this way, such as the Monroe, which is now a mainstream service. Charitable support would allow us to innovate and extend our ways of working beyond that which is currently commissioned.

4.   Current strategy

4.1   The TCF has been involved in reshaping its strategy with aim of becoming more focussed on supporting fund raising for specific projects. In the current uncertain climate, it is now more important to have a range of options available to raise funds to support the Trust's vision. Current projects in hand include:

4.1.1   A proposed lecture series in partnership with the South Bank Centre

4.1.2   A series of seminars and conference exploring implications of new findings in relation to neuroscience and genetics and their impact on social policy

4.1.3   Young people's well-being centre

5.   Trustees

5.1   Now that the deeds have changed to increase TCF's independence from the Trust, we need to seize this opportunity to include a wider range of Trustees who might offer access to a wider network of supporters of our work and increase our fundraising capacity. Through the Trust Director giving up the Chair, a new chair might be found who could bring new focus and energy to the TCF in support of its aims.

6.   Fundraising

6.1   In the past TCF has benefitted from professional fundraising support. In recent years, it has moved away from this approach and has encouraged staff to come forward with projects around which a fundraising initiative could be developed with the help of some key figures outside the Trust.

7. Title

7.1 There has been on going debate about whether the title should be changed to reflect the wider compass of the charity extending beyond the Tavistock Clinic. In addition, in the minds of many Trust staff, the TCF is somewhere to turn to for financial support and the inclusion of the term foundation may encourage the view that the TCF has funds to disburse. The opposite is the case; as mentioned above TCF does not hold large reserves. Running expenses are high although measures have been taken to reduce costs such as moving to an examination of accounts rather than an audit.

7.2 To date no satisfactory alternative title has emerged.

8. Questions for the Board of Directors

8.1 What is the most helpful role TCF can play in support of the Trust?

8.2 How can we engage suitable trustees?

8.3 How can we approach fundraising for specific projects more effectively?

8.4 Should we attempt to interest the Trust's staff, Governors and Members in TCF?