The Tavistock and Portman NHS

NHS Foundation Trust

Board of Directors

Agenda and papers
of a meeting to be held

2.30pm – 5pm
Tuesday 25th May 2010

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

Board of Directors
2.30pm– 5.00pm, Tuesday 25ᵗʰ May 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**

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. **Quarter 4 Complaints Report**   *(Report attached)*
      (Link to Outcome 17)   *For noting*
      Dr Matthew Patrick, Chief Executive

   c. **Quarter 4 Incident Report**   *(Report attached)*
      (Link to Outcome 4)   *For noting*
      Mr Simon Young, Director of Finance

8. **Risk Management Committee Annual Report**   *(Report attached)*
   (Link to all Outcomes 8, 11, 17, 18)   *For discussion*
   Dr Matthew Patrick, Chief Executive

9. **Clinical Governance Committee Annual Report**   *(Report attached)*
   (Link to Outcomes 2, 4, 9, 12)   *For discussion*
   Miss Louise Carney, Trust Secretary

Corporate Governance

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

11. **Committee Reports & Minutes**   *(Minutes attached)*
                                                        For noting

   a. **Clinical Governance Committee, January 2010**

   b. **Patient & Public Involvement Committee, March 2010**

   c. **Risk Management Committee, January 2010**

Quality & Development

12. **Annual Plan**   *(Plan attached)*
   (Link to all outcomes)   *For discussion &*
      Mr Simon Young, Director of Finance   *approval*

13. **Quality Report**   *(Report attached)*
   (Link to all outcomes)   *For discussion*
      Ms Louise Lyon, Trust Director

Conclusion

14. **Any other business**

15. **Notice of future meetings**
      Friday 28th May: Board of Directors Extraordinary, 11am – 1pm
      Tuesday 8th June: Directors' Conference (Outcomes)
      Tuesday 29th June: Board of Directors
      Tuesday 27th July: Board of Directors
      Thursday 9th September : Board of Governors
      Tuesday 21st September: Directors' Conference (Research)
      Tuesday 28th September: Board of Directors
      Tuesday 26th October: Board of Directors
      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, Thursday 29th April 2010

Present:			
Mr Martin Bostock Non-Executive Director	Ms Angela Greatley Trust Chair	Mr Altaf Kara Non-Executive Director	Ms Louise Lyon Trust Clinical Director
Ms Joyce Moseley Non-Executive Director	Dr Matthew Patrick Chief Executive	Ms Emma Satyamurti Non-Executive Director	Dr Rob Senior Medical Director
Mr Richard Strang Non-Executive Director	Mr Simon Young Director of Finance		
In Attendance:			
Miss Louise Carney Trust Secretary	Ms Pat Key Director of Corporate Governance & Facilities (items 8, 10a & 10b)		
Apologies:			
Ms Trudy Klauber Dean of Postgraduate Ed.			

Actions

AP	Item	Action to be taken	By
1	**6**	Miss Carney to arrange a review of the Annual Plan process	**Jul 10**
2	**6**	Mr Young to present final Annual Plan to Board of Directors in May	**May 10**
3	**6**	Mr Young to circulate Annual Plan text to Board of Directors via e-mail	**Apr 10**
4	**8**	"Essential" to be amended to read "Core"	**Immed**
5	**9**	Ms Smith to prepare note on the process of approving contracts	**Jun 10**
6	**9**	Miss Carney to amend *Register of Directors' Interests* as suggested	**Immed**
7	**10a**	Ms Key to list named link for LCDS	**Jun 10**
8	**10b**	Ms Lyon to investigate McKinsey workshops on quality	**Jun 10**
9	**12**	References to be updated prior to publication	**Immed**
10	**13**	Dr Patrick and Mr Strang to discuss position of Business Development & Investment Committee in new structure	**Jun 10**

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

1. Chair's opening remarks
Ms Greatley welcomed everyone to the meeting.

2. Apologies for absence
As above.

3. Minutes of the previous meeting
The minutes were approved.

4. Matters Arising
Outstanding Action 3 – this was provided in item 13. Outstanding Actions 2 and 4 were being done going forwards

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

Ms Angela Greatley, Trust Chair
Ms Greatley had attended a meeting with Chairs of all NHS trusts held at NHS London. Priorities for London identified included:

- The transfer of community services from PCTs to other services, along with delivery at lower cost;

- Decommission a range of hospital services and getting polysystems up and running; and

- Re-designing services by cutting over-performance

It was noted that many NHS organisations had very large deficits so the issue of surpluses in some trusts was a delicate one.

Ms Greatley had also attended an interesting King's Fund seminar on quality in a cold climate. Dr Patrick noted that the North Central Sector faced a potential gap of up to £355m.

Ms Joyce Moseley, Non-Executive Director
Ms Moseley had attended the Portman Symposium, which had been well-attended.

Mr Altaf Kara, Non-Executive Director
Mr Kara had attended a Civitas meeting at which Bill Moyes had discussed the future of the NHS, including the creation of quasi-markets for provider trusts.

6. Chief Executive's Report

Dr Patrick noted that all PCTs in the North Central Sector had identified their preferred providers. Many PCTs are planning, however, on a more differentiated strategic approach to re-commissioning these services over the coming period.

AP1
Dr Patrick noted that the Annual Plan was broadly similar in direction as the previous Plan. In light of this, the Trust had consulted less with the whole Board of Directors on the detail of the Annual Plan this year, but there was more of a sense of ownership for each Service Line Director. Miss Carney to arrange a review of the Annual Plan process.

Dr Patrick tabled a letter from Monitor regarding economic assumptions for Planning. This letter was not specifically addressed to the Trust, but was aimed at applicant trusts and foundation trusts proposing substantial changes to their organisation, such as acquisitions or mergers.

Mr Young noted that the Trust does not need to present a downside case this year, but that the Plan must reflect the economic situation and be

economically realistic. The Trust Board and Executive felt that the Plan was economically realistic.

AP2
AP3
Mr Young noted that the format would be different this year, and would be submitted in Excel templates. The Plan will be submitted to the Board in May in the templates. Mr Young to circulate text version of the Annual Plan by the end of April.

7.   Finance & Performance

Mr Young noted that the Trust's surplus was £650k, above Plan. The EBITDA was 5.1% of income – the key threshold was 5%. The Trust's overall Financial Risk Rating for 2009/10 would, therefore, be 4.

The Trust had had a good financial year. There were a number of factors responsible for this. The Plan had a contingency of £250k, which was less than 1% of the Trust's income, and which had not been called upon. The Trust had had a rates refund for the previous five years of £100k. There were some variances in the budget – the Portman Clinic had an underspend linked to unfilled vacancies, the Day Unit had overachieved, and TCS had finished the year ahead of budget.

Mr Young explained that the dividend payment was 3.5% of the Trust's average relevant net asset worth – land, buildings, debtors offset by creditors. As the Trust had a surplus in its bank, it was required to pay a lower dividend.

Mr Young explained the depreciation figure included the write off of £90k invested in previous years in two projects, which it was now prudent to write off as an asset.

Ms Satyamurti queried the late good performance of TCS, and queried whether the Trust would still have achieved a Financial Risk Rating of 4. Mr Young noted that the Trust would have been able to use its contingency and still be over or in line with Plan.

Ms Satyamurti queried why the Trust had more cash than predicted. Mr Young noted that as well as the higher surplus, this included deferred income: i.e. money that had been received before 31 March but was allocated to project costs after 1 April.

Ms Satyamurti queried what the Trust could do with its surplus. Mr Young noted that it could be used for capital projects, or other non-recurrent projects, but if it were used to fund routine, recurrent costs this would be likely to lead to difficulties subsequently.

8.   Quarter Four Governance Declaration

AP4
The Declaration was approved, subject to changing "essential" to "core".

9. Corporate Governance Report

The sealing of the contract with City and Hackney PCT was approved.

Mr Strang queried the process for the Trust approving contracts. Mr Young noted that the Business Development and Investment Committee had approved the tender, which had included pricing, amongst other things. Prolonged negotiations had resulted in a good contract. The Board queried why the contract had taken so long to be finalised. It was noted that there were no material differences.

AP5

Mr Strang queried whether the Trust sought or received legal advice on every contract. Dr Patrick explained that the Trust had a very good contracts department. Dr Patrick to request a note on the process of approving contracts.

AP6

Miss Carney tabled the *Register of Directors' Interests*. Miss Carney to include all categories even if there were no returns and to add a footnote stating that the lack of disclosure from a Director meant a nil return.

10. Care Quality Commission Reports

10a. Care Quality Commission Compliance 2009/10

The paper presented the year-end report for approval from the Board of Directors. Ms Key reminded the Board of Directors that the full declaration and evidence was presented to the Board of Directors in November. There had been no breaches in the Core Standards and no new risks had been identified between November 2009 and March 2010. The potential weak areas that had been identified in November had been updated.

The Board of Directors was also asked to approve the scoring cards for Child and Adolescent Mental Health Services (CAMHS) and the Learning and Complex Disability Service (LCDS).

AP7

It was noted that the LCDS was a small team, and a lot of work had been undertaken in a short space of time in order to provide the performance assessment for 2009/10. It was agreed to provide a named Lead for LCDS.

With regard to the CAMHS performance assessment, it was noted that headway had been made with regard to criteria 1, but that a great deal of work was still taking place. With regard to criteria 2, it was noted that it was difficult to undertake outcome monitoring with patients once they had left the service. With regard to criteria 4, it was noted that partnership working in CAMHS was very strong.

Ms Key noted that the performance assessments were internal documents and did not have to be submitted to the Care Quality Commission, but that it was good practice to have evidence to hand as the CQC could undertake an inspection at any time. Mr Kara queried the Trust's state of readiness for an inspection. Ms Key noted that the Trust was confident about the level of

evidence available for 2009/10.

Ms Satyamurti noted that induction figures seemed to be slipping. Ms Key explained that this was a quirk in the data where staff had joined after an INSET had taken place.

Mr Bostock queried the correlation between the evidence and scores. Dr Senior explained that a 4 – full implementation – meant that protocols / mechanisms had been implemented and audited. Partial implementation meant that protocols / mechanisms had been implemented, but not audited.

The paper was approved.

10b. Care Quality Commission Reporting 2010/11
Ms Key noted that the Trust was likely to be inspected every year on one or all of the Essential Standards. Very little notice was given of inspections, and the Trust and all its staff needed to be ready for this. Ms Moseley suggested that the CQC might use "mystery shoppers" to inspect the Trust.

Ms Key noted that the Board of Directors would receive exception reports on Standards. Ms Key invited Board members to make any suggestions for improvement.

AP8   Mr Kara noted that Monitor had commissioned McKinsey to provide workshops on quality. Ms Lyon to investigate.

The paper was approved.

11. Standing Financial Instructions
Mr Young drew particular attention to the increased threshold for quotations.

The Instructions were approved.

12. Scheme of Delegation of Power
Miss Carney tabled the explanatory introduction to the Scheme, which explained the relevance of the colours within the Scheme.

AP9   The Scheme was approved, subject to all references being updated prior to publication.

13. Clinical Quality, Safety, and Governance
Dr Patrick noted that the Trust had undertaken a significant review of its governance processes. The Trust was keen to move away from a committee structure to one based on individual responsibility and accountability. Dr Patrick noted that this would mean that if a Director was responsible for the

delivery on a particular aspect of the Trust's Plan, they would manage the resources necessary to fulfil the Plan and would be accountable to the Management Committee and Board of Directors. Dr Patrick tabled an organisational structure chart.

Dr Patrick defined a sub-committee as a committee created by a primary committee to undertake work that was the core responsibility of the primary committee but for which the primary committee has no time. A sub-committee must be chaired by a member of the primary committee.

The impetus for the review was partly external – creating a structure capable of dealing with the demands and challenges facing the Trust – and partly internal – the desire to create a structure capable of producing the highest quality services.

Dr Patrick explained the structure in Appendix 3, noting the Board of Directors, Clinical Quality, Safety and Governance Committee, and the Management Committee, and noting that other areas listed would not necessarily be committees but were work streams with a named individual with clear responsibility and accountability.

It was noted that the next step was to create Terms of Reference and agendas for the Clinical Quality, Safety, and Governance Committee. The new structure would provide greater clarity about the role of the Board of Directors and its committees and what they are responsible for.

Ms Greatley noted that there was a great deal of work to be done around quality, and the new structure would help facilitate this. Ms Lyon noted that Governors would need to be involved in the Trust's quality work.

Mr Strang raised the issue of committee reporting to the Board of Directors, noting that minutes were not particularly illuminating. It was agreed that Committee Chairs would bring key points to the attention of the Board of Directors under the Committee minutes item.

AP10 Mr Kara queried where the Business Development and Investment Committee fit into the structure. Dr Patrick and Mr Strang (BDIC Chair) to discuss.

The Board of Directors approved the new structure.

14. Any other business
None.

15. Notice of future meetings
Noted. Miss Carney noted that the extraordinary meeting of the Board of Directors to approve the Annual Report and Accounts would be held on Friday 28th May 2010.

Outstanding Action Part 1

No.	Due Date	Agenda Item	Action Required	Director / Manager	Originating Meeting
1	Apr-10	16. Research & Development Report	Ms Moseley to arrange meeting with Dr Kennedy	Joyce Moseley	Nov-09
2	May-10	12. Annual Risk Management Review Report 2008/09	Section on vulnerable adults to be included in future reports	Rob Senior / Pat Key	Apr-09
3	May-10	11. Single Equalities Scheme	Equalities discussion paper to be considered at Equalities Training event	Julia Smith	Jan-10
4	May-10	4. Matters Arising	Miss Carney and Dr Patrick to review scheduling of topics for Directors' Conference	Matthew Patrick / Louise Carney	Mar-10
5	Jun-10	15. Constitutional Amendments	Dr Hodges to return to Board of Directors with a proposal on junior membership	Sally Hodges	Jun-08
6	Jun-10	8. Workforce Statistics	Data audit on turnover data to be undertaken	Susan Thomas	May-09
7	Jun-10	7b. Complaints Report	Student Complaints to be presented annually to Board of Directors	Trudy Klauber	Jan-10
8	Jun-10	14. Committee Minutes	Ms Lyon to present report on honorary appointments to Board of Directors	Louise Lyon / Susan Thomas	Oct-09
9	Jun-10	12. Health & Safety Guidance	Briefing on Health and Safety systems to be presented at Board of Directors' Lunch	Pat Key	Oct-09
10	Jun-10	10. Committee Minutes	Clinical Audit and integrated governance to be discussed at Directors' Conference on Outcomes	Rob Senior	Jan-10
11	Jun-10	11. Single Equalities Scheme	Miss Smith to give consideration to the description of mental health as a disability	Julia Smith	Jan-10
12	Jun-10	9. Care Quality Commission Registration	Essential Standards to be presented to Board of Directors on quarterly basis, beginning June 2010	Pat Key	Jan-10
13	Jun-10	11. Annual Training Services Report	Miss Carney to schedule Board of Directors discussion on branding management in relation to training	Louise Carney	Feb-10
14	Jun-10	14. RiO Project Update	RiO Project to return to the Board of Directors	Julia Smith	Feb-10
15	Jun-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	Mar-10
16	Jun-10	11. Francis Inquiry	Drs McKenna, Patrick, and Senior to consider whether a further report on Mid-Staffordshire is necessary	Caroline McKenna / Matthew Patrick / Rob Senior	Mar-10
17	Jul-10	8. Corporate Governance Report	Mr Strang and Miss Carney to review Audit Committee Terms of Reference	Richard Strang / Louise Carney	Mar-10

Outstanding Action Part 1

18	Jul-10	10. Tavistock Clinic Foundation Constitution Update	Tavistock Clinic Foundation to report to Board of Directors with brief of work	Louise Lyon	Mar-10
19	Sep-10	12. Student Feedback Report	Ms Klauber to undertake cross-organisational benchmarking	Trudy Klauber	Sep-09
20	Oct-10	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-09
21	Nov-10	17. Membership Report	Miss Carney to provide comparative data on membership of foundation trusts	Louise Carney	Nov-09
22	Jan-11	22. Contingency for IT Failure	Internal Auditors to be asked to review policy to confirm it meets the Trust's requirements	Simon Young	Jan-09
23	Mar-11	12. Annual Communications Report	Future reports to reflect links Communications Department has with other Departments	Sally Hodges	Feb-10
24	Mar-11	7c. Capital Budget 2010/11	Future Capital Budgets to be put in context of 3 - 5 year planning	Simon Young	Mar-10
25	As appropriate	13. Estates Report	Ms Key to return to Board of Directors with a timetable for Gloucester House relocation	Pat Key	May-09
26	As appropriate	20. RiO Business Case	Future reports to contain glossary of abbreviations used in report	Julia Smith	Nov-09
27	As appropriate	13. Website Analysis	Communications Department to consider the objectives and priorities of the Trust's website, when data becomes available	Kathryn Tyler	Feb-10
28	As appropriate	6. Chief Executive's Report	Ms Moseley to update the Board of Directors on Catch 22's discussions with Big White Wall	Joyce Moseley	Feb-10

Board of Directors : May 2010

Item : 6

Title : Chief Executive's Report

Summary:

The report covers the following items:

1. The General Election, Health, and Our Services
2. And Finally…

For : Discussion

From : Chief Executive

Chief Executive's Report

1 The General Election, Health, and Our Services

1.1 As you all know the UK now has a Conservative-Liberal Democrat coalition government in power. Andrew Lansley, up until the election shadow Health Secretary, has now been appointed the Secretary of State for Health. Other key appointments include two Ministers of State for the Department of Health, Simon Burns (Con.) and Paul Burstow (Lib. Dem.).

1.2 Independence for the NHS has long been identified as a key element of Lansley's policy for the NHS. It is likely that Lansley will announce that an NHS Board will be formed to take the running of the NHS out of politicians' hands (in a manner similar to the Bank of England) in his first months as Secretary of State.

1.3 The new health secretary in his first days of office made a public commitment that 'the real value' of NHS spending would rise in each successive year of this government. He highlighted, however, that this would not protect the NHS from the need to secure greater annual efficiency savings then those in place at present. The definition of 'real value' is important in understanding this. In this context it is taken to mean ahead of the national rate of inflation. It is widely recognised, however, that the rate of NHS inflation sometimes runs at three times that of the national rate; a result of demographic drift (an aging population making greater demands on the health service), the cost of medical advancement and technology, and pharmaceutical costs. Hence the need for the increased spending 'in real value', even with efficiency improvements.

1.4 Mr. Lansley has also indicated that, having campaigned against local hospital closures, he would ensure that the closure or reconfiguration of hospital services would only be considered where it had been justified by the clinical evidence. In particular he indicated a view that in relation to recent planning there has not been sufficient public involvement or involvement of GPs. Many geographic sectors within London have been looking at the configuration of services and sites with a view to improving the quality of services within a tightening 'financial envelope'. Department of Health leaders have previously suggested that the targeted efficiency improvements can only be delivered by 'whole system changes' – which would be likely to include service configuration – rather than within individual organisations.

1.5 'Outcomes not targets' at this early stage seems to be another key theme driving reforms, with the stated aim of moving commissioning budgets closer to the patient, introducing payments by results for GPs, and putting treatment on a more preventative footing.

1.6 Looking at therapeutic priorities, and of particular relevance to our own Trust, the Liberal Democrats seem to have successfully raised mental health up the agenda. Lansley is, at this early stage, listing it alongside cancer as a priority. Additional earmarked spending on both will be limited, however.

1.7 Public health was also a priority for both parties throughout the election campaign and is likely to remain so. An early sign of this is the plan to rename the Department of Health the Department for Public Health. The Department for Children, Schools and Families has already been renamed the Department for Education.

1.8 So what may this mean for our own Trust? It is clear that the commitment to maintain health funding is positive, as is the emphasis on mental health. The likelihood of increased efficiency targets is also not unexpected. In reality, however, it will be factors at a level below this that have potentially more impact.

1.9 Within the North Central Sector (Camden, Islington, Barnet, Enfield and Haringey) some of the PCTs are having to make very substantial savings in order to return their economies to balance after a very difficult year. In addition, mental health funding is often vulnerable in an economic downturn, in part because it is funded on the basis of block contracting as opposed to Payment by Results (activity). This means that mental health has, historically, had to make proportionately higher levels of saving then acute medicine and surgery (although the rates of inflation tend to be higher within the latter two).

1.10 Finally, there is the balance of our own activity as an organisation. Around 50% of our income is related to Training and Education. Funding in these areas is often vulnerable when money is tight; though this has not had a negative effect on NHS training funding for 2010/11. The University sector is also struggling financially with reductions in funding. Our own HEFCE income will reduce significantly, starting with the reductions associated with changes in the regulations around students studying for equivalent or lower qualifications (ELQ; often the case in those deciding to change career). Lastly, within our clinical services we need to remember that Child and Adolescent Mental Health Services (CAMHS) receive much of their funding through the Local Authorities. Local Authority funding is likely to be harder hit then health.

1.11 We all I think know that significant levels of productivity improvement and efficiencies will be required over the coming period. I have spoken before about our target of around 5% per annum. I think that as best we can judge this figure still holds as a reasonable planning assumption. The challenge for us as a Trust is to achieve this at the same time as developing the quality of our services and our culture.

1.12 On the other side of the balance are the opportunities that current policy and circumstances may create. Our Trust specialises in the delivery of high quality services in areas of national priority, namely the training and education of the mental health and social care workforce, psychological therapies and CAMHS. These latter two, and indeed the training opportunities associated with them, are closely linked to the Department of Health's New Horizons policy emphasising prevention, early years intervention and public mental health. In the coming period it will be important that we are able to demonstrate that our services deliver high quality outcomes, excellent patient experience, and real value for money.

1.13 It is also likely that the trend towards re-commissioning clinical services will continue, again creating new opportunities. In addition the Trust has plans for the development of its training portfolio, including the development of distance and e-learning programmes and the further development of our CPD programmes. In all these areas we will aim to build from our areas of existing strength.

1.14 As a Trust we will need to work even more closely with commissioners, providers, patients and other stakeholders in the development of clinical services for local residents. Working as part of a larger system is essential if the quality of patient services is not to suffer in economically difficult times. We will need to do the same with our commissioners, students, university partners and other stakeholders in relation the development of our training and education portfolio. Working collaboratively is, I believe, key to ensuring that we continue to make a real and significant contribution to mental health, and to maintaining and developing that contribution in all domains of our work.

2 And Finally…

2.1 I am delighted to report that two of our services have been shortlisted for national awards. The Family Drug and Alcohol Court (FDAC) has been shortlisted for the Best Achievement of the Year in Children's Services category in the MJ Local Government Achievement Awards. Our online wellbeing service, delivered in

partnership with the Big White Wall, has been shortlisted in the National eWell-Being Awards in the category of Building Community Networks. Congratulations to all of those involved.

Matthew Patrick
Chief Executive
18 May 2010

Board of Directors : May 2010

Item : 7a

Title : Finance and Performance Report

Summary:

No major variances in 2010/11 income and expenditure have been identified at this early stage.

The cash balance at 30 April was £3,787k. Cash is expected to reduce during this year, but to remain at satisfactory levels both this year and next, subject to achievement of planned income and expenditure.

Income and expenditure, capital expenditure, balance sheet and detailed monthly cash flow projections are presented for approval, to be included in the Annual Plan.

The clinical performance in quarter 4 of 2009/10 is also reported here.

For : Information.
Financial projections for Annual Plan for approval.
Cash forecast 2010/11 and 2011/12 for approval.

From : Director of Finance

Finance and Performance Report

1. External Assessments

1.1 Monitor

1.1.1 Quarter 4 returns were submitted by 30 April. The ratings for governance and for mandatory services are expected to remain green. The Financial Risk Rating is expected to remain at 4.

1.1.2 The 2010/11 Plan should lead to a Financial Risk Rating of 3.

1.1.3 Monitor has introduced some additional targets and indicators in this year's Compliance Framework (pages 45 and 60). We expect to comply with all the indicators which apply to us, except the 99% completeness target for Data identifiers. This indicator is given a weighting of 0.5, and we will retain our green governance rating as long as we continue to meet all other thresholds (page 18, diagram 5). This matter is discussed further in the Annual Plan papers for today's meeting.

1.2 The Care Quality Commission

1.2.1 As reported previously, the Trust has been registered by the CQC for 2010/11 without qualification. This registration replaces the previous rating system; there will be no rating of Trusts on the quality of services for 2009/10.

1.2.2 If the financial risk rating of 4 for 2009/10 is confirmed, this should again lead to a CQC rating of "Excellent" for use of resources and financial management.

2. Finance

2.1 2009/10

2.1.1 The annual report and accounts are due to be presented for approval at the Board meeting on 28 May. The audit is almost complete. At this stage, no adjustments have been made to the primary financial statements; so the surplus remains at £651k as reported last month.

2.2 Income and Expenditure 2010/11

2.2.1 The income and expenditure budget for 2010/11 was approved in March. We are not issuing financial statements for April, but no significant variances have been identified at this point.

2.2.2 Main income sources, and the risks in some areas, are briefly discussed later in this report.

2.2.3 Pay costs in April were slightly under budget overall.

2.3 Income and Expenditure 2011/12 and 2012/13

2.3.1 Significant pressures on NHS finances are expected in the next two years. Funding will grow at a much lower rate than in previous years, while demand and activity will continue to rise.

2.3.2 The proposed financial projections assume that national efficiency savings targets of 4% are set for each year. In an uncertain environment, it is also assumed that we lose 1% to 2% of our current income each year, with some commissioners reducing our contracted activity levels to help keep their finances in balance. Such activity reductions would also allow for some cost savings, but the overall productivity target for the Trust remains 5% per year.

2.3.3 Growth remains a key aim. Two priority areas are set out in the Plan, and we believe that these are realistic aims even in the difficult and competitive environment. The financial projections include £6m new income from this growth; but it is assumed that this takes place largely or entirely in year 3 (2012/13).

2.3.4 This growth is important to our strategic objectives, but is not essential to the financial plans for this three-year period. A margin of 5% on the £6m would contribute £300k, or around 1%, to the overall productivity targets. It remains therefore essential that we continue work on identifying efficiency improvements in our existing services in order to remain financially healthy. Projects are already under way within service lines, and the Trust's overall action plan will be updated in June.

2.3.5 The table below summarises the financial projections proposed for the Plan. Cost inflation of 2% each year is assumed; with the 4% efficiency target, this means that NHS contract prices and tariffs would *reduce* by 2% each year; it is assumed that this would apply to other government and local government funding also. The aim remains a surplus of £150k and a contingency of £250k each year.

	2009/10 Actual £000	2010/11 Budget £000	2011/12 Plan £000	2012/13 Plan £000
Clinical	13,342	15,209	14,466	20,031
Training	15,090	16,042	15,634	15,409
Research	129	338	196	194
Consultancy	1,206	1,186	1,174	1,162
Other	532	438	434	430
Total Income	**30,299**	**33,213**	**31,904**	**37,226**
Pay	23,061	26,014	24,851	29,471
Non-pay	5,686	5,652	5,665	6,278
Contingency	0	462	250	250
Total Expenditure	**28,747**	**32,128**	**30,766**	**35,999**
EBITDA	**1,552**	**1,085**	**1,138**	**1,227**
Depreciation/Interest/Dividend	(901)	(935)	(980)	(1,070)
Surplus	**651**	**150**	**158**	**157**

2.4   ==Capital Expenditure==

2.4.1 Capital expenditure in 2009/10 totalled £497k, of which £334k was on estates and £163k on IT and other equipment. This was £65k lower than the budget of £562k, mainly because a lighting and power project (budget £35k) did not take place.

2.4.2 The capital budget for 2010/11 was approved in March, totalling £720k. Similar levels of expenditure are envisaged for the following two years, as shown in the table below. Over the three years, these costs exceed the depreciation charges by some £320k, which will be funded from the planned surpluses or, if necessary, from the current cash balances.

Proposed 3 year capital programme

Project	2010/11 £000	2011/12 £000	2012/13 £000
Tavistock Centre Roof Project	350		
Tavistock Centre new toilets	60	60	60
Tavistock Centre new boilers	90		
Tavistock Centre goods lift		100	
Portman Clinic - convert boilers		50	
Tavistock Centre open plan area		20	150
Environmental improvements to include lighting, corridor radiators, specific windows			250
Other estates improvements		150	
IT hardware and network software	220	220	200
TOTAL	**720**	**600**	**660**

2.5   ==Statement of Financial Position (previously the Balance Sheet) (Appendix A)==

2.5.1 The fixed assets value at 31 March 2010 was £12,870k including intangibles (software). The capital additions of £497k during the year were offset by depreciation and amortisation of £563k.

2.5.2 As previously reported, the cash balance of £3,648k at 31 March was £2,219k higher than plan, and £1,009k higher than the previous year.

2.5.3 At 31 March, the total of debtors and prepayments was £2,801k and total current liabilities were £5,567k.

2.5.4 A detailed debtors report will be presented to the Audit Committee as usual. The main reason for the reduction from March 2009 was that the 2009 balances included invoices which had been issued to 2 commissioners in the last week of March totalling £724k, which were

paid early in April.

2.5.5   The largest item within creditors was £2,770k of deferred income: i.e. invoices which have been issued during 2009/10 but which relate to activity in 2010/11. Within this figure, £1,061k is the summer term share of student fee income invoiced in the autumn for the whole academic year. This is a regular part of the Trust's business (note that for students who pay in three instalments, the final instalment was not due until April, and appears in the debtors balance also.) The other £1,709m of deferred income relates to a number of clinical and other projects where for various reasons the activity is taking place later than expected. This balance will be much reduced during 2010/11; in effect, cash held by the Trust at 31 March will be used to pay the costs of these services in 2010/11.

2.5.6   The provisions of £164k comprised £103k for legal cases in progress; and £61k relating to 2 staff who retired early before 1995, and for whom the Trust remains liable to pay supplementary pension costs.

2.5.7   Taxpayers' equity increased from £12,939k to £13,590k in the year due to the surplus of £651k.

2.5.8   The key factors in the balance sheet projections for 2010/11 and 2011/12 are:
- The planned surpluses;
- The planned capital expenditure; and
- The expected reduction in deferred income.

2.5.9   The projections also assume a £1.2m increase at an estates valuation in April 2011. This does not affect cash balances but it does have some effect on the calculations of dividend and return on assets.

2.6   Cash Flow (Appendices B, C and D)

2.6.1   The monthly forecasts for 2010/11 (Appendix B) and 2011/12 (Appendix C) are attached, for approval as part of the Annual Plan. The forecast cash balances are shown graphically in Appendix D, which also includes the previous 2 years; the highest month-end balance was on 28 February this year, £4,190k.

2.6.2   The actual cash balance at 30 April (also shown in Appendix B) was £3,787k, an increase of £142k in the month. Pay costs were very close to Plan. Income was lower than Plan from PCTs and general debtors. These are timing differences, and PCT income should recover the shortfall in the next two months.

2.6.3   The cash forecasts reflect the key factors set out in 2.5.8 above, and also the seasonal timing of capital projects, student fees and some other income sources. The key reason for the expected cash reduction this year is the utilisation of £1,560k from the deferred income balances (see 2.5.5).

2.6.4 The annual plan will assume that we retain a loan facility of £2.0m, in order to secure liquidity. However, the costs and benefits of this facility will be reviewed again by the Board before it is due for renewal in November 2010.

3. <mark>Training</mark>

3.1 NHS London has confirmed the 2010/11 value of the training contract, with a 1.5% inflation uplift in line with our budget.

3.2 The key areas of uncertainty are student numbers for the academic year starting in October; and income from university partners, which remains under negotiation.

4. **Patient Services**

4.1 <mark>Activity and Income</mark>

4.1.1 The majority of contract values have now been agreed. Total contracted income for the year is in line with budget. No major variances in other sources of clinical income are currently expected, subject to activity levels which will be closely monitored

4.2 <mark>Clinical performance (quarter 4, 2009/10)</mark>

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

4.2.2 DNAs (Did Not Attends) on first appointments have been fairly consistent over the last six months; the percentage fell to 8.8% in the latest quarter, but remains significantly lower than in previous years. Fluctuation is due to the relatively small population.
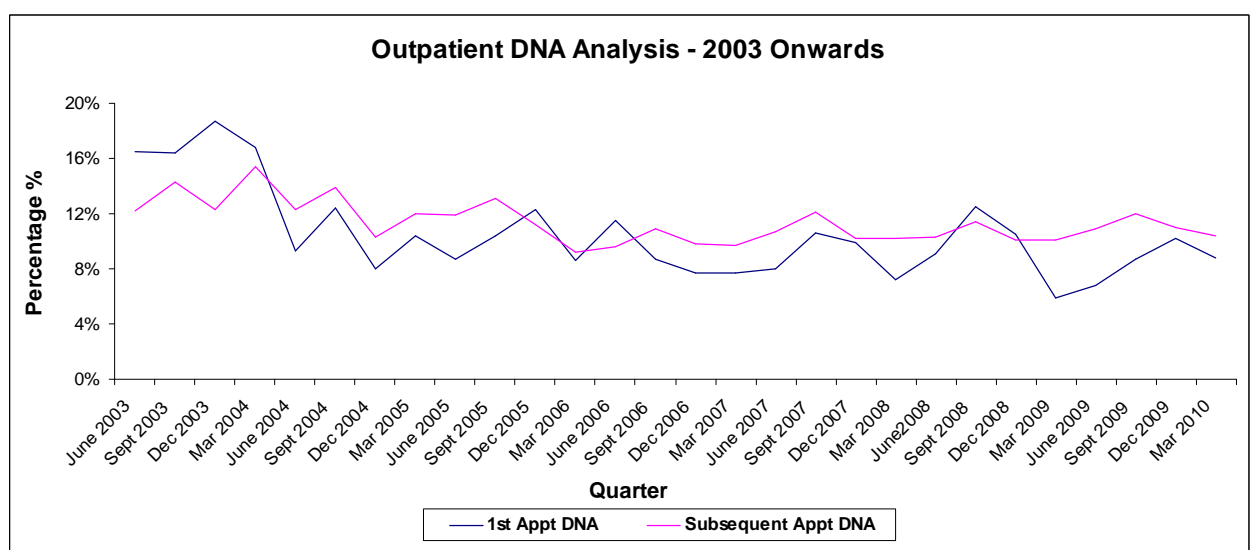
4.2.3 For the larger number of subsequent appointments, the percentage fell slightly to 10.4% which is an improvement on the three previous

quarters this year, though not significantly different from the usual fluctuations.

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.
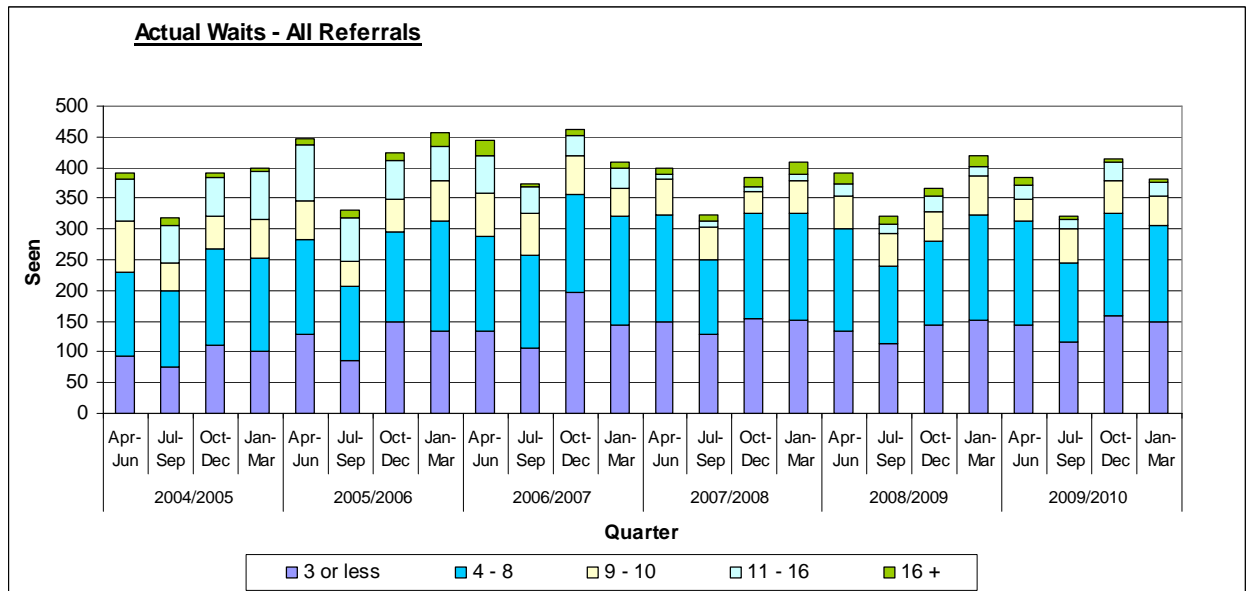
4.2.5 In this quarter, 28 patients (7%) waited 11+ weeks for their first appointment, a reduction from 9% in the previous period; within this, the numbers waiting 16+ weeks remained at 5.

4.2.6 The breakdown of reasons is given below.
- Lack of clinical availability (7)
- Insufficient information from referrer (1)
- Patient delay/Problem engaging patient (6)
- Prior liaison needed (1)
- Referral between Departments (2)
- Error/Not Known (8)
- Cancelled by Trust (2)
- Authorised for inclusion in SLA (1)

4.2.7 Of the 28 cases, 11 were in the GID service. This was partly due to an upsurge in referrals, but included some cases where the referrer or another professional requested a specific date for the first appointment; and 3 cases only just over the 11 week deadline. Action has been taken to deal with the backlog, and a review is taking place to reduce the effects of variations in demand in future.

5. <mark>**Consultancy**</mark>

5.1   TCS income in April was £24k against a budget of £38k (which allowed for Easter). The targets for May and June are £78k per month; the forecast income for May and June is not certain at this point.

6. <mark>**Research**</mark>

6.1   The research income budget is £338k for 2010/11. £165k of this has been deferred from 2009/10 and is therefore secure; there may be a shortfall on the remaining £173k.

6.2   Action to increase income for future years will continue, in order to cover current costs and fund new research projects.

Simon Young
Director of Finance
19 May 2010

Statement of Financial Position – Actual and Projected   Appendix A

	March 2009 restated (IFRS)	March 2010 IFRS unaudited	June	Sept	Dec	March	June	Sept	Dec	March	2013 March
				2010/11				2011/12			
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Non-current assets	12,936	12,870	12,763	13,035	13,118	13,081	14,163	14,426	14,388	14,331	14,391
Inventories	13	2	2	2	2	2	2	2	2	2	2
NHS Receivables	1,074	731	682	577	715	672	566	570	732	656	650
Other receivables	2,310	1,953	973	1,059	2,477	1,731	1,001	1,189	2,746	1,722	1,707
Impaired receivables	(348)	(364)	(364)	(364)	(364)	(364)	(364)	(364)	(364)	(364)	(364)
Accrued income and prepaym'ts	429	481	513	564	573	512	505	555	424	505	500
Investments	0	0	0	0	0	0	0	0	0	0	0
Cash	2,639	3,648	3,524	2,188	1,880	1,527	2,222	1,427	1,526	1,573	1,650
Trade creditors	(364)	(380)	(532)	(382)	(382)	(382)	(370)	(370)	(370)	(370)	(350)
Other creditors	(932)	(859)	(921)	(921)	(921)	(921)	(911)	(911)	(911)	(911)	(900)
Accrued Creditors	(1,330)	(1,558)	(998)	(847)	(848)	(847)	(837)	(837)	(837)	(837)	(820)
Deferred Income	(3,054)	(2,770)	(1,749)	(819)	(2,184)	(1,210)	(782)	(276)	(1,987)	(1,148)	(1,150)
Capital creditors	(1)	0	(20)	(300)	(160)	0	(20)	(300)	(100)	0	0
Dividend creditor	0	0	(112)	0	(112)	0	(113)	0	(113)	0	0
Net Current Assets/(Liabilities)	437	884	998	757	676	720	899	685	748	828	925
Early retirement provision	(46)	(61)	(61)	(61)	(61)	(61)	(61)	(61)	(61)	(61)	(61)
Other provisions	(388)	(103)	(13)	0	0	0	0	0	0	0	0
Total net assets	12,939	13,590	13,687	13,731	13,733	13,740	15,001	15,050	15,075	15,098	15,255
Loans	0	0	0	0	0	0	0	0	0	0	0
PDC	3,403	3,403	3,403	3,403	3,403	3,403	3,403	3,403	3,403	3,403	3,403
Revaluation reserve †	8,208	8,022	8,022	8,022	8,022	8,022	9,222	9,222	9,222	9,222	9,222
I&E reserve †	1,328	2,165	2,262	2,306	2,308	2,315	2,376	2,425	2,450	2,473	2,630
Total taxpayers' equity	12,939	13,590	13,687	13,731	13,733	13,740	15,001	15,050	15,075	15,098	15,255

† ignoring year-end transfers from Revaluation reserve to I&E reserve, which do not affect cash flow or key financial indicators.

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	3,648	4,084	3,707	3,524	3,196	2,779	2,188	2,336	2,253	1,880	2,245	2,129	3,648
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	4,084	3,707	3,524	3,196	2,779	2,188	2,336	2,253	1,880	2,245	2,129	1,527	1,527

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	3,648	3,790	3,613	3,480	3,152	2,735	2,144	2,292	2,209	3,204	3,569	3,453	3,648
Operational income received													
NHS (excl SHA)	892	1,060	914	1,005	1,038	917	904	1,038	917	905	1,036	917	11,543
General debtors (incl LAs)	709	517	880	550	402	379	556	474	423	783	591	458	6,722
SHA for Training	874	914	895	894	914	894	895	914	894	894	915	894	10,791
Students and sponsors	277	150	150	100	0	200	650	250	100	500	100	100	2,577
Other	24	18	18	18	18	18	18	18	18	18	18	18	222
	2,776	2,659	2,857	2,567	2,372	2,408	3,023	2,694	2,352	3,100	2,660	2,387	31,855
Operational expenditure payments													
Salaries (net)	(1,206)	(1,247)	(1,247)	(1,246)	(1,247)	(1,247)	(1,247)	(1,247)	(1,247)	(1,246)	(1,247)	(1,247)	(14,921)
Tax, NI and Pension	(859)	(921)	(921)	(921)	(921)	(921)	(921)	(921)	(921)	(921)	(921)	(921)	(10,990)
Suppliers	(570)	(669)	(734)	(697)	(622)	(510)	(509)	(510)	(509)	(510)	(509)	(510)	(6,859)
	(2,635)	(2,837)	(2,902)	(2,864)	(2,790)	(2,678)	(2,677)	(2,678)	(2,677)	(2,677)	(2,677)	(2,678)	(32,770)
Capital Expenditure	0	0	0	(20)	0	(100)	(200)	(100)	(50)	(60)	(100)	(90)	(720)
Interest Income	1	1	2	2	1	2	2	1	2	2	1	2	19
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	3,790	3,613	3,480	3,152	2,735	2,144	2,292	2,209	1,836	3,569	3,453	2,851	1,483

Cash Flow Plan 2011/12

<div align="right">Appendix C</div>

2011/12 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	1,527	1,868	1,890	2,222	1,982	1,837	1,427	1,720	1,813	1,526	2,176	2,150	1,527
Operational income received													
NHS (excl SHA)	899	1,031	909	897	1,028	908	897	1,027	908	897	1,028	908	11,337
General debtors (incl LAs)	426	443	986	547	471	471	658	511	467	817	540	484	6,821
SHA for Training	881	900	881	880	901	880	881	900	881	880	901	880	10,646
Students and sponsors	704	200	100	0	0	200	600	300	0	600	150	0	2,854
Other	18	18	18	18	18	18	18	18	18	18	18	18	216
	2,928	2,592	2,894	2,342	2,418	2,477	3,054	2,756	2,274	3,212	2,637	2,290	31,874
Operational expenditure payments													
Salaries (net)	(1,160)	(1,160)	(1,160)	(1,160)	(1,160)	(1,160)	(1,159)	(1,160)	(1,160)	(1,160)	(1,160)	(1,160)	(13,919)
Tax, NI and Pension	(921)	(911)	(911)	(911)	(911)	(911)	(911)	(911)	(911)	(911)	(911)	(911)	(10,942)
Suppliers	(508)	(500)	(493)	(493)	(493)	(493)	(493)	(493)	(492)	(493)	(493)	(493)	(5,937)
	(2,589)	(2,571)	(2,564)	(2,564)	(2,564)	(2,564)	(2,563)	(2,564)	(2,563)	(2,564)	(2,564)	(2,564)	(30,798)
Capital Expenditure	0	0	0	(20)	0	(100)	(200)	(100)	0	0	(100)	(80)	(600)
Interest Income	2	1	2	2	1	2	2	1	2	2	1	2	20
PDC Dividend Payments	0	0	0	0	0	(225)	0	0	0	0	0	(225)	(450)
Closing cash balance	1,868	1,890	2,222	1,982	1,837	1,427	1,720	1,813	1,526	2,176	2,150	1,573	1,573

Cash Actual and Plan (£000)
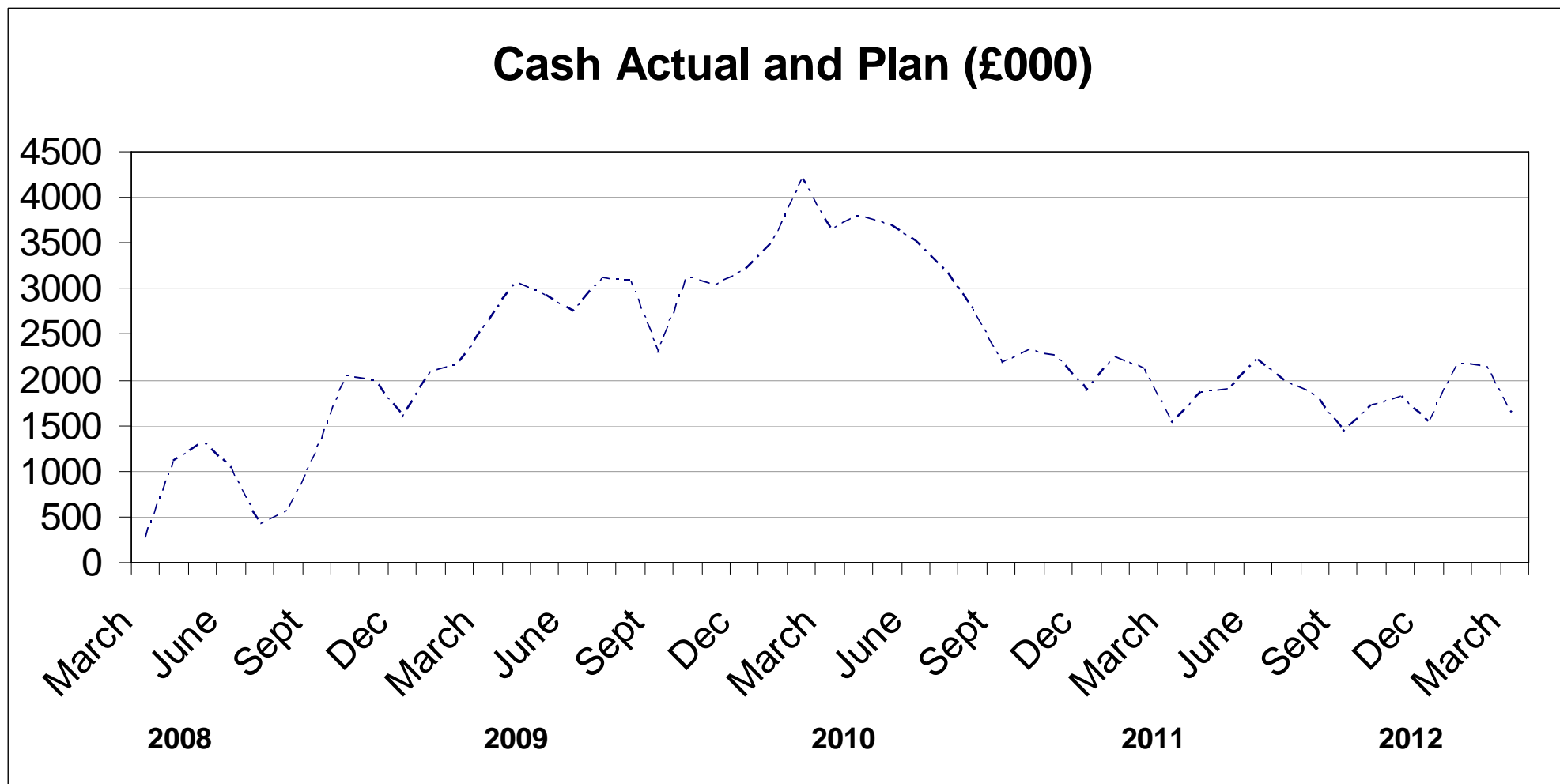
Board of Directors : May 2010

Item : 7b

Title : Quarter 4 Complaints Report

Summary:

This report provides the Board of Directors with an updated summary of formal complaints received during 2009/10.

The Risk Management Committee has considered this report in detail and it is provided for information.

Members of the Board of Directors will note that the Trust's rate of complaints remains low. A narrative summary of all complaints received in 2009/10 is included in the Risk Management Committee Annual Report which is also presented at this meeting.

For : Noting

From : Chief Executive

Summary Formal Complaints Schedule 2009/10

Date complaint received	PCT	Directorate	Core topics	Final response within 25 days*	Outcome/Lessons learned	Complaint status	Closed date
2008/09 (not completed by year-end)							
March 09	Camden	Adult	Patient requesting review of care complaint that patient needed more intensive treatment	Yes	Request considered by the clinical team. More intensive treatment not recommended. Patient informed of decision	Resolved Complaint not upheld	June 2009
QUARTER 1							
April 09	Camden	Adult	Breach of confidentiality Complaint that too much detail shared with GP and referrer Communication difficulties Dissatisfaction with assessment	Yes	Full explanations given to each of the issues raised by the patient Re. confidentiality – review as above Re. communication – review accessibility of PALS service Re. assessment – no evidence of poor practice. Patient discussed nature of assessment with Adult Directorate Head of Clinical Services	Resolved Complaint not upheld	April 09

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* 25 working days is the Trust target for response times. Under the current rules, trust's can negotiate extensions for full response with the complainant if further time would enable a more complete investigation and response to be prepared

Date complaint received	PCT	Directorate	Core topics	Final response within 25 days*	Outcome/Lessons learned	Complaint status	Closed date
May 09	Camden	Adult	Breach of confidentiality Complaint that too much detail of assessment shared with GP and referrer	Yes	Letter retracted and a shorter letter sent Department to review its practice re. patient details shared with other professionals	Resolved Complaint upheld	June 09
QUARTER 2							
July 09	Camden	C&F	Parent expressing concern about level of support offered to child (frequency of treatment)	No	Treatment currently being reviewed with clinician, but needs to be discussed with both parents	Resolved Complaint not upheld	October 09
July 09	Kensington & Chelsea	Adult	Dissatisfied with assessment Breach of confidentiality Too much detail shared with GP/Referrer	Yes	Explanation given of the purpose and nature of the assessment Plan to retract and replace with summaries to be agreed with patient	Resolved Part not upheld Part upheld	October 09
August 09	Barnet	Adult	Dissatisfied with treatment March 2010 – dissatisfied with outcome of meetings with senior clinician	No	Patient requested meeting with senior clinician to discuss concerns. Meeting scheduled to take place 8 October 2009. Several meetings offered before finally taking place November / December. Further appointment scheduled for January 2010. March 2010 – patient asked for	Meetings taking place as requested by patient Last appointment in April 2010 ended on an unsatisfactory	Open

Date complaint received	PCT	Directorate	Core topics	Final response within 25 days*	Outcome/Lessons learned	Complaint status	Closed date
					someone else to assist in resolving concerns. Matter being considered by Adult Department Clinical Director and Head of Clinical Services	note and further complaint	
QUARTER 3							
No formal complaints were received in Quarter 3 of 2009/10							
QUARTER 4							
February 10	Tower Hamleys PCT	Adult	Administrative error leading to further errors so that appointments were not received	Yes	Typing error identified as cause of problem	Resolved Complaint upheld	February 10
February 10	North East Essex PCT	Portman	Non-acceptance of referral Patient felt he was being denied treatment on wrongful grounds	No	Frequent ongoing communications with complainant Clarified with Portman Clinic that referral had been properly considered Meetings offered with Consultant at Portman Clinic, but as at end March 2010 still under negotiation	Ongoing	Open
March 10	Kensington & Chelsea	Portman	A member of a group was distressed by violent outburst by another group	No Patient		Under investigation	Open

Date complaint received	PCT	Directorate	Core topics	Final response within 25 days*	Outcome/Lessons learned	Complaint status	Closed date
	PCT		member (this was reported as an incident at the time of the event)	informed of delay			
March 10	Camden	Support Services	A patient reported that a member of staff was rude to him when he was parking his bicycle	Yes	Upheld Staff member to attend further training	Resolved	
March 10	Camden	CAMHS	Mother alleges that family confidentiality was breached in a case when the Trust raised child protection concerns			Under investigation	Open

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

Board of Directors : May 2010

Item : 7c

Title : Quarter 4 Incident Report

Summary:

This report provides the Board of Directors with a summary of incidents reported in Quarter 4 2009/10, and updates the Board on progress to wards completing action plans of any open Serious Untoward Incidents (SUIs).

All incidents and SUI reports are discussed in detail at the Risk Management Committee.

For : Noting

From : Director of Corporate Governance & Facilities

2009/10 Quarter 4 Incident Report

1.   Introduction and Data Sources

1.1   The Board of Directors have requested a quarterly summary of the incidents that are reported via the Trust's incident procedure, and a progress report on any "open" Serious Untoward Incidents (SUIs) for which agreed actions have not previously been completed. This report is designed to provide that information.

2.   Reported incidents – process

2.1   All incidents that are reported using the Trust's incident form are reviewed by the Health and Safety Manager and details added to the Trust's database. Any clinical incidents are forwarded for review the Governance and Risk Lead who will follow these up with relevant clinicians as required. All incidents are graded on the Trust risk matrix for actual consequence and assessment of likelihood of the incident recurring, action is taken according to the grade.

3.   External reporting to NPSA (clinical incidents)

3.1   All incidents involving patients are reported to the National Patient Safety Agency (NPSA) as part of their national reporting and learning programme. Reports to the NPSA are anonymised in terms of identify to patient / department and only contain a Trust identifier.

3.2   In Quarter 4, the Trust reported a total of 15 clinical incidents. These all related to pupil incidents in the Day Unit where one pupil was reported to be "attacking" another pupil. The NPSA have indicated to the Trust that these incidents should be reported through the National Reporting and Learning Service scheme as "patient violence and aggression" incidents.

4.   External reporting to RIDDOR[1]

4.1   In Quarter 4, The Trust had no RIDDOR reportable incidents.

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[1] Staff injuries where staff are off work for 3+ days

5. Incident Data

Grade and Type[2]	Q4 2009/10	Q3 2009/10	Q2 2009/10	Q1 2009/10	Q4 2008/09 (comparative data)
Red / Amber Incidents (all areas)	0	0	1 (SUI)	1 (SUI) 5 (Amber)	3 (Amber) (Incidents in Day Unit)
Yellow / Green Incidents (Gloucester House)	92	51	18	26	51
Yellow / Green Incidents (all other areas)	15	24	17	14	13
TOTAL	**107**	**75**	**76**	**46**	**67**

5.1 The Quarter 2 figures for the Day unit were low due in part to the summer holidays, during which the Day Unit is closed. There has been a marked increase in reported incidents between Quarter 3 and Quarter 4 in the Day Unit, and the Risk Management Committee noted this as a potential issue. There has been an increase in pupil number from 12-16 which may account for the increased incident rate. None of these incidents were "serious" i.e. all scored under 9 on the risk matrix.

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[2] Red / Amber incidents must be escalated and reviewed. Yellow / Green incidents can be managed at Directorate level.

6.   Progress on SUI Action Plans

6.1   In the Quarter 3 Report, the Board of Directors was advised on progress against an SUI action plan following a suicide whilst in therapy incident in July 2009.

6.2   Currently, the Trust has one open SUI action plan. This is the plan developed following the suicide of a patient in the Adult Department in July 2009, which was presented to the Board of Directors in November 2009. The updated action plan is shown below:

Reference	Recommendations	Lead for Action	Timescale	Progress at January 2010
48	Adult Department to improve arrangements for the management of patient care for D58 patients, and consider establishing a clinical unit for the management of the treatment of these patients.	Philip Stokoe / Michael Mercer	To be fully established by end of Spring Term 2010	Action Plan achieved on target Camden Commissioners have agreed to close the incident The new clinical unit is now fully operational and Michael Mercer will report on effectiveness in September 2010
	Adult Department to provide a progress report to the Risk Management Committee in December 2009.	Michael Mercer	December 2009	Completed Report received by Risk Management Committee
	Medical Director to promote the clinical standards of GP communication across Directorates.	Rob Senior	December 2009	Completed The standards for clinical record keeping which includes standards for GP letters was circulated to clinical staff via the Clinical

				Governance Leads in November 2009
				Issue raised by Trust Director at the Trust Clinics Committee in January 2010

6.3   The Board of Directors are invited to agree to the closure of the SUI.

Pat Key
Director of Corporate Governance and Facilities
May 2010

Board of Directors : May 2010

Item : 8a

Title : Annual Risk Management Review Report 2009-10

Summary:

This report summarises the clinical and non-clinical risk management activities across the Trust for 2009/10. This work has been monitored by the Management Committee and scrutinised by the Risk Management Committee; assurance is provided to the Board of Directors that risk is well managed. This report should be read in conjunction with the annual review of compliance with the Terms of Reference for this Committee.

For : Discussion

From : Chief Executive

Annual Risk Management

Review 2009-10

Introduction

Compared with acute trusts undertaking invasive procedures, or mental health trusts with in-patient facilities, the levels of risk at the Trust are comparatively very low. However, the Trust takes the risks that are apparent very seriously; most of the Trust's clinical work is dealing with children and vulnerable adults, or with patients who pose a risk to themselves or others. The nature of the clinical care provided by the Trust is such that very little medication is prescribed. NHSLA assessment again found the Trust to be managing risk well.

Clinical risk and patient safety
New protocols for risk assessment were introduced as a result of new national guidance. Effective partnership with the NPSA led to a useful change in the way our data is treated nationally. Collaboration with the Clinical Governance Committee yielded additional assurance because of greater scrutiny. The Trust had trained all clinicians that were seeing patients to level 3 child protection.

The Trust is developing more services that will proactively look at mental well being and prevention, these will reduce risks to vulnerable patients. Complaints were few; all complaints were dealt with systematically and this data was used to inform planning and delivery of care.

Health and safety
The Trust complied with all health and safety requirements and responded effectively where required. Health and safety incidents are few, and those that do occur are managed effectively.

Incident reporting and training
Though there are few incidents overall, those that are reported are dealt with effectively and the Trust has been able to learn and develop as a result. The trend of increased numbers of incidents is attributed to better reporting as a result of training and effective management.

Developments in risk management
Since 2009/10, when new resources were allocated to the management of risk, further developments to provide high level assurance that risk was being managed were been reflected in an improved risk rating by the Internal Auditors. The Trust aims to continue improving its performance in this area and sets out indications for work in 2010/11 that will lead to improved practice that will be reflected in the Trust's performance against level 2 of the NHSLA assessment process.

Matthew Patrick, Chief Executive, Chair of Risk Management Committee

Part 1   Patient Safety and Clinical Risk

1.1.   Introduction

The Trust provides outpatient mental health services to people of all ages. The emphasis is on psychological treatments; no physically invasive treatments are delivered and very few patients are treated with medication. Patients are not seen in the Trust while detained under the Mental Health Act, although some patients will have a history of having been detained in the past. Compared with Acute Trusts or Mental Health (in-patient) Trusts, the level of risk to patients is therefore relatively low

In terms of high-risk patients, the Adult Department sees many patients with enduring and complex personality difficulties, and the Portman Clinic engages with a high-risk forensic group. The Child and Family and Adolescent Departments provide generic CAMHS and specialist services to some high-risk groups. In the later situations, notably those services for looked after children, the early intervention for psychosis service and the Tavistock Children's Day Unit, the risks of harm (as a result of behaviour) both to staff and patients can be significant.

Allowing for some under-reporting of behaviour management situations (which are identified as part of clinical presentation rather than as a clinical incident) the low level of reported incidents in our view accurately reflects the low rate of occurrence of such incidents and points towards the safety of our systems. In particular, arrangements for supervision and case review by clinical teams. Nevertheless, the Trust periodically reviews and improves its systems for risk management to ensure that they remain robust and fit for purpose and are adapted as required in line with changes in patient populations and services that we offer. We also remain committed to learning from adverse events as a way of facilitating optimal and safe clinical outcomes.

1.2.   Trust's Clinical Systems & Committees for assuring Patient Safety

1.2.1 Patient Risk Assessment
Clinical staff have always undertaken risk assessment as part of the assessment of any new patient, thereafter as part of a termly review, and again at closure of the case.

In 2008, in response to changes to CPA, and in line with NHSLA requirements, we developed and implemented a formal protocol for clinical risk assessment and updated our forms. During 2009-10, further minor modifications were made to the trust forms for recording risk assessment and compliance with this procedure is monitored via the annual records audit, and as part of clinical supervision.

1.2.2 **Learning from Confidential Inquiries into Suicide and Homicide**
The Medical Director receives, and, where indicated, initiates a review of, reports and enquiries from the National Confidential Inquiry into Suicides & Homicides by People with Mental Illness on a quarterly basis.

1.2.4 **Responding to Safety Alert Broadcasts (SABs) including National Patient Safety Agency Alerts (NPSA alerts)** The Trust reviews and considers all safety alert broadcasts (SABs) and advisory notes produced by the NPSA, but very few have any direct relevance to the work of the Trust.

In 2009-10, the NPSA issued two alerts that were relevant to the trust: one related to the identification of risks to children residing with parents with mental health problems; and the second to safer lithium therapy. In response to the child risk alert, the trust's risk paperwork was updated to add a specific risk question about children at risk and this is now being asked as part of the process. The Lithium alert was circulated for information to relevant staff but is not directly relevant as the trust does not prescribe lithium.

1.2.5 **Reporting patient safety incidents to NPSA**
During 2009-10, the Governance and Risk Lead met with the NPSA lead for the national reporting and learning database to discuss the trust's low central reporting rate. Because of this discussion the trust no longer reports all patient safety incidents (of which there are very few) and all child 'outbursts' (behaviour problems) at the Day Unit when a second child is involved. Under the strict definition used by the NPSA these are classed as 'patient safety incidents'; because of this, though our reported numbers remain very low, we will not appear as a 'non reporter' in national data sets, which are shared with the CQC.

In March 2010, the NPSA published its first summary report of our data. This report related to nine reported incidents between April-Sept 2009. This data is compared to 'other mental health trust's and therefore comparisons are not meaningful due to the nature of the service. The report can be viewed at:-

   http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/directory/?entryid33=25948&char=T.

Despite the low numbers of patient safety incidents, each one is reviewed in detail by the governance team and the Risk Management Committee; further investigation and action taken whenever there is an opportunity for learning.

1.3. **Audit of Clinical Risk Assessment, Risk Management, Case Notes & GP/Referrer**

We have a well-established annual cycle (extending back to 1994) auditing the standards of case notes and referrer communication. Since 2000, this has been extended to completeness of clinical risk documentation.

The records audit for 2009-10 was undertaken on closed records in February/March 2010 and the finding published in March/April. The full report forms part of the annual Clinical Governance Report. This year's audit demonstrated some deteriorating standards in record keeping in some areas of the Trust and as a result, each Clinical Governance Lead is working with their Directorate to develop an action plan to address their local issues. This action plan will be approved by and monitored by the Clinical |Governance Committee (or the new Clinical Audit working group, in the proposed revised risk management structure for 2010-11

1.4. **Review of Serious Clinical Incidents**

The Serious Incident Procedure was used once in 2009-10 following the suicide of a patient whilst in therapy; a detailed investigation was carried out lead by the clinical governance lead for that department and an unconnected psychiatrist from another department. The Board received a copy of the report. The investigation concluded that the trust could not have prevented the suicide, but because of the case, the Adult Department made changes to the way in which it manages the clinical care of patients being treated by D58 students. All recommendations made in the report have been fully implemented.

1.5. **Incident Reporting & Review** – *See Appendices*

All incidents, clinical and non-clinical, were considered by the Risk Management Committee on a quarterly basis. Clinical incidents were also referred to the Clinical Governance Committee. Clinical incident reporting was a standing item on the Clinical Governance Committee agenda. During 2009-10 there continued to be very few reported clinical incidents. When they occurred they were referred to the appropriate Directorate leads that were asked to investigate and reported to the committee so that any general learning points can be shared.

Summaries of all incidents in the year are shown at appendix C. These reports show another year of few incidents across the Trust, with the exception of the Day Unit. The Day Unit has a high number of incidents due to the nature of the work and the requirement to make an incident report for each behavioural problem above a very low threshold (all

behaviour events are either reported as formal incidents or in a behaviour log held by the Day Unit).

In line with NHSLA requirements, the Trust has developed a process for learning from aggregated risk data and the Risk Management Committee now receives a quarterly aggregate analysis report, which brings together any patterns for learning and/or action. At the request of the Board from Q3 2009-10 it receives a short summary report of complaints, claims and incidents for information.

1.6.   Safeguarding Children

During 2009-10, Sonia Appleby took over from David Lawler as Named Professional for Child Protection to work along side Dr Rob Senior Named Doctor for Child Protection. Our clinicians continue to devote careful attention to this aspect of their work.

During 2009-10, the Trust focused on training all staff and quality record keeping; the trust is in the process of completing stratified (levels 1-3) safeguarding training for all staff.

Level 3 training for clinicians working directly with children was prioritized and expedited in the autumn of 2009, this is up to date for all but 7 clinicians who were not treating patients at the time of the training (eg due to maternity leave) 100% will be achieved following the next training session. Level 2 training for all other clinicians was expected to have been be completed by May 2010. Level 1 training, for all staff takes place during induction and INSET training and is on going. In addition, a number of cross-departmental training initiatives and other CPD training opportunities have continued to raise awareness of child protection issues throughout the year.

The Medical Director represents Camden CAMHS on the Local Safeguarding Children's Board. The Trust has considerable expertise in this field and provides clinical/social policy research and other educational initiatives acknowledged as being of a high standard. The Trust provides training and support to senior staff in neighbouring Trusts.

There have been no reported serious incidents during the year.

1.7.   Safeguarding Vulnerable Adults

In the last few years the protection of vulnerable adults has emerged as a significant concern to be addressed by organisations providing services for such people. The Tavistock and Portman NHS Foundation Trust does not provide inpatient or residential services for vulnerable adults or

outpatient services for those suffering from dementia. The Trust does however provide some outpatient services for adults with learning difficulties. A senior member of staff from the Learning and Complex Difficulties Service has been identified with Trust wide responsibility for safeguarding vulnerable adults. No serious incidents or complaints have been received involving the care of vulnerable adults in the last year.

Consistent with the key messages in the Department of Health document *Safeguarding Adults - Report on the Consultation on the review of 'No Secrets' (2009),* we have taken the view that safeguarding requires user empowerment and the participation or representation of people who lack capacity.

To improve our literature and other arrangements for patients with learning difficulties, the Trust has commissioned some advisory work from People First. This has resulted in new documents being produced and there is an ongoing piece of work arising from the consultation with the reception and front of house staff, to improve awareness and responsiveness of staff to vulnerable service users.

1.8.   Assessing Risk and Risk Register

The Trust made some minor enhancements to its Risk Strategy in January 2010 in light of improvements made to risk processes. This included the introduction of an extra column on the risk register that identified whether or not the level of risk was tolerated. This relates to the Trust's 'risk appetite' and showed that the trust is developing its approach to managing risk. This enhancement was made following Board Level Risk Training. The Risk Managed Committee reviewed the full register as it does every year.

1.9.   Patient Safety in its Public Health Aspect

The Clinical Governance Committee continues to review and consider national guidance on patient safety, including NSFs and NICE Guidelines.

The Trust aimed to reduce the risk of suicide and harm to self or others by promoting well-being and addressing risk factors for mentally ill people.

A cross-Government programme of action, New Horizons, was launched to improve the mental well-being of people in England by increasing the quality of mental health care. It is a comprehensive initiative that will be overseen by ten national Government departments. It brings together an alliance of local government, the voluntary sector, professionals, local communities, and individuals to work towards a society that values mental well-being as much as physical health. New Horizons covers a lifetime,

from laying down the foundations of good mental health in childhood, through to maintaining mental well-being into older age. It also emphasises the importance of prevention through to effective treatment and recovery.

The Trust is committed to improving mental health and emotional wellbeing; the Trust believes that high quality mental health services should be available for all who need them, especially those services that can intervene early in young people's lives and early in the development of psychological difficulties. Examples are our perinatal services for first-time teenage parents, other services for parents and our work in schools. In adult services, we have developed a successful collaboration with the Big White Wall, which will improve access to self-help and on-line therapeutic resources. Much of the Trust's research endeavour is also directed to these ends.

1.10. Infection Control

The Trust has a low level of infection control risk because of the non-invasive nature of the outpatient work it undertakes. However, it recognises its duty under the Health Code and has an Infection Control Policy (in line with NHSLA requirements).

Whilst the hygiene code is mainly concerned with the reduction in spread of healthcare acquired infections such as MRSA and C. Difficile, the Trust recognises that it must manage risk associated with the occasional patients who are sero-positive for blood borne viruses (hepatitis B & C, HIV) and a remote theoretical risk of their transmission. This is mainly an issue with children in the Day Unit. In 2005, we consulted the RFH Occupational Health staff who gave clear guidance and staff education. The Health and Safety Policy and the Infection Control Policy detail our procedures for responding to skin break injuries and we have excellent support from our acute clinical colleagues at the Royal Free who provide an expert service to us both via occupational health and A and E as required. The policy also stresses the Trust's commitment to the promotion of high standards of personal hygiene and hand washing for all staff and users of the Trust to reduce the risk of spreads of Norovirus, flu virus and other contagious health hazards. In 2009-10 the Trust increased access to hand washing facilities for staff in the Tavistock Centre, there are now soap dispensers in each kitchen, in addition we have made alcohol hand gel available on each floor at the lift entrance.

Infection control training is a mandatory training requirement and detailed in the Staff Training Policy. The Governance and Risk Lead delivers this training at induction and as part of INSET.

The Trust received confirmation of full registration with the Care Quality Commission ready for April 2010, which included compliance with the Hygiene Code.

There was one infection risk reported in 2009-10, this related to the lack of cleaning materials being available to staff to clear up a 'patient accident'. This has now been rectified.

1.11. Induction and Training With Regard To Clinical Risk

The Staff Training Policy sets out the Trust's commitment to mandatory and optional training in respect of risk management and associated risk areas. In addition, the Trust adopted a template for all new and revised policies and Trust wide procedures that required the author to address the training and monitoring requirements of the policy/procedure to be successfully implemented. This has resulted in greater clarity about training requirements for risk. The Trust general induction session, Trust Clinical Induction Day, local induction requirements, and the INSET Training Days continue to contribute to a climate of greater awareness regarding both clinical and non-clinical risk.

In 2009-10, managers and staff were offered the opportunity to attend specific training on risk assessment and incident reporting. This was attended by small groups of staff, and were well received and resulted in active risk assessments of different areas being undertaken.

The Trust held a half-day training workshop on clinical and non-clinical risk assessment in July 2010, which was well attended by clinical staff and prompted some useful learning. As a direct outcome of the risk assessment activity at this workshop the Trust is investing in violence and aggression training specifically for clinical staff, the first pilot session was planned for April 2010 (and had taken place by the time this report was written).

1.12. Patient Safety & Risk Management Activity in the Individual Directorates

Each Directorate compiled a clinical governance report, which included a report on clinical risk activities during the year.

1.13 Patient Complaints

Patient complaints are an important part of our feedback mechanisms for identifying risks. Fortunately, the Trust receives very few complaints; however, those that were received were dealt with very carefully and where lessons can be learned the trust is committed to doing so. The Risk Management Committee received a quarterly update on complaints. Any

clinical complaints and lessons learned are referred onto the Clinical Governance Committee. The complaint summary table and report for 2010-11 is shown at Appendix A.

1.14   Conclusion and indications for future action

1.   Risk has been well managed and this has been verified through audit and benchmarking.

2.   During the year, the Trust continued to embed our risk approach within our clinical and corporate governance arrangements. As we look to 2010-11, we are planning to improve our structures further so they are better able to cope with the increasing demands of ongoing assurance to meet CQC and NHSLA standards. These plans will, in addition, further enhance our mechanisms to enable us to ensure that we learn from each opportunity there is to improve patient safety, reduce risk and improve quality of care and experience.

3.   The Trust is not complacent despite the low number of clinical incidents. As the Trust expands services to cover new high-risk groups the Trust remains committed to ensuring that staff retain and develop skills in risk assessment, both of individual patients and of wider issues. The Trust will continue to promote incident reporting and learning and encourage effective risk assessment of events/scenarios so that plans can be put in palace to mitigate, as far as possible, risks.

4.   Moving to a paperless patient record with the RIO project brings with it a new set of risks, but we are actively working together to ensure that all the good work that has been undertaken to fine tune our current record keeping paperwork and systems can be incorporated effectively within the RIO framework.

5.   A focus for 2010-11 will be strengthening the processes we have for providing assurance that our robust systems and processes are indeed effective at mitigating risk and improving patient care and experience.

Dr Rob Senior: Medical Director and Board lead for Patient Safety
April 2010

Part 2 - Health & Safety, Security and Fire Safety

A.   General Health & Safety

2.1.   Health and Safety Introduction

To ensure the Trust met health and safety standards the Trust has an IOSH qualified health and safety manager who is responsible for leading on non-clinical risk management, fire safety, security, and is the Trust's Emergency Planning Liaison Officer, working with the Medical Director and NHS London. The Trust also has a Health and Safety Committee with managers or senior staff from all the departments of the Trust, and two Trades' Union representatives. The Committee met three times in 2009-10 to consider Health & Safety issues, incidents and trends, changes to the fabric of the building and any other health and safety issues.

2.2.   Health & Safety Policies

The Trust policies relating to health and safety were updated and revised in period 2007-9 and were reviewed by the NHSLA in January 2009, and were found to be fully compliant with NHSLA standards. Current policies include:

- Health and Safety Policy
- Violence and Aggression Procedure
- Lone Worker Policy (to be revised in 2010/11)
- Security Procedure
- First Aid Procedure
- Healthy Living Policy

2.3.   Emergency Planning

The Health and Safety Manager, along with the recently appointed Estates and Facilities Manager, are revising the Emergency Preparedness and Business Continuity Plans. A management level 'Table top exercise' will take place in the summer of 2010 to comply with the Civil Contingencies Act of 2004. The H&S manager also attends quarterly meetings of the North and Central London Emergency Planning Liaison Officers with the local EPLO Network Manager from NHS London.

2.4.   'Flu Pandemic Contingency Planning

The effect of the NHS flu pandemic planning was minimal on the trust; however, requests from NHS London for data were met (despite this not being a requirement for MHFTs) and staff were encouraged to take up 'immunisation for swine 'flu and seasonal '.

2.5. Security

The Director of Corporate Governance and Facilities is the Trust Security Lead and attends meetings with CFSMS as required. A non-executive directors was given responsibility to scrutinise assurance that security was being managed. The Estates and Facilities Manager chairs a regular meeting with front line staff to communicate issues on security.

At the Tavistock Centre, staff in front line services and the general office have been issued with ID badges and some of those staff have lone worker alarms.

Community and outreach staff that have been identified to be 'at risk' or work alone in the community have been issued with ID badges and lone worker personal safety alarms. If a member of staff has concerns about their situation, they can activate the silent Red Alert; Reliance staff are listening in and will relay the pre-recorded message for the staff location direct to the police. On that Red Alert, the unit also operates as a one-way radio to record the incident so that it can be used for prosecution if necessary. Mobile phones were procured for these staff.

CCTV has been installed on the Child and Family areas of the 1st and 2nd floors at the Tavistock due a significant number of theft incidents in that location.

B Fire Safety

During the refurbishment of the main reception, the revised Fire evacuation routes were exercised and new Fire Risk Assessments were completed for the new floor plans. Regular Fire Evacuation Exercises take place in October (for new the students) and in the summer term for both the Tavistock and Portman Buildings. The Day Unit also has regular fire evacuations organised by the Head teacher.

The Trust now has over 20 trained Fire Wardens and staff have Fire Prevention and Evacuation training and Fire awareness through the biennial INSET Days – (mandatory) training for all staff. All Trust staff working in locations run by other authorities have exercises and fire evacuations organised by that authority.

Testing and Maintenance of Fire Safety Equipment
Several Contracts are responsible for the maintenance and servicing all of our Fire Safety systems and equipment. Testing of the alarms is regularly undertaken by the Maintenance Craftsman. The Trust holds complete records of training and testing at each building.

Lisa J Tucker: Health and Safety Manager

Part 3 Incident Reporting & Mandatory training

3.1 Incident Reporting

The Trust's Incident Reporting and Serious Incident Procedures were assessed as being fully compliant with NHSLA standards in February 2009. Both procedures address barriers to reporting, e.g. the procedures positively encourage staff to report incidents and promote a fair blame culture. This approach is supported by the Trust's 'Raising Concerns at Work' policy.

Incident reporting forms are available to download from the intranet. The form is now a duplex sheet, which staff have found to be less daunting to complete. Incidents are graded and the details added onto the database. The Health and Safety Manager was available to help staff complete incident forms and reporting under Reporting Injuries, Diseases and Dangerous Occurrences Regulation (1995), (RIDDOR). The Governance and Risk Lead was responsible for uploading clinical incidents to the NPSA and for the external reporting of SUIs (to the NPSA and to our Commissioners).

Training on risk management and incident reporting procedures was part of the induction for both clinical and non-clinical staff (and is part of the mandatory INSET days).

The Risk Management Committee receives a quarterly report on incidents and directs further action as required; specific feedback is passed to Directorates. The Risk Management Committee monitors progress on any action that arises from an incident investigation.

Health and safety incidents are reported to the Health and Safety Committee and clinical incidents to the Clinical Governance Committee. Recommendations from both the Health and Safety Committee and the Clinical Governance committee are discussed in the Risk Management Committee, which enhances risk management integration across the Trust.

The Trust continues to have a comparatively low level of incidents see table below, but we are experiencing a slow increase in numbers (though a dip last year) which indicates that staff are becoming more engaged with the value of incident reporting. We do not think that there has been a corresponding risk in the number of incidents that occur.

Year	Incidents reported
2006-7	190
2007-8	221
2008-9	186
2009-10	264

264 were reported in 2009/10 (compared to 186 in 2007/8 and 221 in 2006/7. A summary of incidents reported in 2008/9 is shown at appendix A. The increasing trend is attributed to more reliable reporting due to the better awareness that exists following training.

In the past year, the Trust has had three personal accidents involving members of staff, which were reported under RIDDOR. Two of these relate to injuries sustained by staff working at the Day Unit; one staff member had a broken finger that resulted in a period (12 week) of sick leave, while the other staff member had suffered concussion (3 days off work). A member of Administration staff had an accident at their desk (resulted in restricted movement, and a requirement for physiotherapy); the staff member was off work for 3 days. In all these incidents, the Health and Safety Manager was involved with the Manager of the service in looking at prevention of reoccurrence and lessons learnt. Staff injury incidents and risk assessments of these the incidents were discussed at the quarterly meetings.

Summaries and analysis of incidents are considered at the Risk Management Committee (RMC). Minutes of the RMC are received by the Board of Directors.

In addition to formally reported incidents (via incident form), 'minor incidents' in the Day Unit are locally logged at around 150+ a week. This provides local managers with a day-to-day picture of what is happening in the Day Unit. This method of daily reporting has also been introduced for reception staff at the Tavistock Centre and a diary is kept on the reception desk for any minor occurrences that require monitoring rather than formal reporting. This diary is reviewed regularly by the Health and Safety Manager. This has become a useful tool for both areas and enables the Trust to record the number of instances that are resolved almost immediately, and identifies any patterns that can then be addressed.

3.2 Mandatory Training

The Trust has a fully updated Staff Training Policy; comprehensive training needs analysis of mandatory training was added. This policy has recently been assessed as fully compliant with NHSLA risk management standards. The current TNA schedule is shown at appendix B.

The Trust has reduced its frequency of delivery of core mandatory training via INSET to once in 2 years in response to feedback and in light of very low staff turnover.

In 2008-9, attendance at induction (which contains core mandatory training) was below target (at 66%); efforts in 2009-10 by the HR training team resulted in this figure increasing to 82% at March 2010.
At March 2010, we had achieved 100% for our target for INSET.

Part 4 – Developments in approach to Risk Management

4.1   Risk Register

The Trust continues to use of the risk register as a management tool. The Management Committee review all risks 9+ and the Board all risks 12+ on a quarterly basis.

We continue to refine the strategic register to complement the Annual Plan. It was fully revised in May 2009 in line with the new Annual Plan.

The risk register format has been reviewed by both the NHSLA and the internal auditors and found to be fit for purpose.

In 2009-10, we introduced a column re whether a risk was tolerated; this is now completed for all risks scoring 9+. This process was specifically commented on by the Internal Auditors in their annual risk management report as an exemplar of good practice.

4.2 Internal Auditor's opinion of the Trust's approach to Risk Management

The Trust continued to develop maturity in its approach to risk management. The risk strategy is updated annually.

The Trust was assessed by its internal auditors in November 2009 against a number of standards to assess our risk maturity. The auditors assessed our performance against the following scale, and concluded that the trust was 'risk managed' and close to 'risk enabled '. Their conclusion is shown below:

Quote from Auditors report Jan 2010

"Based upon the work undertaken, our assessment of the Tavistock and Portman NHS Foundation Trust's current position on the risk maturity spectrum is Risk Managed.

This is an improvement from the audit in Feb 2009 just 9 months earlier when the Trust was rated as *risk defined.*

These findings are encouraging and have prompted the Trust to continue to embed the systems that are working well and to enhance further that range of assurance that we rely on both internal and external.

Jane Chapman
Governance and Risk Lead

Appendix A: **summary report on formal complaints received 1 April 2009 to 31 March 2010**

Total complaints received: **10** (compared to 8 in 2008/09 and 10 in 2007/08)

Reporting arrangements:
Details of complaints are presented to the Risk Management Committee, the Management Committee and the Board of Directors on a quarterly basis.

Main themes/issues raised in the complaints (note that some complaints may contain a number of different concerns)

- Breach of confidentiality x 4
- Dissatisfaction with treatment x4
- Communication difficulties x1
- Administrative error x1
- Non-acceptance of referral x1
- Incident in group x1
- Staff attitude x1

Response arrangements and times.
All complaints were investigated by the Chief Executive with the help of the Director of the service complained about. The majority of complainants were offered a meeting with the Clinical Director of the relevant service, or another senior clinician. Summary of response arrangements shown below:

- 5 were responded to within the 25 days timescale
- 1 was not responded to within the 25 day timescale (difficulties arranging appointments with busy parents to discuss issues raised)
- 1 is delayed (patient has been informed)
- 2 are ongoing: one complainant has as yet unable to attend resolution meetings offered, and one complainant has attended a number of meetings with senior clinician to try and resolve matters – as yet unsuccessfully
- 1 is under investigation within time scale

Referral to H S Ombudsman
Complainants who remain dissatisfied with our response are entitled to refer their complaint to the Health Service Ombudsman, in 2009-10 no referrals were made

Changes to practice following complaints:

- One department to review its practice in respect of the amount of detail shared with other professionals.

- Staff training to be provided where indicated.

Lotte Higginson Complaints Manager

Schedule Formal Complaints received 2009-10

Date complaint received	PCT	Directorate	Core topics	Final response within 25 days*	Outcome/Lessons learned	Complaint status	Closed date
**2008/09 (not competed by year end)**
March 09	Camden	Adult	Patient requesting review of care complaint that patient needed more intensive treatment	yes	Request considered by the clinical team. Treatment that is more intensive not recommended. Patient informed of decision	Resolved Complaint not upheld	June 2009
**QUARTER 1 2009/10**
April 09	Camden	Adult	Breach of confidentiality – Complaint that too much detail shared with GP and referrer Communication difficulties Dissatisfaction with assessment	yes	Full explanations given to each of the issues raised by the patient Re. confidentiality – review as above Re. communication – review accessibility of PALS service Re. assessment – no evidence of poor practice. Patient discussed nature of assessment with Adult Directorate Head of Clinical Services	Resolved Complaint not upheld	April 09
May 09	Camden	Adult	Breach of confidentiality Complaint that too much detail of assessment shared with GP and referrer	yes	Letter retracted and a shorter letter sent Department to review its practice re. patient details shared with other professionals	Resolved Complaint upheld	June 09

QUARTER 2 2009/10							
July 09	Camden	C&F	Parent expressing concern about level of support offered to child (frequency of treatment)	no	Treatment currently being reviewed with clinician, but needs to be discussed with both parents	Resolved Complaint not upheld	Oct 09
	Kensington &Chelsea	Adult	Dissatisfied with assessment Breach of confidentiality – too much detail shared with GP/Referrer	yes	Explanation given of the purpose and nature of the assessment Plan to retract and replace with summaries to be agreed with patient	Part not upheld Part upheld	Oct 09
August 09	Barnet	Adult	Dissatisfied with treatment March 2010 – dissatisfied with outcome of meetings with senior clinician	no	Patient requested meeting with senior clinician to discuss concerns. Meeting scheduled to take place 8 October 09. Several meetings offered before finally taking place November/December. Further appointment scheduled for January 2010 March 2010 – patient asked for someone else to assist in resolving concerns. Matter being considered by Adult Department Clinical Director and Head of Clinical Services	Meetings taking place as requested by patient Last appointment in April ended on an unsatisfactory note and further complaint	Open
NO FORMAL COMPLAINTS WERE RECEIVED IN Q3 OF 2009/10							

			QUARTER 4 2009/10				
February 10	Tower Hamlets PCT	Adult	Administrative error – leading to further errors so that appointments were not received	Yes	Typing error identified as cause of problem	Resolved Complaint upheld	February 10
February 10	North East Essex PCT	Portman	Non-acceptance of referral Patient felt he was being denied treatment on wrongful grounds	No	Frequent, ongoing communications with complainant Clarified with Portman Clinic that referral had been properly considered Meetings offered with Consultant at Portman Clinic, but as at end March 2010 still under negotiation	Ongoing	Open
March 10	Kensington & Chelsea PCT	Portman	A member of a group was distressed by violent outburst by another group member (this was reported as a incident at the time of the event)	No Patient informed of delay		Under Investigation	Open
March 10	Camden	Support Services	A patient reported that a member of staff was rude to him when he was parking his bicycle	Yes	Upheld Staff to be offered further training	Resolved	
March 10	Camden	CAMHS	Mother alleges that family confidentiality was breached, in a case when the trust raised child protection concerns			Under investigation	Open

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

List of Statutory and Mandatory Training updated March 2010

Training topic	To be included in trust induction	To be included in local induction	To be included in annual inset day	Frequency of training	Staff Group										
					Admin and Managers				Clinical staff						Doctors
					Office admin and clerical	Non office based support staff	Front line admin and clerical	Managers (including Directors),	Clinical managers	Student psychologists/psychotherapist	Psychologists/psychotherapists	Social workers	Nurses	Clinical outreach workers	Doctors (all grades)
Statutory training															
Back care	☐			all staff once at induction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fire Evacuation procedure		☐		all staff annually (fire drill)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fire Safety			☐	all staff at INSET (two yearly)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Health & safety principles	☐	☐		all staff at induction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Required by CQC and/or NHSLA															
Basic life support				all doctors 3 yearly											☐
Confidentiality (Caldicott)	☐		☐	all staff at induction and INSET (2 yearly)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Safeguarding children intro				All staff at INSET (2 yearly)					☐	☐	☐	☐	☐	☐	☐
Safeguarding children Level 1 (intro)			☐	All staff INSET (2 yearly)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Safeguarding children Level 2				All clinical staff not receiving Level 3 and all admin staff in C and F and other areas who have contact with <16's (2 yearly)				☐	☐	☐	☐	☐	☐	☐	☐
Safeguarding children Level 3				All clinical staff in C and F (2 yearly)					☐	☐	☐	☐	☐	☐	☐
Safeguarding adults			☐	All staff at INSET 2 yearly	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Conflict resolution (Violence and \aggression)				front line staff once (with periodic updates)		☐	☐								

Topic				Description
Clinical supervision				All clinical staff locally continuous
Clinical risk assessment	☐			All clinical staff continuous locally
Promoting Equality & diversity			☐	all staff INSET 2 yearly
Infection Control incl hand washing	☐		☐	all staff at induction and included at INSET 2 yearly
Info. governance & counter fraud	☐			all staff at induction
Manual handling				all staff whose role involves lifting, once and periodic updates
Medicines management	☐			all nursing and medical staff once at induction (with local periodic updates)
Sharps injuries	☐			all staff once at induction (re: sharps injuries)
Investigation of incidents				All staff involved in incident investigation (once)
Risk management update				All Board members and senior managers annually
Risk assessment				All managers once training offered on rolling programme and one to one
Security		☐		All staff as part of local induction
Harassment and Bullying training				All Trust Managers as part of policy briefing once
Health Records Keeping training				All clinical staff continuously as part of supervision
Required by Trust				
First aid training				3 yearly update training all first aiders
Carenotes training				All staff using care notes once before login granted

Appendix C: Annual Incident Report Summary for 2009-2010

Adolescent	Potential harm	1
	Clinical	2
	Clinical	2
	Deliberate self Harm	1
	information incident	3
Adult	information incident	1
C&F	Violence	1
	Verbal Abuse	1
	Theft/Security	2
	Slip/trip/fall	2
	information incident	3
	absconding	1
	injury	1
	Clinical	1
Centre Heights	Damage to Property	1
DET	Security	1
	Injury	1
	information incident	1
	Financial	1
FDAC	Other	1
	information incident	1
General Office	information incident	1
Library	information incident	1
London Underground	information incident	1
Monroe	Threat	1
	Security	1
	Clinical	1
	absconding	1
	Infection control	1
PERU	Physical Incident	1
Portman	Security	2
	Violence / Damage to property	1
RFH A&E	Clinical	1
Tavistock Centre	Verbal Abuse	1
	Utilities	1
	Suicide threat	1
	Slip/trip/fall	2
	Security	6
	information incident	3
	clinical	1
Tavistock Café	Violence	1
	verbal Abuse	1

	TOTAL	**59**

Day Unit	Violence/ Verbal Incident	4
	Violence towards staff	41
	Violence / Damage to Property	24
	Violence	54
	Slip/Trip/fall	5
	Security	1
	Physical incident	10
	Patient Injury	1
	Other (false allegations)	1
	Other	2
	Endangerment	10
	Deliberate self harm	2
	Clinical (violence - pupil to pupil)	33
	Clinical	6
	Absconding	11

	TOTAL	**205**

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

Board of Directors : May 2010

Item : 8b

Title : Annual Review of Compliance with Risk Management Committee Terms of Reference

Summary:

The Risk Management Committee reviewed its assurance activities on risk identification, maintenance of the Risk Register, and management of policies and procedures on risk.

The Committee noted that it did this by receiving reports and ensuring standards were maintained through the provision of training. The Committee liaised with the Health and Safety Committee.

Overall, compliance with the Terms of Reference was high as evidence through the maintenance of high standards in the management of risk. However, limits on management capacity had led to some work not being thoroughly documented to the same high standard as it had been carried out.

Recommendations are made that should improve this function in the future; these include reviewing the assurance process and systems that support it.

For : Approval

From : Chief Executive

Annual Review of Compliance with Risk Management Committee Terms of Reference

1   Introduction

1.1   Under the Terms of Reference for the Committee approved by the Board of Directors, the Committee is required to review its performance on an annual basis to ensure that its continues to meet its Terms of Reference, and present its findings to the Board of Directors each year. This report covers 2009/10. The findings are listed under headings based on the duties of the Committee.

2   Findings

2.1   Attendance

Name	Apr 2009	Jul 2009	Oct 2009	Nov 2009[1]	Jan 2010
Chief Executive*	Y	Y	Y	Y	Y
Medical Director	Y	Y	Y	Y	Y
Trust Director	Y	N	Y	Y	Y
Director of Finance	Y	Y	Y	N	Y
A Non-Executive Director	Y	N	Y	N	N
Director of Corporate Governance & Facilities	Y	N	Y	Y	Y
Governance & Risk Lead	N	Y	Y	Y	Y
Health & Safety Manager	Y	Y	Y	N	Y
Caldicott Guardian[2]	--	--	--	--	--

Committee Chair

2.2   Risk identification

2.2.1   The Committee received and approved recommendations to update the Integrated Risk Strategy in January 2010, and updates to the associated risk procedures, as part of an annual review of risk processes.

2.2.2   On receiving the new requirements from the Care Quality Commission (CQC), and the inherent need to improve NHS Litigation Authority (NHSLA) compliance, a review of systems and structures was initiated. The review found that whilst good quality care was being provided it was sometimes difficult to find evidence that would assure the Board of Directors that external assessors would be satisfied with the outputs from current information systems. The Chief Executive presented a paper to the April meeting of the

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[1] Extraordinary meeting to review Care Quality Commission compliance submission
[2] Caldicott Guardian only attends if required

Board of Directors that set out new arrangements that clarify accountability and deliver assurance.

2.2.3   Ongoing training on risk is provided at induction and INSET, and managers are encourage to use risk assessment and the Risk Register to define and plan to reduce local risks. During the year, there has been an increasing awareness of the Trust's risk approaches and this is reflected in the Internal Auditor's findings.

2.3   Risk Register

2.3.1   The Trust maintained an up-to-date Risk Register for both strategic and operational risks to the Trust. This is examined by the Committee prior to scrutiny at the Board of Directors. In addition, a comprehensive annual report is made to the Board of Directors.

2.3.2   The Internal Auditors undertook an annual review of Risk Maturity in November 2009, and found that the Trust was "risk managed" this is point 4 on a 5-point scale, and is a point higher than for 2008/09. The Auditors informed us that this benchmarked us with the best managed of their clients, to date no Trust has been rated at "5".

2.4   Risk policies and procedures

2.4.1   The Trust's Risk Strategy and associated polices were updated and approved in January 2010. Other risk procedures were updated as the review date became due and those that were of interest to the Risk Management Committee were brought to the Committee for its consideration.

2.4.2   The Committee met quarterly to review management activity; it monitored activities within the Trust that reduced risk. During the year, it received incident reports, complaints reports and Serious Untoward Incident (SUI) reports. Where action plans were agreed, the implementation of those plans was monitored. There was only one SUI in the year; the report and subsequent action plan was received and monitored by the Committee. Not all recommendations were fully met at the time of writing.

2.4.3   The Committee presented a useful paper on leadership in health and safety to the Board of Directors.

2.5   Receive reports

2.5.1 The Committee received reports on incidents, complaints, claims at each of the meetings. It received an integrated report drawing together aggregated learning, in line with agreed procedures. The introduction of the aggregated analysis report was useful in moving towards a strategic overview. The Board of Directors assured this process through receipt and scrutiny of the Committee minutes.

2.5.2 The Committee noted good progress in following through action plans because of adverse incidents.

2.5.3 The Committee noted that the number of complaints was low and that the number of serious complaints was negligible.

2.5.4 The Day Unit was an area in which special attention was given due to the relatively high number of incidents; however, in relation to similar units elsewhere it was noted that this level of incidents was commensurate with the work undertaken. However, the Committee failed to ensure that report it commissioned was delivered in a timely fashion (to date it is still outstanding).

2.6 Training on risk management

2.6.1 A mandatory training needs analysis is undertaken annually and approved by the Staff Training Committee; it was updated in January 2009 and March 2010.

2.6.2 During the year, the Board of Directors and senior managers received training from Mark Bout, Principle Risk Adviser, DNV. Staff received training at INSET, induction, and risk assessment. Incident reporting training sessions were run twice each during the year for middle managers. Additionally, in July 2009 a half day work shop for clinical staff, which covered clinical and non clinical risk assessment, was attended by representatives of all directorates.

2.6.3 The Committee noted the need for managers to exercise their responsibility to ensure staff were receiving training as numbers trained had been disappointing. However, the Committee did not commission any follow-up to see that its direction had been implemented.

2.7 NHSLA Risk Management Standards

2.7.1 The Committee noted the plan to work towards achieving NHSLA Level 2 compliance following success at achieving

NHSLA Level 1 in February 2009. The Trust achieved a 100% pass rate at Level 1; therefore, an action plan to remedy deficiencies was not required.

2.8 Liaison

2.8.1 The Committee received minutes from the Health and Safety Committee.

3 Conclusion

3.1 Risk in healthcare cannot be eliminated and affects, to a greater or lesser degree, the achievement of all Trust objectives. The Committee's role is to provide assurance to the Board of Directors that risk is being identified, and managed and where possible reduced.

3.2 In the course of the year, the Committee had a tendency to be drawn into an inappropriate level of management detail on incidents and processes, which compromises this higher function. The introduction of the aggregated analysis report was a positive step in this direction.

3.3 Whilst on further investigation most matters seemed to have been completed, this was not always apparent from the minutes.

4 Recommendation

4.1 More appropriate forums for discussing management information and planning projects should be developed. A new structure to deliver assurance to the Board of Directors and external regulators should be developed in parallel with a new system for efficient management.

4.2 The Chair and Secretary of the Committee should ensure that a record of all actions completed is included in the minutes.

Board of Directors : May 2010

Item : 9

Title : Annual Clinical Governance Report 2009/10

Summary:

This report summarises the clinical governance activities across the Trust for 2009/10. The report is presented to the Board of Directors as an Executive Summary and list of appendices.

For : Discussion

From : Medical Director

Clinical Governance Report 2009/10

Executive Summary

1 Introduction

1.1 The Trust continues to do well from the perspective of external regulation and scrutiny. Once again we achieved a rating of "excellent" for the quality of our clinical services from the Care Quality Commission (CQC) and achieved Level 1 in the NHS Litigation Authority (NHSLA) risk management standards.

1.2 The increased emphasis on quality contained in high level policy documents (*High Quality Care for All: NHS Next Stage Review Final Report*[1]) has been translated in a sometimes bewildering number of ways by both regulators and commissioners: Quality Accounts, Quality Standards, Quality, Innovation, Productivity and Prevention (QUIPP), Commissioning for Quality and Innovation (CQUINS). They all highlight the importance of effectively engaging clinicians and managers together with the role of information and measurement in supporting quality improvement with particular reference to patient safety, clinical effectiveness and patient experience.

1.3 A number of other factors have contributed to changes in the NHS context within which we operate including the tragic death of Baby Peter in a neighbouring Borough, the enquiry into Mid Staffordshire Foundation Trust (The Francis Report, 2010) and the pandemic influenza.

1.4 The above factors, together with the inevitable additional burden placed on our relatively modest resources in clinical governance, have informed the review of our Clinical Governance, Safety and Governance structures and proposed changes which have been considered and approved by the Management Committee and the Board of Directors.

2 Structure and Organisation

2.1 The new structure has two aims. First, to develop and deliver the Trust's Clinical Quality, Safety and Governance agenda and second, to ensure that sufficient assurance is provided to both the Board of Directors and the Board of Governors around this work.

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[1] Department of Health, *High Quality Care for All: NHS Next Stage Review Final Report*, 2008

2.2 In summary, the Medical Director will chair a new Clinical Quality, Safety and Governance Committee (CQSGC). The Committee will replace the Clinical Governance Committee and will lead and oversee a number of work streams falling under its remit, namely:

2.2.1 Corporate Governance and Risk

2.2.2 Clinical Outcomes

2.2.3 Clinical Audit

2.2.4 Patient Safety and Clinical Risk

2.2.5 Quality Accounts and Contracting Informatics

2.2.6 Patient Experience and Public Involvement

2.3 Responsibility for work streams will be delegated to named Directors who will report to the CQSGC. The Committee will receive and review assurance from these work streams, reporting to the Board of Directors. This Committee will have strong Non-Executive Director representation and the Chief Executive will be a member of the Committee.

2.4 Terms of Reference for the new Committee will come to the Board of Directors for approval in June 2010 and the first meeting of the new Committee will be in July.

3 Safety and Clinical Risk Management

3.1 For a more detailed account of activity in relation to clinical risk and patient safety, the Board of Directors is directed to the relevant sections in the report of the Risk Management Committee which is coming to the Board of Directors this month.

3.1.1 Risk has been well managed and this has been verified through audit and benchmarking.

3.1.2 During the year, the Trust continued to embed our risk approach within our clinical and corporate governance arrangements. As we look to 2010/11, we are planning to improve our structures further so they are better able to cope with the increasing demands of ongoing assurance to meet CQC and NHSLA standards. These plans will, in addition, further enhance our mechanisms to enable us to ensure that we learn from each opportunity there is to

improve patient safety, reduce risk and improve quality of care and experience.

3.1.3   The Trust is not complacent despite the low number of clinical incidents. As the Trust expands services to cover new high-risk groups, it remains committed to ensuring that staff retain and develop skills in risk assessment, both of individual patients and of wider issues. The Trust will continue to promote incident reporting and learning and encourage effective risk assessment of events / scenarios so that plans can be put in palace to mitigate, as far as possible, risks.

3.1.4   Migrating to the new patient record system, RiO, brings with it a new set of risks, but we are actively working together to ensure that all the good work that has been undertaken to fine tune our current record keeping paperwork and systems can be incorporated effectively within the RiO framework.

3.1.5   A focus for 2010/11 will be strengthening the processes we have for providing assurance that our robust systems and processes are indeed effective at mitigating risk and improving patient care and experience.

4   Clinical and Cost Effectiveness

4.1   The Healthcare Commission set out a number of standards which its successor, the Care Quality Commission, has retained relating to clinical and cost effectiveness, these include:

4.1.1   Conforming to the NICE technology appraisals, NICE guidelines and National Safety Frameworks

4.1.2   Ensuring staff continually update their skills

4.1.3   Clinicians participate in clinical audits and service reviews

4.1.4   Healthcare organisations co-operate with each other to ensure that the needs of patients are met.

4.2   The Trust continues to gather evidence against all of the above standards and requirements to ensure our compliance with the latest published guidelines. After a recent meeting with our Camden Commissioners, it was agreed the Trust provide quarterly reports stating adherence and compliance to all published guidelines relating to mental health. Our initial report to these Commissioners' covered the following four guidelines:

4.2.1 *CG82 Schizophrenia* – issued March 2009

4.2.2 *CG89 When to suspect child maltreatment* – issued July 2009

4.2.3 *CG90 Depression in adults (update)* – issued October 2009

4.2.4 *CG91 Depression with a chronic physical illness* – issued October 2009

4.3 Each Directorate has completed baseline assessments for each of the above guidelines detailing their relevance / non-relevance and any action plan they have informed. We have agreed to provide reports on all other relevant guidelines published since 2007 and will endeavour to provide reports on these as soon as practicable.

4.4 Each Directorate continues to provide detailed information regarding their clinical governance activities which list all completed and ongoing audits being undertaken, stating progress, completion and any outcomes to inform / improve our services. These audits are conducted separately from the Trust-wide annual Case Note Audit and an annual Suicide Audit (see risk section above). Our audit database contains all Trust audits by Directorate and it is hoped that this shared information will enhance our work and spread lessons learned throughout the organisation.

4.5 In addition to the above audits the Trust has again taken part in two national audits, on homicide and suicide prevention. Our input to nationally approved audits remains a plus for the organisation and again informs our work with specific patient groups.

4.6 We continue as a Trust to implement outcome monitoring system, which has grown in relation to requirements and input and this has allowed us to identify areas of improvement. We recognise the need to promote the outcome monitoring system within the organisation as a whole and ensure each service line, including outreach services, is working in unison to provide the ever increasing reporting requirements both for internal Board of Directors assurances and also for reporting to our commissioners externally.

4.7 Each Directorate has prepared an annual outcome monitoring report and local recommendations as part of their Directorate report. The activity is summarised below and the reports are available as attachments to this document. Following a recommendation in last year's report outcome monitoring is now discussed bi-annually at the Trust Clinics Committee.

5   Clinical Audit

5.1 Clinical Audit will be a work stream in the new structures led by an Associate Medical Director. Systematic, critical enquiry into the quality and effectiveness of our services and the patient experience is a crucial element of any plan to improve the quality of the services we provide. Medical revalidation will require doctors to participate in regular audits of the services to which they contribute and this is likely to extend to other disciplines. A key element of the Trust clinical audit programme continues to be its annual Case Notes, Referrer and Communication Audit which was completed in January 2010. A number of areas of concern emerged from this year's audit and the recommendations and action plans from this audit are included as an appendix to this document.

5.2 The Clinical Governance Executive Assistant maintains a spreadsheet of all ongoing and completed audits. This promotes information sharing between the directorates and supports the Clinical Quality, Safety, and Governance Committee in its work of considering relevant audits to promote quality practice and/or examine "problem or risk areas".

5.3 **Action points**

5.3.1 The Clinical Governance Executive Assistant will continue to maintain a register of audits taking place within the Trust with the lead person responsible and a timescale for likely completion. Clinical Audit was a standing item at the Clinical Governance Committee and will be a standing item at the Clinical Quality, Safety and Governance Committee, with regular reports from Clinical Governance Leads about activity in their Directorate. (Medical Director, Clinical Governance Executive Assistant, Clinical Governance Leads. Timescale: immediate and on-going).

5.3.2 Specific essential audits, including the Case Note and Suicide Prevention Audits, will be scheduled into the year's programme and staff notified accordingly to promote cooperation. Follow up plans and re-auditing where appropriate will be recorded in the Clinical Governance minutes with timescales.

5.3.3 Each Directorate to prepare a local action plan to ensure that lessons from the Case Note Audit are learned and practice in weak areas improves.

5.3.4 Consider the need for a separate audit of records for patients who attend groups as mode of treatment and commission an audit of record-keeping for groups in 2009/10.

6 Outcome Monitoring

6.1 The importance of outcome monitoring is increasing as it gets incorporated into commissioners' interpretations of quality reflected, for example, in financial incentives dependent on CQUIN targets. Dialogue with commissioners is critical if these demands are to remain relevant and achievable. An outcome monitoring work stream will be lead in the new structures by an Associate Medical Director. Patients' views on quality will be increasingly important in the commissioning and evaluation of services. Work on patient reported and patient determined outcomes which is already underway will need to be prioritised and advanced.

6.2 CAMHS Outcome Monitoring Programme

6.2.1 Routine outcome monitoring data has been collected in the CAMHS Directorate for several years. However, the range of measures used needed to be expanded in order to fulfil the requirements of CORC (CAMHS Outcome Research Consortium). CORC specifies an agreed common set of measures to routinely evaluate outcome from at least three key perspectives (the child, the parent / carer and the practitioner).

6.2.2 The CAMHS Directorate undertook a six-month pilot project across two generic teams in Camden (October 2009 – April 2010) in order to implement the expanded protocol. All processes, including significant additional IT support were put in place and information is now being provided on a monthly basis to the Camden CAMHS Commissioner. However, initial return rates have been low, but to address this issue a number of changes have been made to the format of data collection. In addition, the Trust is hosting a training workshop on outcome monitoring for CAMHS clinicians in May 2010, to help increase the relevance and value of outcome measures for clinicians. There remain concerns, however, that the return rates will not meet the target of 60% required by the Camden CAMHS Commissioners by the end of this financial year (2010/11). An action plan is in place to mitigate this risk. Currently, the expanded protocol is in use in clinical teams providing CAMHS to patients and families living in Camden, with plans later this year to implement the protocol across all services within the Directorate for every new patient referred.

6.2.3   The Learning and Complex Disabilities Service, the Under Fives Service and the Fostering and Adoption Service will be piloting new outcome measures specifically designed for the population of children / young people who attend these services.

6.2.4   Collection and reporting of the agreed CORC dataset has now been implemented across Camden Service Lines. However, for 2010/11 the Directorate needs to improve data collection in the following domains: demographic data, presenting problem, and professionals involved for every new case. There have been technical problems related to use of new forms which have been resolved. An additional outcome monitoring report will be completed in May 2010 to evaluate compliance.

6.2.5   Further work is been undertaken to ensure, where possible, that the outcome monitoring processes and core dataset are compliant with the new electronic patient record system (RiO) which will be launched in September 2010.

6.3 **Adult Outcome Monitoring Programme**

6.3.1   At this time, outcome monitoring in the Adult Directorate is based on the CORE System (Clinical Outcomes for Routine Evaluation) which was developed in the UK for use in psychotherapy to measure outcome, and to provide data for service audit and evaluation. The return rates have remained consistently low over the past number of years. However, a change in the outcome monitoring protocol has had the effect of further increasing the return rates of forms from patients. Now, rather than receiving the end of treatment form by post, clinicians hand the forms directly to patients. In addition, new outcome measures are also being piloted in the Adult Department Brief Therapy Service and will be reported on later in 2010/11.

6.4 **Action Points**

6.4.1   Directors' Conference on 8th June to review outcome monitoring and outline work plan.

6.4.2   Work stream lead for outcome monitoring to draw up action plan for the coming year with emphasis on quality and the patient experience.

7   **Conclusion**

7.1 Challenges exist for the organisation in all areas of clinical governance. Clear accountable leadership of the work streams and Committees in the new structures will facilitate more effective delivery in these areas. The Trust will continue to meet the highest standards for quality, safety and effectiveness in line with externally driven requirements but also to meet our own aspirations and those of our service users. Particular attention must be paid to *evidence* of the safety, quality and effectiveness of our services to withstand more effective scrutiny from regulators and commissioners and as we move to Level 2 NHSLA standards.

Dr Rob Senior
Medical Director
May 2010

Appendices

1	Case Note Audit – Summary and Recommendations 2009/10	M:\Board of Directors\2010-11\2.
2	Clinical Governance Annual Directorate Reports – Child & Family	M:\Board of Directors\2010-11\2.
3	Clinical Governance Annual Directorate Reports – Adolescent	M:\Board of Directors\2010-11\2.
4	Clinical Governance Annual Directorate Reports – Adult	M:\Board of Directors\2010-11\2.
5	Clinical Governance Annual Directorate Reports – Portman	M:\Board of Directors\2010-11\2.
6	Outcome Monitoring Annual Directorate Reports – Child & Family	*Available on request*
7	Outcome Monitoring Annual Directorate Reports – Adolescent	*Available on request*
8	Outcome Monitoring Annual Directorate Reports – Adult	*Available on request*
9	Outcome Monitoring Annual Directorate Reports –	*Available on*

Board of Directors : May 2010

Item : 10

Title : Corporate Governance Report

Summary :

The report covers the following items:

1. NHS Constitution

2. Register of Directors Interests

3. Monitor Updates

4. Directors' Conference

For : Noting

From : Trust Secretary

Corporate Governance Report

1. NHS Constitution

1.1 The NHS Constitution is a legally binding document, the latest version of which came into force on 19th January 2010, to which all NHS organisations in England are expected to have regard to.

1.2 The Constitution contains rights, which are legal obligations, and pledges, which the NHS is committed to achieve, but which cannot be guaranteed.

1.3 The Board of Directors is invited to confirm that the Trust meets all of the Rights and has regards to the Pledges tabled at Appendix A. *The NHS Constitution for England March 2009* and the *Handbook to the NHS Constitution* have been sent to Directors separately. These can also be accessed via the Department of Health's website:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613

2. Register of Directors' Interests

2.1 The Register of Directors' Interests has been amended in line with the suggestions made by the Board of Directors and is presented at Appendix B for information.

3. Monitor Updates

3.1 New Chair

3.1.1 Following the departure of the Executive Chair, Bill Moyes, Monitor has split the role into a Chair and Chief Executive. Steve Bundred took up the role of Chair on 1st May 2010 Mr Bundred was previously Chief Executive of the Audit Commission. The new Chief Executive has yet to be appointed.

3.1.2 The Foundation Trust Network will be hosting a dinner with Mr Bundred for FTN member Chairs and Chief Executives in June.

3.2   Monitor's Business Plan 2010/11

    3.2.1   Monitor has published its Business Plan 2010/11, which sets out its agenda for the year. "*The plan is split into our five core strategy areas and describes what we will deliver this year, working closely with our partners where appropriate. Our first strategy area described in the plan - operating a proportionate, risk-based regulatory regime – will be of particular interest to foundation trusts. It describes the initiatives we will undertake this year to enhance the effectiveness of our regulatory regime.*"

    3.2.2   The business plan can be accessed via the following website:

        http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/about-monitor/business-and-corporate-plans/2009-12/business-pl

4.   Directors' Conference

4.1   The next Directors' Conference will take place on 8th June, and will be on the topic of outcomes.

5.   Foundation Trust Network Conference

5.1   The FTN Governance Conference, "Navigating the storm: governance in changing times", will be taking place on Wednesday 15th September in Central London. "*The conference will explore the challenge for foundation trusts as the NHS recession begins to bite and the consequences of the general election take shape. It will have a particular focus on the role that governance will play in helping foundation trusts to weather the storm.*"[1] Monitor's new Chair, Steve Bundred, will be speaking at the conference.

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[1] Foundation Trust Network, *In Touch*, Issue 113, 14th May 2010

NHS Constitution

The NHS Constitution is a legally binding document, the latest version of which came into force on 19th January 2010, to which all NHS organisations in England are expected to have regard to.

Rights
A right is a legal entitlement protected by law. The Constitution sets out a number of rights, which include rights conferred explicitly by law and rights derived from legal obligations imposed on NHS bodies and other healthcare providers. The Constitution brings together these rights in one place but it does not create or replace them. You'll find a description of the legal basis of each right in the appendix to this Handbook. For information on what each right means for patients and staff, see the relevant sections of the Handbook.

Pledges
This Constitution also contains pledges which the NHS is committed to achieve, supported by its management and regulatory systems. The pledges are not legally binding and cannot be guaranteed for everyone all of the time, because they express an ambition to improve, going above and beyond legal rights.

Access to health services	
Rights	**Pledges**
1 "You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament."	1 "The NHS commits to provide convenient, easy access to services within the waiting times set out in this Handbook to the NHS Constitution."
2 "You have the right to access NHS services. You will not be refused access on unreasonable grounds."	2 "The NHS commits to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered."
3 "You have the right to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary."	3 "The NHS commits to make the transition as smooth as possible when you are referred between services, and to include you in relevant discussions."

4	"You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner."
5	"You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age."
6	"You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution."

Quality of Care and Environment			
Rights		Pledges	
1	" You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality."	1	"The NHS commits to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice."
2	" You have the right to expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide."	2	"The NHS commits to continuous improvement in the quality of services you receive, identifying and sharing best practice in quality of care and treatments."

Nationally approved treatments, drugs and programmes	
Rights	Pledges
1 " You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you." NICE (the National Institute for Health and Clinical Excellence) is an independent NHS organisation producing guidance on drugs and treatments. 'Recommended' means recommended by a NICE technology appraisal. Primary care trusts are normally obliged to fund NICE technology appraisals from a date no later than three months from the publication of the appraisal.	1 "The NHS commits to provide screening programmes as recommended by the UK National Screening Committee."
2 " You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you."	
3 " You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme."	

Respect, Consent and Confidentiality	
Rights	Pledges
1 " You have the right to be treated with dignity and respect, in accordance with your human rights."	1 "The NHS commits to share with you any letters sent between clinicians about your care."
2 " You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests." If you are detained in hospital or on supervised community treatment under the Mental Health Act 1983 different rules may apply to treatment for your mental disorder. These rules will be explained to you at the time. They may mean that you can be given treatment for your mental disorder even though you do not consent.	
3 " You have the right to be given information about your proposed treatment in advance, including any significant risks and any alternative treatments which may be available, and the risks involved in doing nothing."	
4 " You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure."	
5 " You have the right of access to your own health records. These will always be used to manage your treatment in your best interests."	

Informed Choice	
Rights	Pledges
1 "You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons."	1 "The NHS commits to inform you about the healthcare services available to you, locally and nationally."
2 "You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply."	2 "The NHS commits to offer you easily accessible, reliable and relevant information to enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available."
3 "You have the right to make choices about your NHS care and to information to support these choices. The options available to you will develop over time and depend on your individual needs."	

Involvement in your Healthcare and the NHS	
Rights	Pledges
1 "You have the right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this."	1 "The NHS commits to provide you with the information you need to influence and scrutinise the planning and delivery of NHS services."
2 "You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services."	2 "The NHS commits to work in partnership with you, your family, carers and representatives."

Complaint and Redress	
Rights	Pledges
1 "You have the right to have any complaint you make about NHS services dealt with efficiently and to have it properly investigated."	1 "The NHS commits to ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and the fact that you have complained will not adversely affect your future treatment."
2 "You have the right to know the outcome of any investigation into your complaint."	
3 "You have the right to take your complaint to the independent Health Service Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS."	2 "The NHS commits, when mistakes happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively."
	3 "The NHS commits to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services."
4 "You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body."	
5 "You have the right to compensation where you have been harmed by negligent treatment."	

Register of Directors' Interests 2010/11

Register of Directors' Interests 2009/10

1. Introduction

All existing Directors shall declare relevant and material interests forthwith and the Trust shall ensure that those interests are noted in the Register of Directors' Interests. Any Directors appointed subsequently shall declare their relevant and material interests on appointment.[2]

2. Interests

Interest	Name	Disclosure[3]
Directorships, included non-executive directorships held in private companies or PLCs (with the exception of those directorships of dormant companies)	Mr Martin Bostock, Non-Executive Director	• Chairman & Director, Nelson Bostock Communications (wholly – owned subsidiary of CRESTON PLC)
Ownership, part-ownership or directorships of private companies, businesses or consultancies likely or possibly seeking to do business with the National Health Service	Mr Altaf Kara, Non-Executive Director	• Director at Ernst & Young, which offers advisory services to all parts of NHS
Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the National Health Service	*No disclosures made*	
A position of authority in a charity or voluntary organisation in the field of health and social care	Ms Joyce Moseley, Non-Executive Director	• Chief Executive, Catch22, a charity providing services to young people, some of whom may have mental health difficulties. There is a very slight chance (but unlikely) that Catch22 and the Trust could bid for the same contract

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[2] Tavistock & Portman NHS Foundation Trust, *Constitution, Election Rules, Standing Orders*, February 2010, Annex 5, 10.1
[3] A lack of disclosure from any Director indicates a nil return on the Declaration of Interest

Interest	Name	Disclosure[3]
	Mr Altaf Kara, Non-Executive Director	• Trustee, Find The Time – a bone marrow promotion charity. Now dormant
	Ms Trudy Klauber, Dean	• Trustee, Phillis Trail Foundation – scholarships to trainees in child and adolescent psychotherapy
	Ms Louise Lyon, Trust Clinical Director	• Chair, Tavistock Clinic Foundation (Registered charity)
	Ms Angela Greatley, Trust Chair	• Board Member, Headstrong (Irish National Youth Mental Health Centre)
Any connection with a voluntary or other organisation contracting for National Health Service services or commissioning National Health Service services	*No disclosures made*	
Any connection with an organisation entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to lenders or banks	*No disclosures made*	

The following Directors have no interest to declare in any of the above categories:
• Matthew Patrick
• Emma Satyamurti
• Rob Senior
• Richard Strang
• Simon Young

Clinical Governance Committee

Meeting Minutes 26th January 2010

Present:		
Rob Senior (Chair)	Judit Germuska	Maxine Dennis
Joyce Moseley	Pat Key	Stephanie Cooper
Limor Abramov	Hannah Morgan	Sally Hodges (in part)
Caroline McKenna (in part)	Irene Henderson (Minutes)	
Apologies:		
Jessica Yakeley, Jane Chapman, Elisa Reyes-Simpson		

Summary of Action Points:

Agenda item	Subject	Action by
2.1	**CAMHS Risk Training** LA & CM to produce & circulate to CGC members, a short proposal plan to formulate this change and show it as a piece of evidence, able to withstand external scrutiny	**CM & LA**
2.2	**Texting and emailing adolescent patients** LA to forward permission form to all CGC members. MD to discuss within the adult department and feed back.	**LA & MD**
3.1	**Chair's Report – Proposed new structure** RS & LL to produce a paper about the new CG structure for the Management Committee which will also come to the CGC. (IH) to email CGC's and CGC Leads once 11.30 meetings have been confirmed.	**RS & LL**
4	**Letters for GPs** CGC members to inform all staff in their directorate to only send specific information re specific requests to GPs re patients.	**CG Leads**
9.1	**Annual Records Audit** JC to draft Audit Report for the Board by mid March	**JC**
10	**NICE guidelines - standing item** IH to ensure that hard copies of the NICE current guidelines are put in each department's common room.	**IH**
12	**Risk Register – Standing Item** PK to organise access to the risk register for SC.	**PK**
13	**2009 Patient Survey Report** IH to add to March agenda	**IH**

1. **Review of minutes & action points of Clinical Governance meeting 29th September 2009**

The minutes of the 24th November 2009 were agreed. Progress on action points as follows:

2.1   CAMHS Risk Training (2)

LA prepared a paper describing the current situation within Adolescent Dept on how clinicians are being informed about clinical incidents. It seems the message is given in

many forums including induction, team meetings etc and this is thought to be adequate in keeping clinicians reminded of the need for clinical incident reporting. They have however identified 2 gaps

    a) more training is required for clinicians to actually carry out a clinical incident reporting
    b) the lack of evening duty clinical cover may present problems in risky cases, mostly those we have to react quickly to.

ACTION: LA & CM to send a draft paper to all CGC members with a view to forming a cohesive plan.

2.2   **Texting and emailing adolescent patients**

LA produced a permissions form particularly targeted at Adolescent patients. This will be forwarded to the following committees, CGC, back to service lines, then on to the Clinics committee. It was agreed that it would be good to get a uniform policy for an opt-in scheme across the Trust. MD agreed to report back to Adult dept for feedback.

ACTION: LA to forward permission form to all CGC members
        MD to discuss with Adult dept and feed back.

3.   **Chair's Report**

3.1   **Proposed new structure**

The times of the full CGC meeting will change to 11.30am for all future meetings. SH is also trying to move the PPI Committee to allow for this change. This will increase the CGC meetings to 1½ hours and allow the committee to expand it's remit to include quality. The quality Programme Board – Louise Lyon will attend to help identify CGC Leads across all directorates. MD also explained that it is difficult for her to attend the CGC Leads meetings as she other commitments, so we will also try to move the CGC Leads meetings to 11.30am.

ACTION: RS & LL to produce a paper for the Management Committee which will also come to the CGC. This will be dominated by standards and risk driven mainly by external regulations.
        RS (IH) to email CGC's and CGC Leads once 11.30 meetings have been confirmed.

4.   **Letters for GPs**

It has been noted that the Trust standard for responses to GPs regarding patients must contain relevant information only. Our letters must only answer actual requests and not to forward termly summaries which carry far too much detail.

ACTION: CGC members to inform all staff in their directorate to only send specific information re specific requests to GPs re patients.

5.   **Clinical Risk - standing item**

RS confirmed that our planned Level 3 training programme was now complete and all relevant staff have now been trained.

(SH joined the meeting)

6.   CQC requirements - standing item

PK reported that we are now applying to register and this would be complete by the end of this week. Today there is a paper going to the Board to approve the evidence for the Essential Standards. This is similar to the core standards but now includes new work surrounding quality. PK confirmed she met with our assessor last week and the assessor felt we would be compliant.

7.   Other requirements Learning Disability Key Indicator

It was reported that we are on target to meet the CQC requirements.

8.   Outcome Monitoring - standing item

There are no new issues for OM. JG asked when the report was due and RS said it needed to be prepared by the end of April for the May/June Board.
RS explained his bid for a scanner and software was successful and this has now been purchased. This is expected to speed up and enhance the work of the outcome monitoring team and training is organised on this new system for February.

CM added she is meeting today with Camden Outcome Monitoring Steering Group and yesterday she attended the clinical services meeting. CM reported that the vast time consuming efforts by OM staff, teams and CM were not feasible anymore and that a new structure needs to be put in place. CM is suggesting a complete change to our system in North Camden Team, whereby we ask the families to attend 15 minutes earlier than their appointment and they actually fill in the questionnaires there and then. Other services are already using this system and agree it is much better and produces the necessary outcomes. We would also expect staff to score the SDQ's and this will impact on admin staff and receptionists and more training may be required for them. CM also reminded the committee that this work with the outreach services needs to be addressed.

It was noted that a new database for goal based measures and CHI-ESQ was created by Cherie Pope in Informatics, which has helped with this work.

RS asked what position the Royal Free was in and CM explained they are in the same situation as us regarding return rates.

CM reported that there was an Outcome Monitoring Conference on 1st March at the Anna Freud Centre, from 10am – 4pm, including how the data is used and this should be attended by relevant staff.

MD asked if the patients have actually been asked how they would best like to be contacted? This seems not to have happened, except in the Adolescent dept, and it is something that may help us collect more information in the best way. JG asked how the planned changes in OM procedures will affect her role?

9.   Trust Audits - standing item

9.1   Annual records audit
HM explained the Adolescent, Adult & Portman data collection have been completed and JC is drafting the audit report. JG explained they are now starting the North and South Camden C&F audit, about 15 casenotes per team, and have requested the files from medical records archive. RS asked how the casenotes had been selected. JG said it was a random selection. RS requested the draft report by the end of March. MD is to check the Adult audit situation.

RS explained doctors, GMC require evidence of clinical practice audit, where the teams are audited and the doctors contribution via appraisals.

ACTION: JC to draft Audit Report for the Board by mid March.

10.   NICE guidelines - standing item

RS said we have organised a NICE compliance meeting with the Camden Commissioners early next month. RS asked for a draft from the CGC Leads re the following studies; Adult Depression study, antisocial behaviour and borderline studies in time for this meeting.

LA requested a hard copy of the NICE guidelines to be in each department's common room, for ease of access to clinicians.

ACTION: IH to ensure that hard copies of the NICE current guidelines are put in each department common room.

11.   Clinical Risk Reporting - standing item

There were no significant clinical incidents reported since the last meeting.

11.1 Issues arising from Incident at the Portman
The issue of the Portman receiving a less than adequate service from our security team have been addressed in meetings between PK and the Portman. The results of this meeting will be tested once a security incident happens.

12.   Risk Register - standing item

RS just reminded people to update clinical risk registers with any risks. SC asked where the risk register was kept and what information on risk it contained. PK explained there are 2 risk registers one showing low risk and the other medium to high risk.

ACTION: PK to organise access to the risk register for SC.

13.   2009 Patient Survey Report

ERS will give a full report on this in the March CGC. PK explained that the report needs to go to the Board in March to complete our performance indicators. It will require lots of work, so any comments or queries would be welcome prior to that.

ACTION: IH to add to March agenda

14.   AOB

Patient Survey Update
SH gave an overview of the patient survey system. SH explained the postal survey response rate was down 1% at 20%, 75% of whom were fairly satisfied or satisfied and would recommend the service to a friend. SH said the survey often showed 2 groups, those who were very satisfied and grateful and those who were dissatisfied and used the survey to complain. It seems we get little response from the section that feel the service is just ok. It wads felt more telephone and online work needed to be done to help capture this group. SH said she had a resource that could cover this extra work. The overall conclusion is that there was nothing significant arising from the survey that suggests we need to change our procedures at present.

There was discussion surrounding whether patient are being sent too many questionnaires, which in itself would put them off responding.

Next CG Committee meeting:
Tuesday 23rd March 2010 – Board Room – 11.30am

Patient and Public Involvement Committee

Meeting Minutes, 12.00 – 1.00pm, Tuesday 23rd March 2010

Present:			
Sally Hodges Trust wide PPI Lead (Committee Chair)	Laura Baxter Trainee Clinical Psychologist	Kate Bermingham Communications Officer	Martin Bostock Non-Executive Director
Louise Carney Trust Secretary	Stephanie Cooper Trust Governor	Patricia Edwards Patient and Public Representative	Angela Greatley Trust Chair
Debbie Lampon PALS Officer	Ken Rowswell Patient and Public Representative	Kathryn Tyler Communications Specialist	
In Attendance			
Susan Blackwell Executive Assistant, PPI (Committee Secretary)	Katrin Eichhorn Camden Community Development Worker (Agenda item 5)	Kate Spiegelhalter Camden Community Development Worker (Agenda item 5)	Matthew Patrick Trust Chief Executive (Observer)
Apologies			
Angela Alban Patient and Public Representative	Sarah Davidson Adolescent Department PPI Lead	Maggie Fagan Child & Family Department PPI Lead	Simone Hensby Trust Governor
Mary Murphy Ford Adult Department PPI Lead	Georgina Selby Project Assistant, Dept. of Education and Training		

Actions

AP	Item	Action to be taken	By
1	3	KT and DL to design an out-of-hours patient information leaflet	KT / DL
2	3	SH to invite Committee members to join the Quality Improvement Plan working group	SH
3	8	SH to email all Directors to ask how volunteers could assist in their services	SH

1. Chair's Opening Remarks

Introductions
SH introduced and welcomed Katrin Eichhorn, Kate Spiegelhalter, Angela Greatley, Stephanie Cooper and Matthew Patrick to the PPI meeting.

2. Apologies for Absence

Apologies were recorded for the minutes.

3. Minutes of the Previous Meeting

Committee Membership
The Committee is still in the process of establishing who will be the SpR representative.

Out-of-Hours leaflet
At an earlier meeting it was agreed that a Trust wide out-of-hours leaflet

would be produced for patients now the evening service had been discontinued. SH stated this would be designed in collaboration with People First. KT and DL agreed to meet to take this forward.

AP1   **KT and DL to design an out-of-hours patient information leaflet**

Combined Health & Safety and Green Activities Leaflet/People First meeting
DL has met with Hackney People First. DL reported the purpose of this meeting was to discuss improving the representation of people with learning disabilities on the Trust's committees. DL added that one member from Hackney People First and one member from Camden People First were interested in joining the PPI Committee. DL was now considering ways to support these new members and has volunteered to meet with them before and after each meeting. SH suggested the Training Committee might be another committee interested in linking up with People First.

Quality Improvement Plan
At an earlier meeting, it was agreed that SH would email PPI members details about joining the Quality Improvement Plan working group. SH reported that the working group has not yet been set up but once details are received and the meeting dates these will be forwarded to members.

AP2   **SH to invite Committee members to join the QIP working group**

BME Engagement/Update on the Community Development Work
This is an agenda item.

Adult Department Questionnaire
The consultation audit was circulated to members in advance of the meeting. As MMF was not in attendance it was decided to bring this agenda item back to the next meeting.

Adolescent Department Telephone Survey
SDB reported that the verbatim comments from respondents have been received from Limor Abramov and circulated to committee members.

Day Unit Patient Information Leaflet
SH invited members to provide further feedback on the content and language of the Day Unit leaflet. SH reminded members that all new patient information leaflets are reviewed by the PPI Committee to ensure the patient's perspective was considered.

Patient Survey Report
SDB confirmed that the amended report has been circulated to members. SH added that this report would be discussed in line with the departmental feedback to the patient survey.

Adult Department meeting with PPI Patient Representative
SH has discussed KR's meeting with Michael Mercer and Tim Kent with the Adult Department. SH announced that the Adult Department has invited KR to review their letter of consent to patients and to talk to their trainees about what it is like to be in treatment. KR has agreed to do this.

4. Matters Arising

There were no matters arising.

5. Update on the Community Development Work

Kate Spiegelhalter introduced herself as the Bangladeshi Community Development Worker (CDW) for Camden. KS described the Bangladeshi forum she coordinates and also the mental health awareness workshops and training at Voluntary Action Camden (VAC) that she has organised.

Katrin Eichhorn provided an overview of the government's national strategy for race equality and mental health and the role voluntary organisations offered in the delivery of this strategy. KE added that her work involves assisting with the setting up of community groups in Camden, offering ongoing support and advice to those community groups, and linking community groups up with each other. KE concluded that Camden also has a Somali CDW although this post will be extended shortly to include all African community groups in the borough.

SH indicated that there were pockets of community engagement work in the Trust already but the PPI wanted to check if the CDWs were working with any other staff groups to avoid a duplication of work. SH added that when the Trust has targeted specific community groups such as our Somali services we have had some success but the work was very labour intensive. SH also provided background information on the Trust's aim to increase the BME representation on the Board of Governors at the time of the Governor elections last summer and the earlier community engagement work of Britt Krause to develop meaningful relationships with BME groups in Camden.

AG stated that relationship building was the most important factor in BME engagement. KS suggested targeting our patient information leaflets to specific community groups and the VAC would be able to circulate these on our behalf. SH responded that we are in the process of designing a Congolese service leaflet and other Refugee Services leaflets would follow. SH asked the CDWs how we could make our services more accessible to other communities. KE stressed the significance of understanding the different cultural perspectives on anxiety, mental health and coping but also the importance of faith in the work. KE also highlighted that a written leaflet was not always the most appropriate method of communication in some BME communities citing the oral tradition of the Somali community.

KS detailed the Race Equality and Cultural Capacity (RECC) training materials aimed at Trusts to ensure they were delivering their services in an anti-discriminatory way and described the mental health first aid training course which could be run in-house. KE circulated details of the race awareness events planned for next week and agreed to email the details to PPI members. KE also agreed to add the email addresses of the PPI Committee members to the three circulation lists of the CDWs. DL asked

whether we need to train religious leaders in mental health issues. KE answered that the CDWs were already involved in faith work with BME groups. SC noted the effectiveness of distributing information about our services through the religious and community leaders. SH thanked KS and KE and suggested our first step was to circulate information through the three CDW forums.

6.   Departmental Feedback to the 2009 Patient Survey

SH noted that feedback from the Adult Department had been received and this was tabled as a late paper at the meeting. SH announced that the departmental feedback would be included in the PPI's Annual Report alongside feedback from the Patient Survey, PALS, the suggestion box, complaints and other small scale surveys. SDB added that the post-refurbishment survey report is being written up and indicated that mixed views had been received from patients. MP highlighted the importance of timing and indicated that if the survey had been conducted too early we would get similar views to those expressed in the pre-refurbishment survey. SH responded that the survey timing was determined by the Quality Improvement Plan's reporting deadlines but the survey could be ran again. MP suggested surveying new patients and new staff next time.

PE commented that the sample was too small to draw meaningful conclusions. SH added that the sample size was reduced even further when the results from the departments was analysed individually. SH proposed that to address the low response rate we may need to move to a model of telephoning patients similar to the Adolescent Department telephone survey. SH reported that if we were to do this then we would have to notify patients in advance through their appointment letters and our patient information leaflets. SH stated that this proposal would first need to be agreed by the Trust Clinics Committee.

MP asked whether we had considered using patient experience trackers given the low number of complaints and suggestions received each year and the low return rate from the Annual Patient Survey. KT offered to ask whether other Trusts used a tracking system at the next Communications Network meeting. AG stated that most patient experience trackers were in-patient based but we could write our own questions. MP suggested a 'question of the week' survey and SH thought the information kiosk would be the most appropriate location to run such a survey. MB warned that the survey may be self-selecting as only people who generally complete surveys would fill in this survey. SH proposed a combination of survey formats including the telephone survey. AG highlighted the need to keep to the same overall design when using different methods.

SH also proposed using the members log-in section to run surveys. KT stated that this function would soon be operational but there were ongoing technical issues still to be resolved. SH indicated the need to consider how we use this section to communicate more effectively with our membership and improve the dialogue between members and their governors. SH

recommended this be put on the agenda as a standing item.

7. Adult Department Consultation Audits

The Committee agreed to discuss this agenda item at the next meeting.

8. Utilising Volunteer Involvement in the Trust

SH announced that since the launch of the website we had received a number of offers from people wishing to volunteer at the Trust. SH stated that we need to give more thought on how we can develop this resource. LC added that during the governor election campaign, many members of the public who decided not to stand for election expressed an interest in being involved in the Trust. KT suggested an audit of services to ascertain what was available at the Trust. SH agreed to send an email to all staff to ask how volunteers could be of assistance in their services.

AP3 **SH to email all Directors to ask how volunteers could assist in their services**

9. Improving Access to People with Learning Disabilities

SH stated that People First have redesigned three of our patient information leaflets to be more accessible to people with learning disabilities. SH invited Committee members to provide comment and suggested that we would discuss this in more detail at the next meeting. KT reported that the NHS Identity and Branding Office have advised that it is acceptable to use clip-art for the purposes of more clearly illustrating patient information. SH added that Nancy Sheppard was in the process of purchasing a visual guide referencing package in the form of photographs which fitted in with our corporate style.

<u>Date of Next Meeting</u>
12.00 – 1.00pm,Tuesday 27th April 2010
Committee Room, Ground Floor, Tavistock Centre

TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST

Minutes of the Risk Management Committee held
on Tuesday 12 Jan 2010

Present: Dr Matthew Patrick (Chair)
Mr Simon Young (Director of Finance)
Ms. Louise Lyon (Trust Director)
Dr Rob Senior (Medical Director)
Ms Jane Chapman (Governance and Risk Lead)
Ms Pat Key (Director of Corporate Governance and Facilities)
Ms Lisa Tucker (Health and Safety Manager)
Joseph Anderson (minutes)

Action points from meeting 12.1.10			
AP1	**Lone Worker Policy review**	JC to pass copy of questionnaire to CMcK and JY, RS to progress review	JC, RS
AP2	**GP Letters**	LL to raise content of GP letters at Clinical Committee	LL
AP3	**CQC Report on patient Identifiable Information**	SY to prepare a summary of issues/action for the trust	SY
AP4	**Updated policies**	JC to make agreed amendments and pass to MC and Board for approval/ratification	JC
AP5	**High risk patients in C and F**	LT to meet with RH to discuss management of high risk patients in C and F	LT
AP6	**Lapsed registrations**	LT to meet with HR to confirm procedure in place an operational for lapsed registrations	LT
AP7	**Incident report**	To simplify entries on schedule and remove (or explain) jargon	LT
AP8	**Aggregate report for Board**	JC to prepare report for Board along lines discussed	JC

## 1.	APOLOGIES

Mr Martin Bostock (Non-Executive Director)

## 2.	MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 13th October 2009 were agreed.

a) Review of outstanding action points 13.10.2009 **13.10.09 AP1** _Lone Worker Policy_ – JC to send questionnaire to RS & copy to Associate Medical Directors Jessica Yakeley & Caroline McKenna **13.10.09 AP6 update** JC attended a meeting with NPSA to discuss issues of reporting. NPSA suggested that they may require all Day unit incidents to be reported. Has has not yet been pursued by NPSA. . Simon Young suggested it would be better to refer to Day Unit children as Pupils rather than patients in the incident reports.	**AP1 JC**

13.10.09 AP7 LL to take matter of patient information in GPs Letters to Clinics Committee.	**AP2 LL**
AP11 SY advised the committee that the CQC report on use of information was wide-ranging , MP asked SY to pick out any key points for the trust.	**AP3 SY**
3. RISK MATURITY AUDIT REPORT JC presented the results of the internal audit review on risk maturity. The Trust had been assessed as 'Risk Assessed' which was an improvement on 2008/19 and put us in the top group of Trust's assessed by our auditors. Recommendations were simple and easily achieved. The Audit Committee had considered the report at their Jan meeting and were happy with the conclusion and recommended that we did not over stretch our resources in an attempt to achieve to achieve 'Risk Enabled' in 2010-11. The Audit Committee noted that to date the auditors had not found any of their trusts to be 'risk enabled' The committee thanked Jane and Pat for the work that had gone into achieving a positive audit report	
4. UPDATED INTEGRATED RISK MANAGEMENT STRATEGY AND POLICY, AND PROCEDURE FOR LEARNING FORM SERIOUS INCIDENTS JC presented updated versions of the above two policies, which were scheduled for review, for approval . Members made suggestions for amendments to the documents and approved the amended documents for presentation to the Management Committee and the Board of Directors for approval/ratification.	**AP4 JC**
5 and 6 INCIDENT REPORT QUARTER 3 incl REVIEW OF VIOLENT INCIDENTS LT took the members through the incidents reports summary for quarter 3. a number of incidents were discussed in detail: **Re Day Unit incidents involving scissors** LT advised the committee that all knives and scissors at the Day Unit were plastic, and that a Risk Assessment of the use of scissors there has been completed. **Re 'violent C and F patient'** LT to meet with Rita Harris regarding high scoring incident and whether decision that patient no longer be seen alone was clinically justified. RS asked whether this decision had been taken to the team meeting.	**AP5**

Re Absconding in Day Unit. SY did not feel that the fact that Day unit children were not absconding as far as the road (as in previous quarterly reports) offered assurance that the problem was under control. JC pointed out that the facility was not locked and all reasonable arrangements were in place to reduce this risk . MP said that in his view the lack of a purpose built site increased the risk PK said a meeting on possible relocation was scheduled for 18th Jan 2010.	
Lapse of registration for externally employed staff . SY raised this as the incident had been scored low for likelihood. The committee asked that LT confirm the current arrangements with HR to gain assurances that the procedures are in place and operational	**AP6 LT**
MP asked that the wording on the incident forms be simplified and any jargon used explained (e.g. Day unit descriptions) .	**AP7 LT**
7. COMPLAINTS REPORT QUARTER 3 JC presented the Informal & Formal complaints for quarter 3 . No new formal complaints were received in this quarter. . There was still one open complaint for August, which was being followed up in line with the patient's wishes. The formal complaints report was approved for presentation to the Board. The informal complaints schedule was reviewed and noted by the RMC. This is not presented to the Board.	
8. AGGREGATE ANALYSIS QUARTERLY REPORT JC provided a verbal update on aggregate analysis. As no new complaints or claims had been received in the quarter this was technically a 'nil report. The committee discussed the format of a summary report for the Board, which had been requested. A format for a Board report was agreed in principle JC to prepare.	**AP8 JC**
9. NHSLA LEVEL 2 PREPARATION UPDATE & PLANNING JC informed the members that progress was not moving forward as quickly as planned due to the demands of meeting the evidence requirements for both the CQC Standards for Better heath and Essential Standards. It was hoped that progress could be accelerated from April with a plan to tie in evidence for Essential Standards with evidence for NHSLA Level 2.	

10. Central Alert Service (CAS) ALERTS QUARTERLY REPORT LT described the process for receiving and acting on CAS alerts. Most related to faulty equipment (both clinical and non clinical) and use of medication, so very few were of direct relevance to the Trust. In past quarter one alert relating to Lithium therapy had been sent to RS for review and one alert from NPSA re 'Being Open' has been reviewed and JC can confirm that the Trust's procedure is compliant with requirements.	
11. ANY OTHER BUSINESS none	
12 DATE OF NEXT MEETING 20th April 2010 12.30-14.00	

Board of Directors : May 2010

Item : 12

Title : Annual Plan

Summary:

The Annual Plan is presented for approval.

The Plan sets out the vision and key priorities for the Trust over the next three years, taking into account the external factors that will have a significant impact on our activities.

It has been developed by service line directors and central directorates over several months, and reviewed with the Board of Governors. A draft text has been reviewed by Directors, and the Plan is now presented in the new form required by Monitor.

For : Approval

From : Director of Finance and Chief Executive

Monitor's requirements

The Annual Plan is due to be submitted to Monitor by 31 May. This year, Monitor requires each Foundation Trust to submit the Plan using two templates:

- Financial and Strategy template
- Governance template

These are attached for the Board to review and approve. The key content is based on the longer text previously circulated, and takes account of the responses received from Directors and also the helpful discussion at the recent meeting of the Board of Governors.

The Governance template includes:

- A declaration to be signed on behalf of the Board, with a supplementary page concerning one point which we cannot certify.
- Service Performance table detailing what (if any) targets the FT is declaring a forward risk against.
- Membership template.
- Additional information template (which does not apply to us).

The Financial and Strategy template includes detailed financial projections (*which are summarised in today's Finance report, and are not included here*) and nine strategy templates. We are asked to complete these "in such detail as is necessary to demonstrate that the Trust Board has a shared and clear vision, planned key priorities, considered material risks (both internal and external), assessed potential downsides and mitigations, and that the Trust plan is one shared by and agreed with key stakeholders."

Overall vision

- Template 1: Vision and key priorities

External risks

- Template 2: Key external impacts (we have chosen to include here positive factors that could lead to opportunities, as well as those which bring risks)

Strategic plans

- Template 3: Clinical quality
- Template 4: Service development strategy
- Template 5: Workforce strategy
- Template 6: Capital programmes (including estates strategy)
- Template 7: Operational / financial effectiveness
- Template 8: Leadership and governance
- Template 9: Regulatory

Additional schedules

As well as the two main templates described above, we are to submit three other

- Schedule 2, an update on the contracted activity levels for our mandatory clinical services
- Schedule 3. an update on the contracted activity levels for our mandatory education and training
- An additional table on the financial position of our principal commissioners.

These schedules are currently being completed, and will be tabled at the meeting for information. No other documents are to be sent to Monitor.

Publication and next steps

Monitor will publish (in the FT directory on its website) the nine Strategy Templates; a financial summary; schedules 2 and 3; and summary membership data.

Feedback from their review process is expected by the end of July, followed by a more detailed stage 2 review for those FTs where Monitor has identified weaknesses in the planning process and/or significant risks to their authorisation. They estimate that up to 20 FTs (15%) will be subject to stage 2 reviews.

21 May 2010

![Monitor - Independent Regulator of NHS Foundation Trusts]

APR Governance and Performance Template

Version 1.0

Tavistock and Portman NHS Foundation Trust

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Tavistock and Portman NHS Foundation Trust

Board Statements

2010/11

In the event than an NHS foundation trust is unable to fully self certify, it **should not** insert an 'X' in the relevant box. It must provide commentary (using the section provided at the end of this declaration) explaining the reasons for the absence of a full self certification and the action it proposes to take to address it. Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.

Clinical quality

The board of directors is required to confirm the following:

X	The board is satisfied that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients;
X	The board is satisfied that, to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements; and
X	The board is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the NHS foundation trust have met the relevant registration and revalidation requirements.

Mandatory services

The board of directors is required to confirm the following:

X	The board is satisfied that it expects its NHS foundation trust to be able to continue to provide the mandatory services specified in Schedule 2 and Schedule 3 of its Authorisation.

Service performance

The board of directors is required to confirm the following:

	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2010/11.

Risk management

The board of directors is required to confirm the following:

Tavistock and Portman NHS Foundation Trust

Board Statements

2010/11

X	Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;
X	All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;
X	The necessary planning, performance management and risk management processes are in place to deliver the annual plan;
X	A Statement of Internal Control ("SIC") is in place, and the NHS foundation trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk);
X	The trust has achieved a minimum of Level 2 performance against the requirements of their Information Governance Statement of Compliance (IGSoC) in the Department of Health's Information Governance Toolkit; and
X	All key risks to compliance with their Authorisation have been identified and addressed.

Compliance with the Terms of Authorisation

The board of directors is required to confirm the following:

X	The board will ensure that the NHS foundation trust remains at all times compliant with their Authorisation and relevant legislation;
X	The board will ensure that the NHS foundation trust will, at all times, have regard to the NHS constitution;
X	The board has considered all likely future risks to compliance with their Authorisation, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks;
X	The board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance with their Authorisation; and
n/a	For an NHS foundation trust engaging in a major joint venture, or any Academic Health Science Centre, the board is satisfied that the NHS foundation trust has fulfilled, or continues to fulfil, the criteria set out in Appendix D4 of the Compliance Framework.

Tavistock and Portman NHS Foundation Trust

Board Statements

2010/11

Board roles, structure and capacity

The board of directors is required to confirm the following:

| X | The board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the board; |

| X | The board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability; |

| X | The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills; |

| X | The management team have the capability and experience necessary to deliver the annual plan; and |

| X | The management structure in place is adequate to deliver the annual plan objectives for the next three years. |

Signature

Printed Name

Date

In capacity as Chief Executive & Accounting Officer

Signature

Printed Name

Date

In capacity as Chairman

Signed on behalf of the board of directors, and having regard to the views of the governors

Tavistock and Portman NHS Foundation Trust

Board Statements

2010/11

If the Board feels unable to sign any of the statements the Board Statements worksheet
Please complete this analysis for all areas where the Board is unable to fully self-certify.

The Issue:

The Trust does not expect to comply with one of the mental health indicators set in the 2010/11 Compliance Framework (Appendix B), namely 99% completeness on data identifiers. Note 15 of Appendix B lists seven items from the mental health minimum data set for which 99% completeness is required. The Trust expects to attain 95%+ for all these items except marital status, for which we expect to attain approximately 60%.

We are currently migrating to a new patient information system, RiO, in 2010/11. This has the priority call on our resources. It should also be noted that moves to new information systems are often accompanied by an initial fall in data quality. We will take some steps to improve data quality in 2010/11, but it will not be until 2011/12 that we will be able to significantly refocus our efforts on data quality and completeness.

This should include (1) a description of the issue that has arisen, identifying the area(s) of the Authorisation to which it applies, (2) an assessment of the consequences of the issue including the magnitude (e.g. performance levels achieved or estimated) and (3) the timeframe in which it will come into effect or if it has already done so, when it occurred

Proposed Actions:

• To increase NHS number completeness through RiO implementation September 2010.
• An improvement of 5% in coding of marital status has been agreed with commissioners as part of our data quality improvement programme by March 2011
• To identify priorities for data completeness and accuracy post RiO implementation March 2011

This should include (1) a summary of the proposed actions that will be put in place to address the issue, (2) the process that will be applied in reviewing the effectiveness of these actions as appropriate to the circumstances of the issue, and (3) a work plan that details the timelines of these actions

Next Steps:

Data quality will be reported to all commissioners and the Board of Directors on a quarterly basis.

This should include (1) a list of the third parties the NHS foundation trust has and intends to notify of the issue and (2) a proposal of the support required from Monitor (if any)

Press button for additional page

Membership Information Required

This is your 2009/10 annual membership & election report and 2010/11 annual membership plan

Membership size and movements

Public constituency

			2009/10	2010/11 (estimated)
At year start (April 1)	+ve		4,493	4,910
New members	+ve		898	800
Members leaving	+ve		481	400
At year end (31 March)			4,910	5,310

Staff constituency

			2009/10	2010/11 (estimated)
At year start (April 1)	+ve		495	526
New members	+ve		90	90
Members leaving	+ve		59	60
At year end (31 March)			526	556

Patient constituency

			2009/10	2010/11 (estimated)
At year start (April 1)	+ve			0
New members	+ve			
Members leaving	+ve			
At year end (31 March)			0	0

Analysis of membership at 31 March 2010

Public constituency

	Number of members	Eligible membership
Age (years):		
0-16	0	1998227
17-21	41	3188986
22+	4,869	37695670
		42882883
Ethnicity		
White	2678	39561045
Mixed	124	365321
Asian or Asian British	230	1895137
Black or Black British	294	878717
Other	1,584	182663
		TRUE
Socio-economic groupings*:		
ABC1	4133	20999815
C2	158	6149928
D	34	6976630
E	585	6540173
		FALSE
Gender:		
Male	953	20635338
Female	3,957	22247545
		TRUE

Patient Constituency

	Number of members	Eligible membership
Age (years):		
0-16		
17-21		
22+	0	

Election Turnout

Constituency	Date of election in 09/10	Total eligible to vote	Turnout (%)
Public: Camden	03/11/2009	505	15.6%
Public: Rest of London	03/11/2009	2353	10.5%
Staff: Admin & Technical	03/11/2009	154	28.6%

Notes:

a   All data to be input in positive integers.

b   Socio-economic data should be completed using profiling techniques (eg: post codes) or other recognised methods. To the extent socio-economic data is not already collected from members, it is not anticipated that NHS foundation trusts will make a direct approach to members to collect this information.

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Membership Strategy

(strategy to build and maintain our membership base)

We are pleased with the size of our membership, and are continuing to develop lively ways of interacting with Members in a more lively way (see Membership Engagement below)

We will continue to work to bring the profile of our Public Membership more in line with that of London. We are also mindful of the fact that we do not have any black or minority ethnic representation on our Board of Governors.

A member recruitment campaign planned for 2011/12, well in advance of the next Governor elections due in autumn 2012, will cover these aims and will also aim to increase our under-16 membership.

At the same time, we plan to develop and launch 'family membership' to be more reflective of our user population. The minimum age of members will remain 14, but we also wish to involve and engage users who are younger than this, through a separate type of membership.

Membership engagement

(how we engage with our membership base)

The Trust aims to build its work around the needs of patients, students and other users. Governors and members have a key contribution to make to the future direction and nature of the Trust. In order to ensure that this position is achieved, increasing time and resourcing is being devoted to supporting and facilitating our governance structures.

Development aims for the next three years (in addition to the recruitment aims stated in the box above) are:

2010/11
• Improve communications between members, Governors and Trust through website and fora
• Support the newly configured Governors' performance committee
• Encourage patients' views through members' contribution to the members newsletter
• Increase the number of relevant small scale surveys on issues meaningful to patients, such as the environment
• Increase the number of events that patients and local public can attend and contribute to

2011/12
• Develop the opportunities for patients/public to get involved with the work of the trust through voluntary work
• Pro-actively engage with relevant representative community groups

2012/13
• Develop the range of member led/member developed events
• Increase the number of patients/members involved in service developments as advisors

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Tavistock and Portman NHS Foundation Trust

Compliance | **Not fully compliant**

Priority	Targets as per Compliance Framework 2010/11		Threshold	2010/11 CF Weighting	2010/11	Links		APR Service Performance Score
					Declared risk of failure			
1	C.difficile year on year reduction		0	1.0		If failed please comment here	Click here to add contract cases for 2010/11	0.0
1	MRSA - meeting the MRSA objective		0	1.0		If failed please comment here	Click here to add contract cases for 2010/11	0.0
1	All cancers: 31-Day Wait For Second Or Subsequent Treatment	Anti Cancer Drug Treatments	98%	1.0		If failed please comment here		0.0
1		Surgery	94%	1.0		If failed please comment here		
1		Radiotherapy (from 1 January 2011)	94%	1.0		If failed please comment here		
1	All cancers: 62-Day Wait For First Treatment	From Consultant Screening Service Referral	90%	1.0		If failed please comment here		0.0
1		Urgent GP Referral To Treatment	85%	1.0		If failed please comment here		
1	Maximum time of 18 weeks from point of referral to treatment for admitted patients	Aggregate	90%	1.0		If failed please comment here		0.0
1		By specialty (3 or more specialties)	90%	0.5			Click here to add specialty type	0.0
1	Maximum time of 18 weeks from point of referral to treatment for non-admitted patients	Aggregate	95%	1.0		If failed please comment here		0.0
1		By specialty (3 or more specialties)	95%	0.5			Click here to add specialty type	0.0
2	4 hours A&E wait from arrival to admission, transfer, or discharge		98%	0.5		If failed please comment here		0.0
2	31-Day (Diagnosis To Treatment) Wait For First Treatment	All cancers	96%	0.5		If failed please comment here		0.0
2	Two week wait from referral to date first seen	All cancers	93%	0.5		If failed please comment here		0.0
2		For symptomatic breast patients (cancer not initially suspected)	93%	0.5		If failed please comment here		
2	Thrombolysis within 60 minutes (where this is the preferred local treatment)		68%	0.5		If failed please comment here		0.0
2	Screening all elective in-patients for MRSA		100%	0.5		If failed please comment here		0.0
2	Care Programme Approach (CPA) patients	Follow up contact within 7 days of discharge	95%	0.5		If failed please comment here		0.0
2		Having formal review within 12 months	95%	0.5		If failed please comment here		0.0
1	Minimising delayed transfer of care		<=7.5%	1.0		If failed please comment here		0.0
1	Admissions had access to crisis resolution home treatment teams		90%	1.0		If failed please comment here		0.0
1	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5		If failed please comment here		0.0
2	Data completeness: identifiers		99%	0.5	Yes	Board Statement - Add Page 1		**0.5**
2	Data completeness: outcomes		tbc%	0.5		If failed please comment here		0.0
2	Self certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5		If failed please comment here		0.0

Total Score	**0.5**
Service Performance Rating	GREEN

Tavistock and Portman NHS Foundation Trust

Targets as per Compliance Framework 2010/11		Threshold	2010/11 CF Weighting	2010/11 Declared risk of failure	ALL ACUTE FTS SHOULD PROVIDE MRSA AND C.DIFF INFORMATION IN YELLOW BOXES BELOW			
					Actual cases 2009/10 **post 72 hours**	Contract cases 2010/11		
C.difficile year on year reduction		0	1				*Comments*	Return to main sheet
					Actual cases 2009/10 **post 48 hours**	Contract cases 2010/11		
MRSA year on year reduction		0	1				*Comments*	Return to main sheet

		Threshold	2010/11 CF Weighting	2010/11 Declared risk of failure	Total specialties forecast to be breached	List specialties forecast to be breached		
Maximum time of 18 weeks from point of referral to treatment for admitted patients	Aggregate	90%	1.0	0				
	By specialty	90%	0.5		0	Type of specialty:	Type of specialty:	Type of specialty:
						Return to main sheet		
Maximum time of 18 weeks from point of referral to treatment for non-admitted patients	Aggregate	95%	1.0					
	By specialty	95%	0.5		0	Type of specialty:	Type of specialty:	Type of specialty:
						Return to main sheet		

Independent Regulator
of NHS Foundation Trusts

Forward Plan Financial Return (IFRS)

Tavistock and Portman NHS Foundation Trust NHS FT

Plan for y/e 31 Mar 2011 (and 2012, 2013)

FT forward planning template IFRS version v1.01 customised for use by FT with MARS ID 'TAVIPORT'.

This spreadsheet completed by (and Monitor queries to be directed to):

Name: Simon Young

Position: Director of Finance

Telephone number: 0208 938 2468

Email address: syoung@tavi-port.nhs.uk

Date: 21 May 2010

Approved on behalf of the Board of Directors

Chair

Electronic signature:

1. Overview

NHS foundation trust plans for 2011 – 13 include financial forecasts for three years which will reflect forward looking assumptions, projections or estimations, at least, as to:

· revenues and costs;
· contracts and changes in productivity;
· the likely impact of various external and internal factors;
· key risks, including in relation to the Authorisation, and effective mitigations;
· capital and other investment projects;
· leadership and necessary key skills;
· potential acquisitions and / or disposals; and
· clinical quality objectives and service development.

Each of the above should be underpinned by detailed planning and proposed actions, identification of key responsibilities and clear accountability, and a shared strategic vision led by the Trust's Board and agreed with governors, commissioners and other key stakeholders. To deliver this the Trust's Board must plan, understand, articulate and clearly communicate:

· the Trust's vision;
· the Trust's strategy and how this aligns with its vision;
· key delivery risks to the strategy: internal and external; controllable, semi-controllable and non controllable;
· for each of the main parts of the strategy, the key priorities, actions and resources (both financial and human) needed to deliver them;
· measures of progress and milestones along the way;
· any regulatory risks and mitigations;
· communication and stakeholder engagement.

The strategic part of the annual plan is designed to ensure that:
· NHS foundation trust Boards (both directors and governors) have properly considered and delivered the above requirements for good planning to underpin the delivery of high quality healthcare services;
· the Trust's financial plans demonstrate an integrated and effective approach to, and output from, high quality strategy and realistic planning, and;
· if not, to identify gaps and actions to fill them;

When assessing the effectiveness of the strategic, operational and financial planning undertaken by a Trust as part of the Annual Plan Review, Monitor will consider the clarity with which a Trust Board can describe its overall strategic vision and, for each of the main areas of its business, identify key priorities, assess risk, and design a co-ordinated and credible plan for delivery of its three year plan.

Set out below is guidance for completion of each of the main templates within the plan. Within each template, Boards will be expected to describe succinctly the Trust's key priorities (it is likely that for each template there will be up to a maximum of 10 priorities). For each of the priorities in the templates, the Trust's Board should be able to demonstrate a clear link between its vision for the Trust, strategic objectives, key operational action plans and the assumptions used to drive the plan.

All measures of progress or milestones must be SMART – Specific, Measurable, Achievable, Relevant, Time-bound.

Where more detailed information is already included within the input sheets from which the financial plans are derived, then this information should be referenced (and where appropriate not repeated) within the templates below.

After each template is a box to add further comment by way of additional clarification, although additional comments, if any, should also be limited in length. Annex A sets out, at a high level, the main stages in the development of the three year plan and the key elements which underpin each.

Template 1: Vision and key priorities

Guidance: The Board should be able to describe where it believes the Trust is currently placed in terms of progress towards the delivery of its overall vision and strategy, where in this context it aims to get to over the next three years, and the main priorities which will need to be delivered to secure the required progress.

The Trust's vision should describe at the highest level the strategic objective of the Trust and in particular how it wishes to be viewed by its patients and service users, staff, commissioners and other key stakeholders. In most cases this will reflect but not be the same as the Trust's vision statement. The vision should be shared in particular by the Board of Directors and the Board of Governors. Comment as to the likely timescales for the delivery of the vision may be appropriate particularly if this falls outside the three year period of the annual plan.

The Trust Board should be able to articulate the key changes required in order to evolve and develop the Trust from its present position and the key elements of the organisation that need to be in place to achieve the vision. In all parts of the Trust's plan, including the financial forecasts, there must be a clear link between its overall vision and the strategic objectives, operational plans and key assumptions
These main priorities for the next three years are likely to be high level and may, for instance, represent the 'top five' for the Trust. Milestones should similarly be high level but measurable by the Board, to enable an objective assessment as to progress towards their delivery.

The Trust's current position is summarised as:

The Tavistock and Portman NHS Foundation Trust is committed to improving mental health and emotional wellbeing. We believe that high quality mental health services should be available to all who need them. Our own contribution is distinctive in the importance we attach to social experience at all stages of people's lives, and in our focus on psychological and developmental approaches to the promotion of health and the prevention and treatment of mental ill health.

The majority of the Trust's clinical services are Child and Adolescent Mental Health Services. The Trust is the main CAMHS provider for Camden, and provides both generic and specialist CAMHS services to Camden and in a number of other boroughs. The Trust also provides a range of specialist adult mental health services, including transition services for adolescents and a variety of adult psychological therapy services. In 2009 the Trust set up a new primary care psychological therapy service for adults in Hackney. The Portman Clinic forensic psychotherapy services and our Learning and Complex Disability service are subject to specialist commissioning; and the Gender Identity Development Service is nationally commissioned.

Education and training for the mental health and social care workforce is provided alongside clinical services, with the aim of maximising our contribution. Our trainings are valued by individuals, by their employers and by commissioners.; and we have continued to develop and deliver new programmes responsive to their needs. Most of our courses are university-accredited, and we have built strong relationships with our two main university partners. With partners, we are now working on establishing the mental health stream of UCL Partners (UCLP) Academic Health Science Centre (AHSC) and also on proposals for the Health Innovation and Education Cluster (HIEC) associated with UCLP. The Trust's training contract is held by NHS London on behalf of other education commissioners, and the Trust is expected to deliver training and education on a national level.

The Trust's consultancy service provides high quality psychologically informed consultancy on complex human factors in organisations. These services are delivered to chief executives, directors, senior managers and other professionals in the public, private, and non-statutory sectors.

Over the last 15 years, the Trust has grown steadily, mostly by organic growth but also with the transfer of services and the development of new services in response to tender invitations. At the same time, we have also steadily improved productivity so as to provide better services and also to meet our financial targets. Over the whole of 2009/10 the Trust received a financial risk rating of 4 from Monitor (exceeding our plan), and under the new CQC regime we have been registered without qualification. All of these ensure that the Trust is moving into an exceptionally difficult economic climate from a strong platform.

The Trust's vision over the next three years is to:

The Trust aims to work closely with commissioners and other providers in the provision of high quality services to local residents. Working as part of a larger system is essential if the quality of patient services is not to suffer in economically stringent times.

Significant levels of productivity improvement and efficiencies will be required in a likely environment of financial constraint. The Trust will aim to achieve these while protecting and developing the quality of its services.

In addition, we are seeking to improve and increase access to our patient services. In this we will aim to build on our areas of existing strength, including the community provision of comprehensive integrated child and adolescent mental health services (CAMHS), specialist expertise such as Forensic Psychotherapy and work with Looked After Children, and the development and delivery of Psychological Therapies across the age range in community and specialist settings.

We are also aiming to build on our strong training portfolio, increasing the range of academically validated postgraduate courses and continuing professional development programmes we provide, as well as our professional qualifying courses. In addition we will be pursuing new opportunities in blended or distance learning. This will enhance the positive reach of the Tavistock and Portman to influence quality Mental Health Provision.

The Trust is unusual in the range of its activities. All of these, however, are closely integrated and share the same underlying values and philosophy:

• Emotional disturbance and mental ill health are common, can be as disabling as serious physical illness, and affect not only individuals but also those around them

• A person's experiences within family and community have a lasting impact on their development

• Groups and organisations can be a source of support and well-being, but can also become dysfunctional and ineffective, resulting in real distress or even causing breakdown

• Having a sense of belonging and being accepted is important to people's mental health

There is presently a high rate of change in the NHS, with both service and organisational re-configurations being planned and high levels of financial pressure and anxiety. In this environment, it is essential that the Trust must be – and must be experienced as being – outward looking; aligned and responsive to external preoccupations and agendas; high quality; innovative; relevant; helpful; and contemporary; all whilst retaining the distinctiveness of our contribution.

Key priorities for the Trust which must be achieved in the three years of the annual plan to underpin the delivery of the Trust's vision,

Key priority (and timescales)	How this priority underpins the strategic vision	Key milestones (2010/11)	Key milestones (2011/12)	Key milestones (2012/13)
Work closely with commissioners and other providers in the provision of high quality services to local residents.	Maintain and develop quality of care despite economic pressures	Retain CQC registration without condition, and green governance rating from Monitor	Retain CQC registration without condition, and green governance rating from Monitor	Retain CQC registration without condition, and green governance rating from Monitor
Productivity improvements of 5% per year	Maintain quality of care while meeting financial targets. Achieve national efficiency targets and offset the effects of any small income losses.	Achieve the agreed budget (with a small surplus) and retain quality standards	Identify and deliver savings to ensure a small surplus again	Identify and deliver savings to ensure a small surplus again
Tender for new adult psychotherapy services	Improve access to our patient services	Evaluation of first year of Hackney service. Development of other new service models.	Secure further contracts for services based on these models	Secure further contracts for services based on these models
Bid for CAMHS services in relation to tendering opportunities	Improve access to our patient services	Successful implementation of new and transferred services in Haringey & Barnet	Secure further contracts for specialist services and/or whole borough CAMHS	Secure further contracts for specialist services and/or whole borough CAMHS
Patient engagement	Contribute to further quality improvement through the development of the patient-centred culture.	Encourage patient views through members newsltr. Increase small scale surveys. Increase events.	Member recr'mt. Launch 'family membership.' Develop opps for involvm't through voluntary work.	Develop the range of events. More patients/ members advising on service developments.

Key priority (and timescales)	How this priority underpins the strategic vision	Key milestones (2010/11)	Key milestones (2011/12)	Key milestones (2012/13)
Outcome monitoring	Contribute to further quality improvement and to efficiency. Improve access, by ensuring that the right services are offered to each potential patient.			
Continue the development of short CPD programmes and also of e-learning modules	Improve access to our education and training	Improve range of CPD courses. Develop and implement at least one new e-learning module.	Build e-learning portfolio to include blended learning. Ensure CPD prog responsive to need.	Further development of blended learning portfolio
Develop high quality e and blended learning programmes with an already proven partner.	Improve access to our model geographically and by experimenting to reach a larger number of professionals who come to the model for the first time	Key partnerships established with at least one project initiated, to build confidence in new model.	Devel't of a range of blended learning opps appropriate to market need and demand	Devel't of a range of blended learning opps appropriate to market need and demand
Implementation of new patient record system, RiO	Contribute to further quality improvement and to efficiency, with faster access to records and stronger security. System available to support potential new services also.	Implementation in all our existing services	Benefits realisation	Benefits realisation
Renovation and improvements to our buildings	Improve the patient and student experience. Cut carbon emissions in line with our sustainability agenda. Improve space and asset utilisation.	Roof project. New boilers.	Day Unit relocation.	Lighting, corridor and window improvements.

Template 2: Key external impacts

Guidance: The key external impacts template should reflect the significant external impacts on the Trust's plans, and for each of these, a brief description of the related risks and impact on the delivery of the plan, the actions taken and / or planned to be taken to mitigate the impact and residual risks which may then remain, the expected or planned outcome, measures of progress and the person accountable in each case.

Key external impacts will vary by Trust and also evolve or develop over time, but may include:
* *Overall healthcare funding and the wider economic environment (both with regard to the Trust and its commissioners);*
* *Tariff changes;*
* *Quality incentives / penalties;*
* *Other contractual arrangements and challenges;*
* *Service reconfiguration;*
* *Demand management (e.g. practice based commissioning);*
* *Innovation and technology;*
* *Pay – national and local negotiations;*
* *Other changes in national or local policy or law;*
* *Competition, co-operation and patient choice;*
* *Demographic changes.*

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Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Public sector recession: £15-20bn reduction in NHS funding	1. Existing commissioners are more likely to wish to reduce their investment. 2. Funding for new developments.will be scarce.	Continue to work closely with commissioners (clinical and training) to ensure that our services meet their needs. Target growth in areas that are still expected to be funded.	The Plan allows for a small percentage loss of income, with corresponding savings.	Achieve 2011/12 income at least at the levels projected in this Plan.
NHS 2010-2015: from good to great. New government confirming the requirement for further efficiency improvements.	Difficulty in maintaining quality of services in relation to loss of staff	Productivity planning in advance of need. Work of service redesign begun across the Trust supported by clear service line information.	The Trust aims to develop and improve the quality of services while retaining a financial risk rating in line with plan.	Quality accounts, CQC registration and Monitor Risk Ratings
Local politics with possible PCT and trust mergers and reconfiguration of the local health economy	Difficulty in maintaining key relationships with commissioners and local providers critical to continued business	Retain active engagment with sector work alongside commissioners, providers and other key stakeholders.	While tremendous uncertainty exists within the Health Sector, the Trust will work to develop its mental health contribution	Developing service portfolio, closely aligned to community and commissioner need
New Horizons (wellbeing, early interventions, public mental health)	An opportunity to contribute in this area, in relation to prevention, early years interventions, and public mental health.	We will be developing our services to ensure that we meet the needs of existing and new commissioners in these areas	Maintain existing contracts. Secure new contracts.	Clinical income at least in line with Plan projections each year

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Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Evidence Based Practice (NICE)	Range of services commissioned becomes more limited in period of financial constraint	Programme in place to improve evidence base for existing and new services and interventions	Enhanced range of evidence based interventions with adjusted balance towards EBP	Service range aligns with population and commissioning need expressed through

Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
IAPT – further development and review of the services already established	As for all providers, both an opportunity and a risk.	To work collaboratively with commissioners and other service providers in reviewing services.	The plan anticipates some losses and more gains resulting from these reviews	Clinical income at least in line with Plan projections each year, which include some growth in this area
The Bradley Report (2009) addresses the mental health needs of offenders and the training needs of staff	Opportunity to promote the Portman Clinic's training and consultancy services. Also an opportunity to increase community service provision.	Develop existing relationships with prisons, medium secure hospitals and women's secure services to identify and meet service needs.	New and increased activity to at least offset reductions in other areas	Overall Portman income levels maintained or increased throughout Plan period
Emphasis on vulnerable groups, including child protection and safeguarding	An opportunity to contribute to developing policy and delivery agendas from existing expertise.	We will be developing our services to ensure that we meet the needs of existing and new commissioners in these areas	Maintain existing contracts. Secure new contracts.	Clinical income at least in line with Plan projections each year
Payment by Results: The Dept of Health plans to introduce a tariff for mental health services – or at least a currency – by 2013/14	Block contracts and the lack of currencies give mental health services a weaker contracting position than acute hospitals. Our Plan allows for continued pressure on mental health funding as a result.	A currency for adult services is now published. We will be testing and introducing this in 2010/11. As part of a London programme, this Trust is leading the development of possible currencies for CAMHS.	No major effect anticipated in the Plan period	Ensure that the Trust is fully involved in the development and implementation of currencies

Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Development in the Foundation Trust model: membership organisations/mutuality	Model depends on successful engagement.	Continue to develop the contribution of our Board of Governors. Build membership and engagement.	The Plan sets targets for engagement (see separate Governance and Performance template)	Greater influence of Governors and members over the Trust's services and plans.

Template 3: Clinical quality

Guidance: A key strategic focus of the Trust's plan is to describe its main clinical quality priorities for the three years of the plan, key actions required to deliver these, the risk of delivery and how the Board will measure progress for each and gain appropriate assurance in a reliable and consistent manner.

These clinical quality priorities should be consistent with those disclosed in the quality accounts within the Trust's published report and accounts. It is important that the key clinical quality objectives reflect not only the Trust's own strategic focus but also those of its commissioners, patients and service users.

Clinical quality priorities	Contribution to the overall vision	Key actions and delivery risk	Performance in 2009/10	3 year targets / measures 2010/11 2011/12 2012/13
1. Clinical Outcome Monitoring 1.1 CAMHS Outcome Monitoring Programme: One of the key objectives has been to expand the range of measures used within CAMHS, in order to fulfil the requirements of CORC (CAMHS Outcome Research Consortium). 1.2 Adult Outcome Monitoring Programme: At this time, outcome monitoring in the Adult Department is based on the CORE System (Clinical Outcomes for Routine Evaluation). The return rates for the CORE forms have remain consistently low over the past number of years. The objective therefore has been to increase the return rates.	Offering our patients effective high quality interventions is central to our vision. Outcome monitoring is one way of assessing the effectiveness of the interventions offered;increasing return rates offers a more complete picture of where treatment is more or less effective. We also believe that outcome measures should reflect patients specifc needs and expectations and we therefore plan to pilot measures for specific patient groups.	1.1 In order to increase the rate of returns for CAMHS, a range of measures have been put in place: 1..2There remain concerns, however, that the return rates will not meet the target of 60% required by the Camden CAMHS commissioners by the end of this financial year (2010/11). An action plan is in place to mitigate this risk. 1.2 To increase the returns rates for the Adult Department, clinicians hand the end of treatment forms directly to patients arther than posting them.	1.1 The CAMHS directorate undertook a 6 month pilot project across two generic teams in Camden (October 2009 – April 2010) in order to evaluate the implementation of the expanded protocol. All processes, including significant additional informatics support were put in place and information is now being provided on a monthly basis to the Camden CAMHS Commissioner. However initial return rates have been low. 1.2 For the Adult Department, the Post-Assessment return rates for 2009/10 at 55.7% (N=49) was slightly lower than expected using the new protocolhowever at the time of writing a number of forms provided to patients in the period before 31st March 2010 have still to be returned	Targets for 2010/11: 1.1.1 To increase the return rates for CAMHS to 60% and above. 1.1.2 To implement the expanded protocol across all CAMHS services within the directorate for every new patient referred. 1.1.3 To pilot the new outcome measures within the Learning and Complex Disabilities Service, the Under Fives Service and the Fostering and Adoption Service. 1.1.4 To improve data collection in CAMHS across an agreed range of domains. 1.2.1 To further increase the return rates of forms from patients in the Adult Department. 1.2.2 The data from the new outcome measures currently being piloted within the Adult Brief Therapy Service will be evaluated.

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Clinical quality priorities	Contribution to the overall vision	Key actions and delivery risk	Performance in 2009/10	3 year targets / measures 2010/11 2011/12 2012/13
2. Access to clinical service and health care information for patients and public	Improve access - and equity of access - to our services. To promote public health and well-being through providing accessible information and advice on common life issues	2.1 We view the Trust website as a key portal of access to, and a key route for disseminating information about, the Trust and its services. In 2008 a strategic decision was made to redesign the website to ensure that it was fit for purpose. In 2008/09 the communications team conducted a survey, through the membership newsletter, to establish ideas about what patients thought was important to consider in the redesign. We appointed a design company and they also conducted user testing. The patient population felt strongly that the website needed to be organised around the kinds of questions patients (and our student users) might ask. 2.2 We are also producing new and improved information leaflets, to be available both through the website and through other means.	2.1 The website has been completely revised and the new site was launched in July 2009. There have been several rounds of user testing on the new website, where patients have been asked to search for particular pages and then have given feedback on the ease of navigation through the site, which has led to further improvements.	Targets for 2010/11: 2.1 After the site has been live for a year we will conduct a further survey through the members' newsletter to check that the site is functioning as it should. 2.2 (a) The Communications Team is preparing a series of downloadable leaflets on Life Issues which will offer information and advice in relation to common issues encountered across the life span. The series will be launched in 2010/11 and will make a contribution to promoting public health and well-being. 2.2 (b) Following a consultation from People First, the Trust has developed information leaflets suitable for people with learning disabilities and will make these available from 2010/11.

Clinical quality priorities	Contribution to the overall vision	Key actions and delivery risk	Performance in 2009/10	3 year targets / measures 2010/11 2011/12 2012/13
3. Improvements to the built environment and facilities In 2009 we focussed on refurbishment of high traffic ground floor areas, responding to concerns that had been raised in previous patients' surveys about the 'tired' condition of the building. Such comments were far from universal, however, many patients giving positive feedback about the 'feel' of the building and praise for the artwork.	To provide an environment which demonstartes the respect and dignity with which we aim to treat patients. To provide an environment which is welcoming and accessible and promotes inclusion	3.1 In order to improve the quality of the environment for patients, refurbishment work was undertaken during the summer 2009. This included the ground floor reception and waiting area; PALS / patient information area; space between the reception area and the lifts, and commissioning of new art work for the waiting area and the corridor leading to the lifts. 3.2 Once the refurbishment had been completed a survey was carried out to ascertain the impact of the changes made. Feedback forms were placed in the waiting rooms of the Adult, Child and Family and Adolescent Department for two weeks, during which a total of twenty forms were completed.	60% of the respondents to a post-refurbishment survey thought that the new design and layout of the main reception and the waiting area made the ground floor look better. In response to the feedback received, there have been measures taken to address the concerns raised about the refurbishment work. Other patient feedback has included the Experience of Service Questionnaire (ESQ).The feedback from this questionnaire in relation to the environment is reasonably positive and included helpful suggestions.	Targets for 2010/11: 3.1 A further survey of the improvements to the built environment and facilities will be undertaken in 6 months. 3.2 A rolling programme of refurbishments is in hand and plans are in development for improvements to the use of external spaces

Clinical quality priorities	Contribution to the overall vision	Key actions and delivery risk	Performance in 2009/10	3 year targets / measures 2010/11 2011/12 2012/13
4 Patient and Public Involvement	Involvement of patients and the public, including our students and members is key to further development of high quality, accessible services tailored to our patients' needs	Targets for 2010/11: 4.1 Undertaking a stakeholder consultation on the quality of our clinical services in liaison with the Patient and Public Involvement Committee (the PPI committee includes patient, public and Governor representatives who will be involved in the planning of this work) 4.2 Inviting patients and carers to take part in consultations (for example, on patient information and confidentiality) 4.3 Developing more creative ways of obtaining feedback such as using the internet and telephone surveys, and events such as themed open meetings.	This is a new priority for 2010/11. We did not set targets for 2009/10, although work has been progressing for over 10 years in this area	Targets for 2010/11: 4.1 completing a stakeholder consultation on the quality of our clinical services in liaison with the Patient and Public Involvement Committee 4.2 Completing and reporting on consultations involving patients and carers 4.3 Developing and evaluating more creative ways of obtaining feedback.

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Clinical quality priorities	Contribution to the overall vision	Key actions and delivery risk	Performance in 2009/10	3 year targets / measures 2010/11 2011/12 2012/13
5 Maintaining a high quality, effective workforce	The provision of high quality effective and innovative clinical serices is central to our vision and this can only be achieved through maintaining an effective workforce	The Trust has always performed well in staff surveys. Our most recent survey is also very positive, in fact improving on the strong surveys of previous years. In many areas the Trust ranks in the top 20% of mental health trusts, for example in the percentage of staff expressing strong satisfaction with their jobs and in the percentage of staff who would recommend the Trust as a place to work or to receive treatment. However, recent staff surveys have reported significant levels of stress amongst the staff group, which the Trust needs to address.	This is new priority which we have identified for 2010/11 and we have not therfore reported on in 2009/10 although this has always been an area we have regarded as highly important within our organisation as indicated by eg over 90% of our staff have completed a PDP in 2008/9 and in 2009/10.	Targets for 2010/11: 5.1 We aim to put in place a range of measures to reduce work related stress. 5.2 We aim to maintain a well-trained, flexible and creative workforce through providing personal development plans, supporting Continuing Professional Development and continuing to support workshops aimed at enhancing clinical learning and development.

Template 4: Service development strategy

[Guidance: the main service development priorities in the plan should be described in enough detail so as to provide evidence as to the contribution they are expected to make to the plan, the actions necessary to implement them, key risks, resourcing requirements (financial and human capital), and measures by which the delivery of the service development will be tracked and assessed.

Each of these priorities should be categorised under one of three headings: (1) organic or innovation (i.e. delivered internally by the Trust or through co-operation); (2) acquisition, merger, investment, tender etc (i.e. through some form of corporate action or activity external to the Trust); or (3) by transferring out / discontinuing an activity (in agreement with commissioners).

Where relevant details are included within the input sheets from which the financial forecasts are derived, then reference to those service development plans should be made in the template above.

Service development priorities	Contribution to the overall vision	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
Organic / innovation:				
Ensure that our services meet patient and commissioner needs and fit with those services provided by other health, local authority and voluntary sector organisations, delivering improvements in quality and productivity through review and reconfiguration	Ensure that the Trust continues to be a leading provider of CAMHS and psychological therapies, providing high quality, efficient, modern services	Review services delivered under the London specialist contract by March 2011. Review adult psychological therapies with major commissioners March 2011. To improve information for commissions about our CAMHS services, by developing an information model for Camden CAMHS. Risk: commissioners and other services time constraints mean engagement is difficult.	Dedicated staff time from Service Development and Clinical Directorates.	2010/11 London and Adult review complete and assessment of commissioner satisfaction, with objectives set for 2011/12. Information model completed December 2010
In collaboration with commissioners, select and develop 3 areas of excellence which have high potential to improve service quality and productivity in children's services and adult services	To make an appropriate contribution to improving children's and adult services.	Business cases for 3 areas to be completed by December 2010. Risk: funding constraints prevent commissioners from investing in services even if they will realise productivity gains	Dedicated staff time from Service Development and Clinical Directorates.	2010/11 Business cases developed 2011/12 and 2012/13 Extended services achieved in all 3 areas
Respond to the wellbeing and public mental health agendas and build on the success of Big White Wall projects	To make a significant and distinctive contribution to mental health provision	Implementation of Big White Wall wellbeing service. Risk associated with complexity of delivery in a new environment (online)	Implementation resources within Business Development team, and clinical time in relation to governance.	2010/11 Successful implementation of existing contracts 2011/12 and 2012/13 Further roll out.

Service development priorities	Contribution to the overall vision	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
Support and develop our NHS London training contract	To make a significant and distinctive contribution to mental health provision	Active engagment with commissioners to ensure alignment of aims and objectives within a constrained funding environment	Sufficient development time within Directorate of Education and Training, coupled with sufficient Business Development resources	2010/11 Development of trainng portfolio in line with commissioning intentions. 2011 onwards - AHSC and HIEC involvement as a vehicle for the development of translational education and trainng (bridging the gap between research and improved clinical practice).
Develop blended learning and distance learning opportunities	To improve access to services and widen potential interest in the Trust's distinctive contribution, in this case beyond traditional geographic, funding or time constraints.	Exploration of key partnerships for the delivery of blended learning. Risks associated with investment in new products and markets.	Additional IT and AV infrastructure. Additional IT and AV expertise and support. Investiment (time and money) in developing expertise and confidence. Ensuring successful modest pilot blended learning	2010/11 Key partnerships established with at least one project initiated. Ensure at least one pilot is up and running to test market and build confidence in this new model. 2011 onwards - The development of a range of blended learning opportunities appropriate to market need and demand
Build on the success of our CPD programmes	To make a significant and distinctive contribution to mental health provision	Continued development of CPD programmes, aligned with workforce need and commissing strategy. Risk associated with reductions in funding for training and education.	Development of more effective marketing and development team, including additional dedicated resources.	2010/11 CPD programmes increase in number and continue to recruit. 2011 onwards - Continued broadening of range, responsive to need.

Service development priorities	Contribution to the overall vision	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
Acquisition etc:				
Develop CAMHS in one or more boroughs in relation to tendering opportunities	To increase access to Trust CAMHS	To identify CAMHS commissioning intentions by September 2010. Risk: No further services come forward for tender	Director time	2010/11 A clear picture of commissioning intentions. 2011/12 or 2012/13 Secure at least 1 new significant CAMHS (and new specialist contracts)
Secure one or more contracts for adult psychotherapy services	To increase access to Trust adult psychological therapy services	To identify Adult commissioning intentions by March 2011. Risk: Few services come forward for tender which are in the Trust's areas of expertise	Business development and marketing resources.	2010/11 A clear picture of commissioning intentions. 2011/12 and 2012/13 Secure at least 1 new contract per year
Transferred / discontinued activity:				
We have no plans to transfer out or discontinue any activities				

Template 5: Workforce strategy

Guidance: the main workforce focused priorities envisaged in the plan should be described, the actions necessary to implement them, key risks to implementation, resourcing requirements (financial and human capital), and measures by which the delivery of the planned changes in workforce size, mix or configuration will be tracked.
When considering the main workforce priorities, the following may be included:
• Changes in headcount (including benchmark evidence), mix or flexibility (i.e. mix of agency, bank, permanent);
• Key recruitment, training, retention and development initiatives;
• Redundancy and natural wastage programmes;
• Pay, rewards and other key remuneration initiatives or workstreams;
• Other workforce issues which may impact the plan.

We will publish plans in full except where the Trust indicates that it wishes to exclude specific limited information for publication purposes. For instance, where there are workforce related activities which include commercial or confidential matters which the Trust may not at this stage wish to be published in full, the Trust should indicate this clearly on its plan submission.

Where proposed workforce changes may risk impacting service provision or clinical quality, this potential risk should be recognised explicitly in the plan together with the specific actions proposed to mitigate it.

Key workforce priorities	Contribution to the plan	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
1. Planning and implementing the service and staffing changes to deliver 5% per annum productivity improvements is the key workforce challenge.	These improvements are needed in order to maintain our financial position, with national efficiency savings targets expected to be at least 4% each year, and other pressures	Service line directors and central directorates to undertake zero-based review of operating methods, to identify efficiency improvements without damage to quality	Directors' time. Finance and HR support. External consultancy to be considered.	Identify and agree service changes and workforce plan for 2011/12 by Oct 2010. Same for 2012/13, by July 2011. Implement each year.
2. Further develop Equalities and Human rights (Two Ticks revalidation, SES, Senior Management and board development)	The action plan developed within the SES will enable the Trust to promote and embed the scheme into our functions and policies.The trust maintains the two ticks "positive about disabled people" status and continues to find new ways to take positive action where appropriate with regards to disability	The objectives within the SES Action plan have clear indication of outcomes expected within agreed timelines. To be qualified to continue using the two ticks symbol on an annual basis, the Trust has to be compliant with 5 main positive about disabled people commitments envisaged in the scheme	HR Director & HR managers in relation to HR action points	Outcomes from the Action Plan 2010 to 2012
3. Revalidation of Doctors and development of medical appraisal system	This is in line with strengthening Drs' appraisal system to ensure Drs' fitness to practise can be revalidated on a 5 yearly cycle and ensure high quality patient care continues to be provided	Project plan in place to deliver streghtened appraisal system, including ongoing training, 360 degree feedback and system audits. system ready in time to meet external validation requiremnts.	Medical Director and Assistant Medical Director input required. Project lead in Human Resources, with ongoing input required from Director, Asst Director and Recruitment Supervisor.	Identify and agree work plan 2010/11 Consider external deadlines and ensure each project stage is met 2010/11

Key workforce priorities	Contribution to the plan	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
4. ISA and CRB checking - new and extended compliance requirements	These compliant requirements allow the Trust to make safer recruitment and licensing decisions by identifying candidates who may be unsuitable for certain work, especially those involving children or vulnerable adults.	On 31 May 2010 the current CRB forms will cease being issued and those who need to renew their CRB disclosures in 2010 (those obtained up to 2005) must apply for renewals by end of May 2010. All applications must cease on the old CRB forms by 20 June 2010. From June 2010 new VBS forms and packs (for both CRB and ISA registration) will be available. ISA registration is being introduced from 26 July 2010, and becomes mandatory on 1 November 2010 for new employees, those moving jobs and volunteers; a new CRB/ISA registration application form will be introduced. Over the next few years until 2015 the scheme will be phased in to include all employees including existing employees. It will be illegal for employers to take on a new person for coming into contact with children or vulnerable adults if they are not ISA-Registered.	HR administrator and advisor, with inputs from HR Director & HR managers as required.	Work through the timeline as indicated in the Action column

Key workforce priorities	Contribution to the plan	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
5. Middle management development and career development (Leadership and Talent Management)	Building middle management capability is key in achieving efficienc and productivity as well as ensuring managers are equipped to deal with the changes required to meet the priorities contained in the plan	Implementation of a developmental programme that covers internal development needs as well as the wider NHS and healthcare leadership agenda.	Identified funds to develop and provide required training. Time off facilities for staff to attend training as well as support and encouragement from immediate line managers.	Provide introductory programme in 2010 - assess and analyse feedback. Provide more in depth programme in 2010/11 and seek to expand development group to junior and more senior managers

Key workforce priorities	Contribution to the plan	Key actions and delivery risk	Key resource requirements	Measures of progress 2010/11 2011/12 2012/13
6. Further utilisation of HR technology through ESR to maximise benefits e.g. e-learning	Improved technology to achieve efficiencies and savings where possible. Improved processes move staff away from transactional activity to more proactive developmental work.	Identify pilot/test areas tor introduce specific ESR developments. Ability to identify time to dedicate to these areas of work may prove difficult. Ensuring benefits are realisable.	Some Human Resources time moved to this area of work. Support from other areas and departmenst in the Trust in delivering pilot area requirements.	identify and agree areas of activity to take forward 2010/11. identify supportand implement pilot areas/departments 2010/11. Benefits realisation analysis 2011/12
7. Integrated workforce planning through better liaison with finance and service leads	Improved planning and ensuring areas where shortfall or surpluses may arise are addressed earlier. Planned activity to achieve growth and sustainability.	involvement in wider NHS London workforce planning processes, integrated planning meetings with Finance and service leads preventing disjointed, unco-ordinated planning processes.	Workforce planning meetings and service meetings will require Directors time and HR Managers and Finance time.	involvement in 2010/11 NHSL workforce planning cycle. Ongoing workforce planning process 2011/12
8. Investigate and promote the NHS health and wellbeing agenda: e.g. welfare initiatives, flexible working, stress awareness interventions and policies	Improved health and well being at work, as part of the Trusts inititiave to promote and embed the wider Health and Well being agenda.Have a better understanding of what ''well being'' is and skills associated with improved well being & psychological health.)	Promoting health and well being will lead to better efficiencies (cost associated with staff sickness) & improved performance will likely lead to greater productivity	HR Director, HR Manager in partnership with staff side and engagement with other directorates	Identify what well being means within individual & larger work context -2010-11

Template 6: Capital programmes (including estates strategy)

[Guidance: the main capital expenditure priorities in the plan should be documented, together with amounts, timing and linkages to the delivery of the plan. In addition, key actions and delivery risk underpinning each should be identified. Each of the capital expenditure priorities should be shown under the following main headings:
• Development – this includes building of new capacity (through whatever funding source) or significant reconfiguration or upgrade of existing facilities.
• Maintenance or replacement capex – this includes planned or urgent maintenance capital expenditure or expenditure to replace existing facilities.
• Other capital expenditure – this includes purchases of equipment, technology, intellectual property and significant IT expenditure etc
• Other estates strategy – this includes net proceeds or expenditure on estates reorganisation or other estates strategy to either use the existing estate more efficiently or to release proceeds from surplus or unused assets.
Where delays either in proposed capital investment programmes (including maintenance, equipment, refurbishment or new builds) or in the delivery of an estates strategy may risk impacting service provision or clinical quality, this potential risk should be recognised explicitly in the plan together with the specific actions proposed to mitigate it.
Where relevant details are included within the input sheets from which the financial forecasts are derived, then reference to those capital expenditure plans should be made in the template above.]

Key capital expenditure priorities	Amounts and timing	Contribution to the plan (including service delivery)	Key actions and delivery risk
Development:			
New and existing Trust bases on community sites	Key part of operational and estates strategy, but no capital cost expected	Improve access to Trust services	
Relocate Tavistock Children's Day Unit in more suitable accommodation	Site to be identified during 2010/11. May be shared; likely not to be owned.	Improve service quality and efficiency. Reduce estates costs.	
Develop accessible outside space on the roof of the Tavistock Centre	£350k. Summer 2010	Improve environment for students, conferences, staff. Increase income.	
Maintenance:			
3-year improvement programme for main Trust buildings	2010/11 £60k (plus roof - see above). 2011/12 £230k. 2012/13 £460k.	Improve service quality and efficiency.	
Boiler renewal, Tavistock Centre Boiler conversion, Portman Clinic	£90k. Summer 2010 £50k. Summer 2011	Sustainability - carbon reduction. Energy cost savings.	
Other capital expenditure:			
IT and telephony network: rolling programme of devel't and replacement	£220k 2010/11. £220k 2011/12. £200k 2012/13	Support new systems (incl RiO). Develop communication methods.	
Other estates strategy:			
Relocate GID and Monroe services, using rooms previously leased out	Lease termination payment made in 2009. Relocations during 2010.	Improve patient experience. Integrate staff and services.	
Space utilisation review.	2010/11. No capital cost.	Improve service quality and efficiency. Reduce estates costs.	

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Template 7: Operational / financial effectiveness

Guidance: any other significant productivity / efficiency priorities in the plan should be set out, together with amounts, timing and linkages to the delivery of the plan. In addition, the key actions and potential delivery risks, any resource requirements (capital and human) and key milestones underpinning these should be identified. Clearly, in some instances there will be overlap with other priorities included in other templates (e.g. workforce strategy, capital expenditure and service development strategy) and where this is the case these should be referenced in the template.

The key focus of this template will be to bring together any other operational efficiency priorities not already identified elsewhere (e.g. procurement, other non-front line services, development and realisation of specific commercial opportunities, improvements in financing or other costs etc.

Where relevant details related to CIPs are included within the input sheets from which the financial forecasts are derived, then reference to those CIPs should be made in the template above.

Key operating efficiency programmes	Amounts and timing	Contribution to the plan	Key actions and delivery risk	Resource requirements	Milestones 2010/11 2011/12 2012/13
Further development of service line management	No separate targets or resource requirements.	Lead productivity planning through service redesign and by identifying and acting on loss-making or low margin activities.	Clearer separation and allocation of main income sources to inform service line reporting. Agree improvement targets for each service line.	Management time. Link to HR objectives (template 5, point 1). New finance system (target April 2011).	Identify and agree service changes and workforce plan for 2011/12 by Oct 2010. Same for 2012/13, by July 2011. Implement each year.
see also template 4 (lines 1 and 2, review of services)					
see also template 6 (energy cost savings, relocation and space utilisation)					

Template 8: Leadership and governance

Guidance: the leadership skills, and supporting governance processes and procedures, necessary to deliver the plan are a key focus and will develop and may fundamentally change as:
* *Current contracts expire or key personnel leave;*
* *Current gaps are filled;*
* *Service development initiatives (either organic or external) are implemented;*
* *Workforce, efficiency or estates programmes are rolled out;*
* *Acquisitions, investments or mergers are considered and progressed;*
* *Specific and material financial or operational challenges grow or decline;*
* *External impacts change.*

Planning leadership change, succession and development is core to ensuring that skills are in place to design and then deliver plans to mitigate risk and deliver the overall vision and strategy for the Trust. These should be supported by effective and functioning governance and assurance processes and procedures. Where there are shortfalls, gaps or specific risks then plans need to be in place and described to rectify them. Clear evaluation of current or future skills gaps and requirements going forward, leadership change and governance changes is important.

In the context of the current state of Board leadership and effectiveness, and the needs in the future to deliver the three year vision, the Trust Board should set out its priorities for leadership and governance development and evolution, consistent with the plan. This may in many cases entail external advice and periodic re-assessment to assist the Board to agree and then build its own effectiveness.

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2010/11 2011/12 2012/13
Maintain existing high levels of staff retention and contestability for management positions	During economically hard times with challenging productivity targets staff morale and engagement can drop. In addition, management and leadership posts can seem like a less attractive option.	Maintain active communication with the staff group around the Trust's position and planning. Ensure that the staff group are informed and engaged around management challenges. Ensure that Job Planning and Professional Development Planning is conducted with all staff in a meaningful manner.	In each year to maintain current levels of staff retention and contestability for management positions.
Ensure we recruit and retain the highest quality staff available in our spheres of activity	The configuration of some management/leadership roles (e.g. part-time and time-limited) at present is not supportive of advertising these roles externally when the incumbent finishes their term of office.	Review job descriptions of key management posts to ensure that roles are configured in a manner that supports external advertment of all key roles.	All job descriptions adjusted to support external advertment in 2010/11
Ensure that internally, staff have sufficient opportunities for development and training towards taking more responsible positions	Without support for their development high calibre internal staff will neither develop the required skills nor appetite for more senior management and leadership positions.	Middle management training implemented in 2010. Active use of PDPs. Creation of Associate Director roles (including Dean, MD and FD) in 2009/10	2010 onwards - build on newly established middle management training, improving access and quality of training. Associated with this, create enhanced opportunities for developing management experience, including shadowing and mentoring.
Ensure that succession plannning is an active and ongoing subject within both Management Committee and Board of Directors	If not addressed succession planning becomes routinised, with consequent failure to recruit to key posts	Succession planning is on agendas for both Management Committee and Board of Directors, with sufficient time for full discussion of key roles.	

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2010/11 2011/12 2012/13
Ensure that the Board of Directors has a balanced and effective membership	One NED coming to the end of her term of office in October 2010	Desired skill set already identified by Board of Directors and Board of Governors. Appointments panel already convened with clear task and timetable for action.	2010 - appoint new NED of high calibre with requisite skill set.

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Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2010/11 2011/12 2012/13
Ensure that the Board of Directors, and its membership, are enabled to function to the highest of their abilities	A high functioning Board is critical to organisation development and governance.	NED training opportunities, including individual funded training opportunities and group membership of NED programmes, including the Kings Fund programme. Annual Board reviews. Board Conferences.	Over the course of the Annual Plan to ensure that all NEDs and EDs have access to sufficient training opportunities, supported by appraisal and professional development planning. Full programme of Board Conferences. Regular Annual Board reviews.
Ensure that the Management Committee, and its membership, are enabled to function to the highest of their abilities	With the NHS sector under considerable economic stress, top teams can cease to function to their highest ability.	Continue regular programme of facilitated away days for the Management Committee focused on the optimisation of present and future functioning. Support through regular reviews of Management Committee functioning	Over the course of the Annual Plan to ensure that actions identified are implemented on a regular basis.
Ensure that the Board continues to receive assurance on all key indicators and processes	The Board must receive relevant, timely and reliable information on the Trust's operations, to support decision-making, identify problems and risks and take action.	Implement the new integrated governance and assurance system recently approved. Maintain and develop all existing assurance structures, including finance and performance reporting, audit committee, internal audit and counter-fraud, and risk management.	Annual reviews by Audit Committee and Board of assurance processes, to ensure that they remian fit-for-purpose.

Template 9: Regulatory

[Guidance: the plan should identify current and future regulatory risks, including registration (CQC) and risks to the Authorisation. The plan should also identify key actions to mitigate any material risk and measurement of progress towards rectification. This includes, but is not limited to:
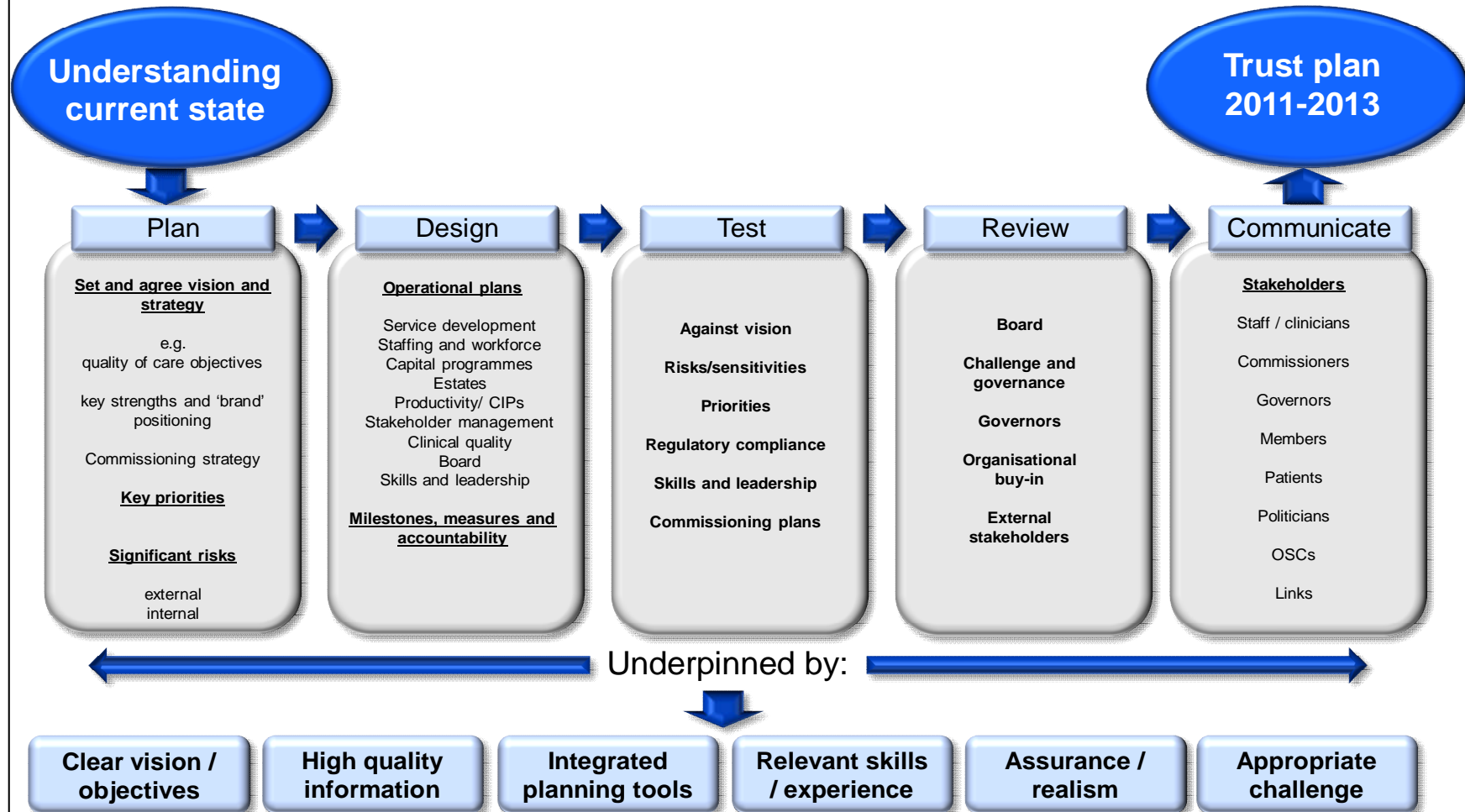*• Service performance;*
• Clinical quality and governance;
• Governance processes and procedures;
• Financial stability, profitability and liquidity;
• Risk to the provision of mandatory services;
• Private patient income cap;
• Co-operation or completion rules;
• NHS constitution;
• Ongoing registration with CQC and any conditions.
Ensuring ongoing regulatory compliance, with the processes, procedures, assurance and oversight in place to first predict potential breaches with confidence and then take action where necessary, is central to the design and delivery of a high quality plan, and then its implementation.
Clear and realistic evaluation of current or future regulatory risks and accountabilities over the three years of the plan is a key requirement.

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2010/11 2011/12 2012/13
Financial stability and liquidity	The Trust could move from surplus to deficit if productivity gains are not sufficient to meet the annual efficiency targets and any other pressures.	Actions throughout this plan are designed to meet this risk and ensure that the Trust remains compliant with its obligations and its authorisation. See templates 1, 2, 5, 6 and 7. The measures needed for 2010/11 are all in place. The Board receives monthly reports including forecasts.	Financial risk rating of at least 3 throughout the period.
CQC registration	Registration without qualification is dependent on continuing to maintain performance against a wide range of standards.	Actions throughout this plan are designed to meet this risk and ensure that the Trust remains compliant with all CQC requirements. See templates 1, 2, 3 and 4. The Board has recently authorised the implementation of an integrated governance and assurance system in relation to quality and safety of services, and will receive assurance reports quarterly.	Maintain registration without qualification throughout the period.
Governance rating	The Board declaration with this Plan states that the Trust is currently non-compliant with one of the new indicators (99% data completeness), leading to service performance score of 0.5.	Continue regular review and reporting to Board of expected performance on all targets, with action plans where needed.	Maintain green governance rating throughout the period, with a maximum score of 0.5.
No risks are currently envisaged to the provision of mandatory services; or of breaching the NHS constitution, the private patient cap, the co-operation and competition rules or any other regulatory requirements.			

Strategic planning – key phases

Monitor
Independent Regulator
of NHS Foundation Trusts

Understanding current state

Trust plan 2011-2013

Plan	Design	Test	Review	Communicate
Set and agree vision and strategy	**Operational plans**	**Against vision**	**Board**	**Stakeholders**
e.g. quality of care objectives	Service development	**Risks/sensitivities**	**Challenge and governance**	Staff / clinicians
key strengths and 'brand' positioning	Staffing and workforce	**Priorities**	**Governors**	Commissioners
Commissioning strategy	Capital programmes	**Regulatory compliance**	**Organisational buy-in**	Governors
Key priorities	Estates	**Skills and leadership**	**External stakeholders**	Members
	Productivity/ CIPs	**Commissioning plans**		Patients
Significant risks	Stakeholder management			Politicians
external	Clinical quality			OSCs
internal	Board			Links
	Skills and leadership			
	Milestones, measures and accountability			

Underpinned by:

Clear vision / objectives	**High quality information**	**Integrated planning tools**	**Relevant skills / experience**	**Assurance / realism**	**Appropriate challenge**

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Board of Directors : May 2010

Item : 13

Title : Draft Quality Report

Summary :

The draft Quality Report 2009/10 incorporates the requirements set out in the Department of Health's Quality Accounts Regulations and requirements set by Monitor.

The Report sets out five clinical quality improvement priorities for 2010/11 and reports on progress on the three priorities selected for 2009/10. In addition, performance against indicators is reported under the three domains: patient safety; clinical effectiveness; and patient experience.

The final report will include responses from the local LINks and our host PCT Commissioner but the local Health Scrutiny Committee have let us know that they are unable to provide a response this year.

The Quality Report is due to be submitted to Monitor by June 8th along with a Statement of Internal Control. The Quality Accounts are due to be uploaded on NHS Choices by June 30th.

The Board is asked to review the attached draft report and to approve the selection of the five quality improvement priorities for 2010/11.

For : Discussion

From : Trust Clinical Director

Quality Report

Part 1   Chief Executive's Statement

The Trust remains proud of its record for the provision of high quality mental health services. In previous years the Healthcare Commission awarded the Trust the highest rating of excellent for the quality of our clinical services. Under the new Care Quality Commission regulation the Trust has achieved registration without conditions. *High Quality Care for All* (June 2008) offered a welcome focus on the quality of clinical services. The introduction of Quality Accounts now offers an opportunity for us to work with patients, the public, staff, the Board of Governors, the Board of Directors, our commissioners and other stakeholders to ensure that we provide the highest quality services and continue to offer innovative ways of improving mental health.

Over the last year our Quality Programme Board has overseen progress on quality improvement plans and has worked to develop our approach to implementing a quality programme which is both robustly sponsored by senior management and the Board of Directors, and locally owned in each clinical service line through clear lines of communication, reporting and accountability. Over the coming year, we will be implementing an integrated system of Clinical Quality, Safety and Governance. This system will also provide assurance to the Board of Directors and ensure that the work streams that fall within this domain deliver on their objectives, supported through adequate and equitable resourcing across the Trust at service line level. Each service line within the Trust already produces an annual report to the Board of Directors which includes financial, performance, clinical quality and staffing data.

The majority of the national indicators proposed for mental health do not apply to our Trust because we provide specialist out patient services and few indicators have been developed which apply either to CAMHS or adult psychological therapies. However, we are keen to find ways of capturing and demonstrating the quality of the services we offer through expanding data collection and identifying areas for development, using national measures where they exist to allow benchmarking.

In summary, the Trust is absolutely committed to the quality agenda and to the areas of patient experience, clinical outcomes and safety that comprise it. We intend to work closely with all of our stakeholders in order to ensure that we deliver on our commitments.

I confirm that I have read through this quality report which has been prepared on my behalf. I have ensured that whenever possible that the report contains data that has been verified and/or previously published in

the form of reports to the Board of Directors and confirm that to the best of my knowledge the information contained in this report is accurate.

Dr Matthew Patrick
Chief Executive
xx June 2010

Part 2   Priorities for quality improvement and statements of assurance

1   For the year 2010/11 priorities for quality improvement have been selected taking into account a range of views and external factors. Key inputs have included:

- Patient feedback on experience of Trust services

- Quality agenda as set out in *High Quality Care for All*[1]

- Consultation with the Board of Directors, the Board of Governors, and staff

- Consultation with commissioners though reporting on Quality Improvement Plans for 2009/10 and agreeing CQUIN targets for 2010/11.

2   We have added two new priorities to the three we worked on in 2009/10 making a total of five priorities for 2010/11; the two new priorities are patient and public involvement, and maintaining a high quality effective workforce. Thus the priorities for 2010/11 are as follows:

- Clinical Outcome Monitoring

- Patient and Public Involvement

- Improvements to the built environment and facilities

- Access to clinical service and health care information for patients and public

- Maintaining a high quality, effective workforce

3   Our aim is that all of these priorities will be supported through the involvement of Governors and Membership

4   Clinical Outcome Monitoring

4.1   CAMHS Outcome Monitoring Programme

    4.1.1   Routine outcome monitoring data has been collected in the CAMHS Directorate for several years. However, the range of

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[1] Department of Health, *High quality care for all: NHS Next Stage Review Final Report*, June 2008

measures used needed to be expanded in order to fulfil the requirements of CORC (CAMHS Outcome Research Consortium). CORC specifies an agreed common set of measures to routinely evaluate outcome from at least three key perspectives (the child, the parent / carer and the practitioner).

4.1.2   The CAMHS Directorate undertook a 6 month pilot project across two generic teams in Camden (October 2009 – April 2010) in order to implement the expanded protocol. All processes, including significant additional IT support were put in place and information is now being provided on a monthly basis to the Camden CAMHS Commissioner. However initial return rates have been low, but to address this issue a number of changes have been made to the format of data collection. In addition, the Trust is hosting a training workshop on outcome monitoring for CAMHS clinicians in May 2010, to help increase the relevance and value of outcome measures for clinicians. There remain concerns, however, that the return rates will not meet the target of 60% required by the Camden CAMHS commissioners by the end of this financial year (2010/11). An action plan is in place to mitigate this risk. Currently, the expanded protocol is in use in clinical teams providing CAMH services to patients and families living in Camden, with plans later this year to implement the protocol across all services within the directorate for every new patient referred.

4.1.3   The Learning and Complex Disabilities Service, the Under Fives Service and the Fostering and Adoption Service will be piloting new outcome measures specifically designed for the population of children / young people who attend these services.

4.1.4   Collection and reporting of the agreed CORC dataset has now been implemented across Camden Service Lines. However, for the year 2010/11 the department needs to improve data collection in the following domains: demographic data, presenting problem, and professionals involved for every new case. There have been technical problems related to use of new forms which have been resolved. An additional outcome monitoring report will be completed in May 2010 to evaluate compliance.

4.1.5   Further work is been undertaken to ensure, where possible, that the outcome monitoring processes and core dataset are compliant with the new electronic patient record system (RiO) which will be launched in September 2010.

4.2 Adult Outcome Monitoring Programme

4.2.1 At this time, outcome monitoring in the Adult Department is based on the CORE System (Clinical Outcomes for Routine Evaluation) which was developed in the UK for use in psychotherapy to measure outcome, and to provide data for service audit and evaluation. The return rates have remained consistently low over the past number of years. However, a change in the outcome monitoring protocol has had the effect of further increasing the return rates of forms from patients. Now, rather than receiving the end of treatment form by post, clinicians hand the forms directly to patients. In addition, new outcome measures are also being piloted in the Adult Department Brief Therapy Service and will be reported on later in 2010/11.

5 Patient and Public Involvement

5.1 The Trust places great store by patient and public involvement, including students and other non-patient users of our services. In the coming year we will be:

5.1.1 Undertaking a stakeholder consultation on the quality of our clinical services in liaison with the Patient and Public Involvement Committee (the PPI committee includes patient, public and Governor representatives who will be involved in the planning of this work)

5.1.2 Inviting patients and carers to take part in consultations (for example on patient information and confidentiality)

5.1.3 Developing more creative ways of obtaining feedback such as using the internet and telephone surveys, and events such as themed open meetings.

6 Improvements to the built environment and facilities

6.1 In 2009 we focussed on refurbishment of high traffic ground floor areas, responding to concerns that had been raised in previous patients' surveys about the 'tired' condition of the building. Such comments were far from universal, however, many patients giving positive feedback about the 'feel' of the building and praise for the artwork.

6.2   Our review of patient feedback included all the possible feedback mechanisms including the Experience of Service Questionnaire (ESQ). Most data from the ESQ has come from the Adolescent Department where it has been most used. However the ESQ was piloted in the Child and Family Department from October 2009 until March 2010 before being formally incorporated into the outcome monitoring procedure for the department effective from 1st April 2010 for Camden Service Lines. The feedback from this questionnaire in relation to the environment is reasonably positive although there have been additional comments about the books in the waiting areas (need for more) and the therapy rooms (seeming sparse). We have recently been donated books by an author parent and have donations of popular children's magazines.

6.3   In order to improve the quality of the environment for patients, refurbishment work was undertaken during the summer 2009. This included the ground floor reception and waiting area; PALS / patient information area; space between the reception area and the lifts, and commissioning of new art work for the waiting area and the corridor leading to the lifts.

6.4   Once the refurbishment had been completed a survey was carried out to ascertain the impact of the changes made. Feedback forms were placed in the waiting rooms of the Adult, Child and Family and Adolescent Department for two weeks, during which a total of twenty forms were completed.

6.5   Similar to the pre-refurbishment survey, the feedback received during the post-refurbishment period was mixed. However, 60% of the respondents thought that the new design and layout of the main reception and the waiting area made the ground floor look better. In response to the feedback received, there have been measures taken to address the concerns raised about the refurbishment work. These measures have included adding plants, soft furnishing and a frosted glass screen. The lighting on the ground floor corridor has been softened and the some of the artwork has been changed. A further survey will be undertaken in 6 months.

6.6   The Patient and Public Involvement (PPI) Lead is a member of the Trust's Design Advisory Group in order to ensure that there is on-going review of the feedback received from patients about the environment. The Design Advisory Group is led by the Trust Director, who is the Trust Board Design Champion and the group includes active Governor participation .This also ensures that there is a process in place for improving and maintaining the quality of the environment based on a range of views including patients, Governors, Members and staff.

6.7 A rolling programme of refurbishments is in hand and plans are in development for improvements to the use of external spaces

7 Access to clinical service and health care information for patients and the public

7.1 We view the Trust website as a key portal of access to, and a key route for disseminating information about, the Trust and its services. In 2008, a strategic decision was made to redesign the website to ensure that it was fit for purpose. The communications team conducted a survey, through the membership newsletter, to establish ideas about what patients thought was important to consider in the redesign. We appointed a design company and they also conducted user testing. It was apparent that the patient population felt strongly that the website needed to be organised around the kinds of questions patients (and our student users) might ask. The website has, therefore, been completely revised and the new site was launched in July 2009.

7.2 There have been several rounds of user testing on the new website, where patients have been asked to search for particular pages and then have given feedback on the ease of navigation through the site, which has led to further improvements. After the site has been live for a year we will conduct a further survey through the members' newsletter to check that the site is functioning as it should.

7.3 The Communications Team is preparing a series of downloadable leaflets on Life Issues which will offer information and advice in relation to common issues encountered across the life span. The series will be launched in 2010/11 and will make a contribution to promoting public health and well-being

7.4 Following a consultation from People First, the Trust has developed information leaflets suitable for people with learning disabilities and will make these available from 2010/11.

8 Maintaining a high quality, effective workforce

8.1 The Trust has always performed well in staff surveys. Our most recent survey is also very positive, in fact improving on the strong surveys of previous years. In many areas the Trust ranks in the top 20% of mental health trusts, for example in the percentage of staff expressing strong satisfaction with their jobs and in the percentage of staff who would recommend the Trust as a place to work or to

receive treatment. The percentage of staff reporting that they work extra hours for the Trust remains high, as in previous years although this year somewhat less than before, which is an improvement. One less positive feature, however, is that staff surveys have also reported significant levels of stress amongst the staff group. Over 2010/11, we aim to put in place a range of measures to reduce work related stress.

8.2 In addition we aim to maintain a well-trained, flexible and creative workforce through providing personal development plans, supporting Continuing Professional Development and continuing to support workshops aimed at enhancing clinical learning and development.

9 Involvement of Governors and Members

9.1 We believe that the quality of our services will benefit from working more closely our Governors, and Members; they are key to our future direction and nature of the Trust.

9.2 While achieving this aim is not straightforward, in pursuit of it increasing time and resourcing is being devoted to supporting and facilitating our governance structures. Over the coming year we want also to focus on development and support of links between Members and Governors. Website and e-mail possibilities are being explored. We also aim to include a Governor in each of a number of key quality committees and work streams within the Trust in order to promote closer working between the executive, the staff and Governors and through their links, the Membership.

9.3 In this way we would hope to make the most of our Governors' and Members' contribution to the continuing improvement of the quality of our patient services.

10 Statements of Assurance from the Board of Directors

10.1 Review of Services

10.1.1 During 2009/10, the Tavistock and Portman NHS Foundation Trust provided four NHS services.

10.1.2 The Tavistock and Portman NHS Foundation Trust has reviewed all the data available to them on the quality of care in 4 of these NHS services.

10.1.3 The income generated by the NHS services reviewed in 2009/10 represents 44% of the total income generated from

the provision of NHS services by the Tavistock   and Portman NHS Foundation Trust for 2009/10.

10.2 Participation in Clinical Audits and National Confidential Enquiries

10.2.1   During 2009/10 there were no national clinical audits and 2 national confidential enquiries covered NHS services that Tavistock and Portman NHS Foundation Trust provides.

10.2.2   During 2009/10, the Tavistock and Portman NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

10.2.3   The national clinical audits and national confidential enquiries that the Tavistock and Portman NHS Foundation Trust was eligible to participate in during 2009/10 are as follows:

10.2.3.1   National Homicide Audit

10.2.3.2   National Suicide Audit

10.2.4   The national clinical audits and national confidential enquiries that the Tavistock and Portman NHS Foundation Trust participated in during 2009/10 are as follows:

10.2.4.1   National Homicide Audit

10.2.4.2   National Suicide Audit.

10.2.5   The national clinical audits and national confidential enquiries that Tavistock and Portman NHS Foundation Trust participated in, and for which data collection was completed during 2009/10, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

10.2.5.1   National Homicide Audit   100%

10.2.5.2   National Suicide Audit   100%

10.2.6   The reports of two national clinical audits were reviewed by the provider in 2009/10 and the Tavistock and Portman NHS Foundation Trust intends to take the following actions to

improve the quality of healthcare provided. No action required.

10.2.7 The reports of eleven local clinical audits were reviewed by the provider in 2009/10 and the Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

10.2.7.1 To provide feedback of the findings to the Board of Directors, Executive Committee and clinicians within the relevant department where audit undertaken and to the PPI Lead, as appropriate covering a range of services. For example, feedback and guidelines have been provided to clinicians for improving the quality and consistency of information recorded in patient case files, following the Case Note Audit.

10.3 Participation in clinical research

10.3.1 The number of patients receiving NHS services provided or sub-contracted by the Tavistock and Portman NHS Foundation Trust that were recruited during that period to participate in research approved by a Research Ethics Committee was approximately 70.

10.4 The use of the CQUIN framework

10.4.1 A proportion of the Tavistock and Portman NHS Foundation Trust's income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between the Tavistock and Portman NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from Robin Bonner, Head of Service Development and Agreements, email: rbonner@tavi-port.nhs.uk.

10.4.2 The total financial value was £43,000. Achievement of goals is currently in the final stages of ratification. The Trust expects to receive £42,000 of the £43,000.

10.5 Registration with the Care Quality Commission (CQC) and periodic / special reviews

10.5.1 The Tavistock and Portman Foundation NHS Trust is required to register with the Care Quality Commission and its current registration status is full registration without conditions.

10.5.2 The Care Quality Commission has not taken enforcement action against the Tavistock and Portman Foundation NHS Trust during 2009/10.

10.5.3 The Tavistock and Portman Foundation NHS is not subject to periodic review by the Care Quality Commission.

10.5.4 The Tavistock and Portman Foundation NHS has not participated in any special reviews or investigations by the CQC during the reporting period.

10.6 Information on the quality of data

10.6.1 The Tavistock and Portman Foundation NHS did not submit records during 2009/10 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

10.6.2 The Tavistock and Portman Foundation score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 88%.

10.6.3 The Tavistock and Portman Foundation NHS Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Part 3   Other Information

This section gives an overview of the quality of care offered by the Trust based on performance in 2009/10 against indicators used in the 2008/09 Annual Report.

1   Patient Safety indicators

1.1   NHSLA level

1.1.1   In March 2009, the NHSLA awarded the Trust a Level 1 rating with a 100% pass rate for compliance with the requirements for written process. This assessment is valid for two years. The Trust is committed to continuing to improve the safety of Trust services and aims to achieve Level 2 rating in March 2011, which will demonstrate that its risk management and patient safety policies and procedures are effective in practice.

1.2   Number of patient safety incidents

1.2.1   The Trust has a relatively low incident rate due to the nature of its patient services. Many of the reported incidents have occurred in the Trust Specialist Day Unit which includes a school for children with emotional difficulties and challenging behaviour. Following a discussion with the National Patient Safety Agency (NPSA) over the course of the year, the Trust now reports all incidents in the Day Unit, which involve pupil to pupil violence as "clinical incidents". All other clinical incidents, which are generally few in number, continue to be reported to the NSPA on a monthly basis via the intranet National Reporting and Learning Service (NRLS) staff portal. The total reported incidents (both clinical and non-clinical) in 2008/09 was 187. This rose to 264 in 2009/10, which was thought to be related to a general increase in awareness of incident reporting across the Trust. The Trust had one Serious Untoward Incident (SUI) in 2009/10, which was fully investigated and the subsequent report submitted to the Board of Directors and Camden Commissioners, and submitted to NHS London as required. The Board of Directors has monitored compliance with the action plan and the SUI is closed. The Trust routinely promotes incident reporting at the Trust-wide Induction, INSET and other risk training events.

1.3   Monitoring of adult safeguarding alerts

1.3.1   The importance of safeguarding vulnerable adults, by identifying and reporting those adults who might be at risk, has been

highlighted by the Trust. This has been through the mandatory training provided at the annual Trust INSET day, and via email reminders to Trust staff over the course of the year. During the past year, the LCDS (Learning and Complex Disabilities Service) has liaised with local authorities on two separate occasions, concerning two vulnerable adults, who were already known to their Local Authority prior to their contact with the Trust. So that the Trust remains active in responding to and monitoring the needs of this group, staff continue to be encouraged to submit the Trust incident reporting form.

1.3.2   Adult safeguarding alerts will be monitored regularly over 2010/11

1.4   Electronic recording of Children in Need

1.4.1   Last year, when determining the objectives for Patient Safety for 2009/10, the Trust set itself a target of electronically recording those children in need. However, it has not been possible to take this forward, because of problems with the definition of "children in need", which extends beyond the Trust. However, it is recognised that this is an area which requires further work.

1.5   Attendance at Trust-wide induction days

1.5.1   Last year we set ourselves a target of improving attendance at Trust-wide induction from 66% in 2008/09 to 75% in 2009/10. We are pleased to report that attendance rose to 85% in 2009/10.

1.5.2   Our target for 2010/11 is to maintain a high level of attendance at Trust-wide induction and to focus on attendance at local level to achieve a 75% attendance rate.

1.6   Attendance at mandatory training

1.6.1   97% of the target staff attended the mandatory INSET day during 2009/10 (which all staff are required to attend once every two years), where staff were provided with training in the following areas:

- Risk assessment
- Infection control
- Confidentiality and Caldicott guidance
- Health and safety (including lone workers)

- Equality and Diversity

- Information Governance

- Safeguarding children Level 1

- Safeguarding Adults

- Fire safety

1.6.2 Safeguarding of Children

 1.6.2.1 97% of the target staff group attended Safeguarding of Children Level 1 training.

 1.6.2.2 50% of the staff required to attend the Level 2 training have completed this, with a further 25% scheduled to complete this training in May 2010.

 1.6.2.3 94% of those required to attend Level 3 training had completed their training at March 2010.

 1.6.2.4 We will ensure staff are offered updated Safeguarding of Children training as required and monitor attendance.

2 Clinical Effectiveness

2.1 Monitor number of staff with Personal Development Plans

2.1.1 Through appraisal and the agreement of Personal Development Plans we aim to support our staff to maintain and develop their skills. A Personal Development Plan also provides evidence that an appraisal has taken place.

2.1.2 The number of staff with Personal Development Plans in 2009/10 was 93%, an increase on the level for the previous two years, with a figure of 92% in 2008/09 and 77% in 2007/08.

2.1.3 For the 2010/11 we aim to achieve a return rate above 90% in order to demonstrate that we now have a consistently robust system in place.

2.2 Evidence of increase in range of treatment modalities

2.2.1 The Trust is a national leader in the provision of systemic psychotherapy and psychodynamic psychotherapy. Alongside this, the Trust is increasing the range of treatments available so that

we can offer therapies to a greater range of patients and offer a greater choice of treatments to all our patients. Some of these developments include extensions of approaches we already use, as well as new developments based on combining elements know to be effective within two or more established modalities of treatment.

2.2.2　Over 30 staff are now trained to basic level in Interpersonal Therapy (IPT) and a cohort are proceeding to practitioner level training, with a smaller group now approaching supervisor level.

2.2.3　Dynamic Interpersonal Therapy (DIT) is a brief psychodynamic competency based approach developed by the Trust in collaboration with the Anna Freud Centre. Six staff have completed basic training in DIT.

2.2.4　Both IPT and DIT have been approved as appropriate treatments to offer within Improving Access to Psychological Therapies (IAPT) programmes nationally.

2.2.5　Seven staff trained in Mentalisation Based Therapy (MBT), an effective treatment for people with personality disorders. A Mentalisation based variant of Multi Systemic Therapy is being offered for young people on the cusp of care.

2.2.6　Within family approaches, FAST (Family and Schools Together) is being piloted. This approach is amongst the top five evidence-based family interventions in the USA and is just being introduced in the UK.

2.2.7　The Trust is also delivering EMDR (Eye Movement Desensitisation and Reprocessing) for highly traumatised children and Relationship Development Intervention (RDI) as a component of autism services.

2.2.8　Cognitive Behaviour Therapy is continuing to develop within the Trust as a treatment modality.

2.2.9　Over the coming year we will work to embed new approaches and monitor whether patients have been offered a choice of treatment where that is appropriate

2.3　Outcome monitoring returns data

2.3.1　The Trust is committed to using outcome measures for evaluating the effectiveness of the clinical interventions it provides. The ongoing challenge faced by services is how to obtain reasonable return rates, sufficient to enable the Trust to effectively evaluate

its clinical services. There are many factors which can contribute to low return rates, such as the perceived lack of relevance and usefulness of these measures, both by patients and clinicians alike. It is important to note, at the time of writing this report, a number of forms sent to patients and clinicians in the period before 31st March 2010 had still to be returned. For this reason, the 2009/10 post assessment return rates for most departments and services were slightly lower than expected.

2.3.2 Child and Family Department

2.3.2.1 Up until 2009, the Child and Family Department, in line with the recommendations of CORC (CAMHS Outcome Research Consortium) have used three standardized measures: The SDQ (Strength and Difficulties Questionnaire), which has been completed by services users and teachers; and the CGAS (The Child Global Assessment of Functioning) and the PIRGAS (Parent-Infant Relationship Global Assessment), both which are completed by clinicians, the CGAS for children ages 4-16 and the PIRGAS for children under the age of 3.

2.3.2.2 Outcome data has been collected within three services, the generic Child and Family Department (consisting of specialist services and teams), the North Camden Team and the South Camden Team. For the SDQ forms completed by young people, the return rates only include those patients seen as part of the Fostering, Adoption and Kinship Team, within the Child and Family Department and North and South Camden teams. As a consequence, the overall figures are low for this outcome measure. The return rates for these services are as follows:

2.3.2.2.1 The Child and Family Department:

2.3.2.2.1.1 The *Pre-Assessment* return rates for the <u>SDQ for Young People</u> for the 2007/08, 2008/09 and the 2009/10 periods were 54.5% (N=6), 66.6% (N=4) and 25% (N=3). For the same reporting periods the return rates at the *12 month Treatment stage* were 23.8% (N=3), 14.3% (N=2) and 11.1% (N=1).

2.3.2.2.1.2 For the <u>Parent and Teacher SDQ</u>, the *Pre-Assessment* return rates for 2007/08, 2008/09 and 2009/10 periods were 74.1% (N=132), 68.3% (N=93) and 41.3% (N=50). At the *12 month Treatment stage* the respective return

rates were 43.5% (N=122), 41.9% (N=115) and 42.5% (N=86).

2.3.2.2.1.3 For the <u>CGAS and the PIRGAS,</u> completed by clinicians, the return rates at the *Post-Assessment Stage* (at the point when this scale is first used) for the 2007/08, 2008/09 and the 2009/10 periods were 68.2% (N=86), 63.9% (N=119) and 58.8% (N=71). There was an increase of returns rates for the *Treatment End Stage*, which has been maintained over the past 3 years with return rates of 74% (N=104), 78% (N=50) and 76.6% (N=23) from clinicians for the same reporting periods.

2.3.2.2.2 The North Camden Team:

2.3.2.2.2.1 The *Pre-Assessment* return rates for the <u>SDQ for Young People</u> for the 2007/08, 2008/09 and the 2009/10 periods were 100% (N=1), 0% (N=0) and 50% (N=3). For the same reporting periods, excluding 2007/08, the return rates at the *6 month Treatment stage* were 0%% (N=0) for 2008/09 and 8% (N=2) for 2009/10 periods.

2.3.2.2.2.2 For the <u>Parent and Teacher SDQ</u>, the *Pre-Assessment* return rates for 2007/08, 2008/09 and 2009/10 periods were 71.4% (N=25), 60.3% (N=38) and 60% (N=43). At the *12 month Treatment stage* the respective return rates were 35.2% (N=25), 28.0% (N=28) and 28.0% (N=21).

2.3.2.2.2.3 For the <u>CGAS and the PIRGAS,</u> completed by clinicians, the return rates at the *Post-Assessment Stage* for the 2007/08, 2008/09 and the 2009/10 periods were 63.8% (N=23), 60.0% (N=9) and 81.8% (N=9). There was an increase of returns rates for the *Treatment End Stage*, which has been maintained over the past 3 years, with high return rates of 100% (N=23), 97% (N=34) and 96% (N=24) from clinicians for the same reporting periods.

2.3.2.2.3 The South Camden Team:

2.3.2.2.3.1 The *Pre-Assessment* return rates for the <u>SDQ for Young People,</u> which were only applicable for the 2008/09 and the 2009/10 periods, were 28.5% (N=2) and 31.5% (N=6) respectively. For the same reporting periods, the return rates at the *6 month Treatment stage,* were 0%% (N=0) for 2008/09 and 0% (N=0) for 2009/10.

2.3.2.2.3.2 For the <u>Parent and Teacher SDQ</u>, the *Pre-Assessment* return rates for 2007/08, 2008/09 and 2009/10 periods were 50.0% (N=2), 31.8% (N=7) and 31.3% (N=26). At the *12 month Treatment stage* the respective return rates were 35.2% (N=26), 32.9% (N=29) and 31.3% (N=29).

2.3.2.2.3.3 For the <u>CGAS and the PIRGAS,</u> completed by clinicians, the return rates at the *Post-Assessment Stage* for the 2007/08, 2008/09 and the 2009/10 periods were 100% (N=3), 90.0% (N=9) and 100% (N=15). For the *Treatment End Stage*, the return rates were100% (N=1), 83% (N=5) and 83.3% (N=5) from clinicians for the same reporting periods.

2.3.2.3 The steps which are being taken to improve the return rates include a greater involvement of the clinician in encouraging families to complete these forms; mandatory training for clinicians and administrative staff highlighting the relevance and important of these tools for demonstrating clinical effectiveness; and the addition of the 'Added Value Score' for the SDQ, as a key indicator of performance in CAMHS from 2010.

2.3.2.4 As part of the plan to expand the range of measures collected in the Child and Family Department, in line with the requirements of CORC, a key development will be the introduction of a "goal-based measure", where the young person and family will determine what they wish to change over the course of treatment. In addition, information will be routinely collected concerning their experience of the service using the CHI-ESQ.

2.3.3 *The Adolescent Department*

2.3.3.1 The outcome measures used in the Adolescent Department are part of the Achenbach System of Empirically Based Assessment, and include forms to be completed by the young people and another form to be completed by the clinician and Significant Other (someone the young person nominates to complete the form).

2.3.3.2 At the Pre-Assessment stage, the return rates for 2007/08, 2008/09 and 2009/10 for patients were as follows: 79.2% (N=122), 86.5% (N=122) and 98.4% (N=121), and respectively for the Significant Other, 68.3% (N=71), 82.5% (N=85) and 95.4% (N=83). However, the Post-Assessment figures were less favourable for patients, the Significant Other group and clinicians. Covering the 2007/08, 2008/09 and 2009/10 periods, the rate of returns for patients was 14.4% (N=14), 20.7% (N=28) and 17.7% (N=31) respectively. Although the returns rates are low, the actual number of forms returned by young people has increased over time. The figures for the Significant Other group over the same reporting periods were 12.5% (N=12), 14.8% (N=19) and 14.1% (N=23). Whereas, for clinicians, the return rates were 35.5% (N=33), 36.2% (N=42) and 29.0% (N=38) respectively.

2.3.3.3 In order to increase the rate of returns from service users, the Adolescent Department is planning to introduce new outcome monitoring measures. Initially, information will be gathered from a series of focus groups with young people to determine which measures are likely to be suitable for the young people who attend the Adolescent Department. It is anticipated that these new measures will prove more effective in encouraging young people to provide feedback on their mental well-being and so increase the rate of returns.

2.3.3.4 However, in terms of considering clinical effectiveness, it is helpful to consider the information based on the data covering 6 years, from 2003-2009, using the Achenbach System of Empirically Based Assessment (ASEBA) measures. From this data, it is evident that at the 'Pre-Assessment' stage 54% of patients fell within the 'clinical' domain, whereas at the 'Post-Assessment' stage, this drops to 46% and to 32% at the 'End of Treatment'. These figures indicate that over the past 6 years patients attending the Adolescent Department have demonstrated improvement over time, from the point of assessment to the end of treatment.

2.3.4   The Adult Department

2.3.4.1 Outcome monitoring in the Adult Department is based on the CORE System (Clinical Outcomes for Routine Evaluation) which was developed in the UK for use in psychotherapy to measure outcome, and to provide data for service audit and evaluation.

2.3.4.2 The Adult Department has consistently obtained very favourable return rates from patients at the Pre-Assessment Stage, as follows: 92.6% (N=274) for 2007/08; 95.0% (N=245) for 2008/09 and 99.5% (N=213) in 2009/10. In addition, historically the Post-Assessment return rates for clinicians have been high, with a figure of 98.0% (N=296) in 2007/08 and 93.7% (N=238) in 2008/09, but with in the number of returns for 2009/10 decreasing to 78.7% (N=140). However, the Post-Assessment return rates increased for patients from 39.2% (N=62) in 2007/08 to 56.1% (69) in 2008/09. The figure for 2009/10 at 55.7% (N=49) was slightly lower than expected, and doesn't reflect the increase in the return of forms from patients, which has been identified since the change in protocol.

2.3.4.3 With a commitment to increasing the return rates in November 2009 changes were made to the protocol, whereby the clinician now provides the end of treatment form directly to the patient. Although the data has yet to be fully analysed, this change has resulted in a slight increase in the return rates from patients, dating from the time when the protocol was changed. In addition, new outcome measures are being piloted in the Adult Directorate Brief Therapy Service and will be reported on later this year.

2.3.5   The Portman Clinic

2.3.5.1 There are limitations of the CORE as a measure of outcome for a forensic population receiving psychotherapeutic treatment, as seen at the Portman Clinic, as evidenced from the relatively low return rates from both clinicians and patients of completed CORE forms, particularly at the end of treatment stage.

2.3.5.2 Even though the Pre-Assessment returns rates were reasonably favourable for 2007/08 at 81.0% (N=59), for 2008/09 at 73.2% (N=60) and 2009/10 at 73.3% (N=44), the Post-Assessment return rates for both patients and clinicians has decreased over the past 3 years. For patients,

the return rates were as follows: 54.5% (N=18) in 2007/08, 46.2% (N=24) in 2008/09 and 38.2% (N=13) in 2009/10. For clinicians, the figures were 97.7% (N=43) in 2007/08, 77. % (N=47) in 2008/09, and 43.6% (N=17) in 2009/10.

2.3.5.3 Because of the limitations of using the CORE as the sole outcome measure, the Portman Clinic have been investigating the use of other pre-existing validated instruments measuring outcomes considered more appropriate for a forensic population. These instruments include: The Global Assessment of Functioning (GAF) to measure symptom change; the Shedler-Westen Assessment Procedure (SWAP), a clinician rated measure); the Millon Clinical Multi-axial Inventory-III (a patient-rated measure), to measure personality change; and the Global Assessment of Relational Functioning Scale (GARF), a clinician-rated measure, to assess the quality of patients' interpersonal relationships. Portman clinicians have been piloting the use of the SWAP on patients as part of the assessment, with favourable results.

2.3.5.4 In conclusion, as outlined above, all departments and services across the Trust are committed to improving the rate of returns of the forms used for evaluating clinical effectiveness. In addition, progress is being made to include measures which are more relevant and meaningful for the specific patient group, more sensitive to change, and which are based on patient-determined change. Furthermore, the success of using telephone interviews with young people for the CHI-ESQ, suggests that there are benefits to considering other methods to improve response / return rates, such as the use of e-mail and the Internet / Trust website etc.

3   Patient Experience

3.1 Percentage of patients rating care "excellent" / "very good" / "good"

3.1.1   Feedback from patients who responded to the most recent yearly patient survey demonstrated that 70% either rated their care as "excellent", "very good" or "good", a figure which the Trust has achieved consistently for the past five years. 73% felt that they were listened to and treated with respect and dignity, and 69% would recommend the Trust to their friends or family members.

3.1.2 For 2010/11 we are aiming for 70% or more of those patients responding to the survey to rate their care as "excellent" / "very good" / "good".

3.1.3 In consideration of the fact that the response rate to patient surveys is low for young people, the information from CHI-ESQ (Experience of Service Questionnaire) was used to obtain the views of young people attending the Adolescent Department, aged 16 and over, following their Assessment in the Department. Rather than completing this questionnaire on paper, young people were invited to complete this Questionnaire by telephone interview. This proved most successful, as almost 80% of patients who agreed to participate (in a pilot run over a period between 2008 and 2009) provided feedback. Overall the responses from patients has been very positive and so far 100% of those asked said they would certainly recommend the help offered in the Adolescent Department to a friend if they needed it; and that overall the help they received was good. 91% felt that they were 'listened to'; and that they were 'treated well'. The weaker points were: not offered 'convenient appointment time', the 'convenience of the location', and 'convenient facilities'.

3.1.4 It is planned to use the CHI-ESQ more widely within the Trust and continue to explore innovative ways of gaining meaningful patient feedback about the quality of care.


3.2 Decrease number of negative comments received about environment

3.2.1 As one of the priorities for Quality Improvement in 2009/10, work was undertaken to refurbish and improve the reception and waiting areas on the ground floor, toilet facilities and the access to refreshments. Overall, the feedback was positive, with 60% of the patients responding positively to the changes made to the reception and waiting area, whilst 25% of the respondents were dissatisfied with the redesign of this area. As indicated above under priority 3, improvements to the built environment, measures have been taken to address the negative feedback received concerning the refurbishment work.

3.2.2 The survey will be repeated in six months to monitor patients' views about the refurbishment and to ensure that any further need for change is identified

3.3 Monitor DNA rates

3.3.1 The "did not attend" rate (DNA) for 2009/10 was 8.8% for first attendances, which is a decrease compared to the 2008/09 figure of 9.5%, while the DNA rate remained at the 10.4% for subsequent appointments. Compared with other mental health trusts, with a historical DNA rate of 14%, this could generally be regarded as a positive indicator for patient satisfaction with their care. However, one of the future tasks will be to obtain an updated figure for other mental health trusts.

Diagram 3: Outpatient DNA Analysis

Outpatient DNA Analysis - 2003 onwards
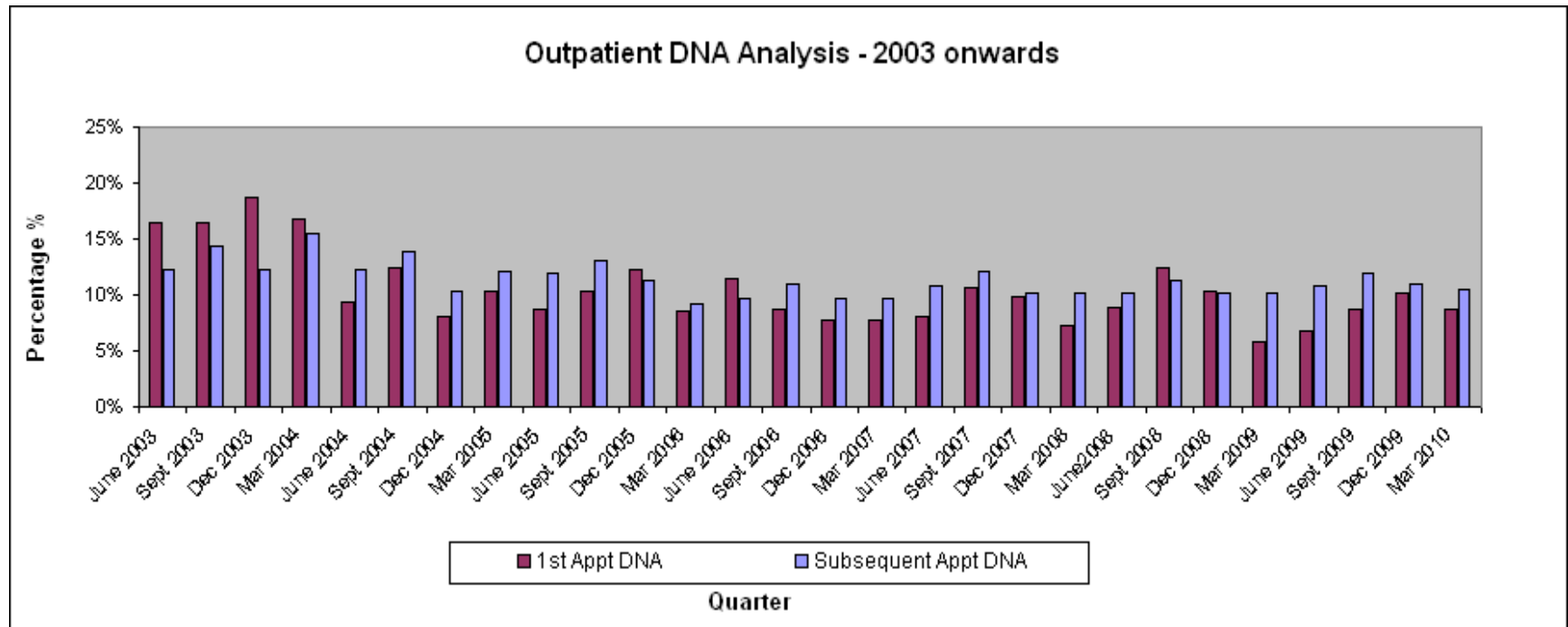
3.4   Monitor rate of complaints received

3.4.1   The Trust received a total of ten complaints in 2009/10, which is consistent with the figure for 2007/08, but slightly higher than the number of complaints recorded for 2008/09, which was eight. In accordance with the complaints procedure, all complaints were investigated by the Chief Executive, in conjunction with the relevant Service Director. In response to one of the complaints, the Trust has changed its practice concerning the amount of patient information shared with other professionals. In addition, staff training has been provided where required.

3.5   Pilot using text messaging to communicate with patients over 16

3.5.1   Recent feedback from young people indicated that they would prefer to receive communication concerning appointments either by text or email, rather than by letter. This information was obtained from young people (aged 16-18) who participated in two focus groups held at a local comprehensive school in Camden in 2009. A pilot project is planned for 2010/11 on the use of text messaging with some of the young people attending the Adolescent Department who agree to be contacted by text. The results from this pilot project will be reviewed to consider whether the use of text messages might be implemented with other patient groups in the Trust. If it is to be implemented, then guidelines will be developed which will apply across the Trust.

4   Performance against key national priorities and National Core Standards

4.1   The Mental health indicators and performance thresholds set out in Appendix B in the Compliance Framework are not applicable to The Tavistock and Portman Foundation NHS Trust, as the Trust does not provide services to which the indicators would apply.

4.1.1   The Mental health indicators and performance thresholds set out in Appendix B in Monitor's *Compliance Framework*[2] are not applicable to the Tavistock and Portman Foundation NHS Trust, as the Trust does not provide services to which the indicators would apply.

4.1.2   The Tavistock and Portman Foundation NHS Trust declared full compliance with all 26 core standards to the   Healthcare

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[2] Monitor, *Compliance Framework 2010-11*, March 2010

Commission / Care Quality Commission, in its declaration in October 2009, and has provided assurance to its Board of Directors in April 2010 that full compliance was maintained throughout 2009/10.