

# Board of Directors

## **Agenda and papers** of a meeting to be held

2.30pm – 4.30pm  
Tuesday 29<sup>th</sup> March 2011

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

# **Board of Directors**

2.30pm – 3.30pm, Tuesday 29<sup>th</sup> March 2011

## **Agenda**

### ***Preliminaries***

**1. Chair's opening remarks**

*Ms Angela Greatley, Trust Chair*

**2. Apologies for absence**

**3. Minutes of the previous meeting**

*(Minutes attached)*

*For approval* p.1

**4. Matters arising**

*(Report attached)* p.6

### ***Reports & Finance***

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

*For noting*

**6. Chief Executive's Report**

*Dr Matthew Patrick, Chief Executive*

*(Report attached)*

*For discussion* p.7

**7. Finance & Performance Report**

**a. Finance & Performance Report**

*Mr Simon Young, Director of Finance*

*(Report attached)*

*For noting* p.13

**b. Budget 2011/12**

*Mr Simon Young, Director of Finance*

*(Report to follow)*

*For noting*

**c. Capital Budget 2011/12 & Plan**

*Ms Pat Key, Director of Corporate Governance & Facilities*

*Mr Simon Young, Director of Finance*

*(Report attached)*

*For noting* p.21

### ***Corporate Governance***

**8. Health & Social Care Bill Update: Governance in NHS Foundation Trusts**

*Ms Louise Carney, Trust Secretary*

*(Report attached)*

*For noting* p.29

**9. Clinical Quality, Safety, & Governance Committee Report**

*Dr Rob Senior, Medical Director*

*(Report attached)*

*For discussion* p.35

- |  |                   |      |
|--|-------------------|------|
| <b>10. Annual Schedule of Board of Directors</b> | (Report attached) |      |
| <i>Ms Louise Carney, Trust Secretary</i>         | For approval      | p.69 |

## 11. Trust Policies

- |   |                   |      |
|---|-------------------|------|
| <b>a. Data Quality Policy</b>   | (Report attached) | p.76 |
| <i>Ms Justine McCarthy-Woods, Quality Standards &amp; Report Lead</i> | For noting        |      |

## Quality & Development

- |   |                   |      |
|---|-------------------|------|
| <b>12. Quality Report</b>   | (Report attached) |      |
| <i>Ms Justine McCarthy-Woods, Quality Standards &amp; Report Lead</i> | For discussion    | p.87 |

- |  |                |
|--|----------------|
| <b>13. Annual General Meeting Planning</b> | For discussion |
| <i>Dr Matthew Patrick, Chief Executive</i> |                |

- |   |                |
|---|----------------|
| <b>14. Academic Health Science Centres and Health Innovation and Education Clusters Updates</b> | For discussion |
| <i>Dr Matthew Patrick, Chief Executive</i>  |                |

## Conclusion

- 15. Any other business**

## 16. Notice of future meetings

Thursday 28<sup>th</sup> April : Board of Directors  
 Thursday 5<sup>th</sup> May : Board of Governors  
 Tuesday 24<sup>th</sup> May : Board of Directors  
 Thursday 2<sup>nd</sup> June : Ex. Board of Directors (*Time TBC*)  
 Tuesday 14<sup>th</sup> June : Directors' Conference (*Board Review*)  
 Tuesday 28<sup>th</sup> June : Board of Directors  
 Tuesday 26<sup>th</sup> July : Board of Directors  
 Monday 12<sup>th</sup> June : Directors' Conference (*Topic TBC*)  
 Thursday 15<sup>th</sup> September : Board of Governors  
 Tuesday 27<sup>th</sup> September : Board of Directors  
 Tuesday 25<sup>th</sup> October : Board of Directors  
 Tuesday 8<sup>th</sup> November : Directors' Conference (*Plan Review*)  
 Tuesday 29<sup>th</sup> November : Board of Directors  
 Thursday 1<sup>st</sup> 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 – 3.30pm, Tuesday 22<sup>nd</sup> February 2011

Present:			
Ms Angela Greatley Trust Chair	Mr Martin Bostock Snr Independent Director	Ms Lis Jones Nurse Director	Mr Altaf Kara Non-Executive Director
Ms Trudy Klauber Dean	Ms Louise Lyon Trust Clinical Director	Ms Joyce Moseley Non-Executive Director	Dr Matthew Patrick Chief Executive
Dr Ian McPherson Non-Executive Director	Dr Rob Senior Medical Director	Mr Richard Strang Deputy Trust Chair	Mr Simon Young Director of Finance
In Attendance:			
Miss Louise Carney Trust Secretary (minutes)	Dr Rita Harris CAMHS Director (items 5, 7, & 8)	Mr Graham Music CAMHS Service Line Director (item 7)	Ms Susan Thomas Director of Human Resources (item 8)

### Actions

AP	Item	Action to be taken	Resp	By
1	3	Miss Carney to amend minutes.	LC	Immed
2	5	Ms Greatley to forward FTN presentations	AG	Immed
3	5	Ms Greatley to forward any briefings on changing role of NEDs and Governors	AG	As approp
4	5	Ms Klauber to prepare briefing on workforce development, education and training consultation	TK	Mar 11
5	8	Ms Greatley and Miss Carney to deliver lunch time briefing on NED links to Trust work	AG LC	Mar 11
6	8	Non-Executive Directors to consider whether CAMHS Directorate should have two NED links	NEDs	Mar 11
7	9	White Paper Update to come off agenda as standing item	LC	Immed

### Actions Agenda item

### Future Agendas

#### 1. Trust Chair's Opening Remarks

Ms Greatley welcomed everyone to the meeting, and thanked Mr Strang for chairing the January Board of Directors' meeting.

#### 2. Apologies for Absence

None.

#### 3. Minutes of the Previous Meeting

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

#### 4. Matters Arising

Mr Bostock noted that he had received no comments on the Trust Chair's Objectives. The Board agreed the draft objectives they had seen were now finalised.

Ms Greatley noted that the meeting with the Non-Executive Director Appraisal Committee to discuss the timetable of objectives was set for March.

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

### ***Angela Greatley, Trust Chair***

Ms Greatley had participated in an Expert Group on the subject of Young People, Maturity, and Criminal Justice, convened by the Barrow Cadbury Trust for "T2A" – Transition to Adulthood. T2A is a group of voluntary and research organisations with interests in criminal justice and young people's issues. The meeting, held at the House of Lords and convened by Lord Keith Bradley, featured many leading academics. Ms Greatley brought to the meeting the Trust's perspective on multi-agency and interdisciplinary practice and professional educational issues with working with young people and criminality. The meeting provided a good opportunity for the Trust's work to be recognised in this field.

AP2 Ms Greatley had also attended a Foundation Trust Network meeting, where discussions included the Health and Social Care Bill, tariffs and Payment by Results, the role of Monitor, and the role of the Foundation Trust Network. There was also a discussion about the changing roles of Non-Executive Directors and Governors, who will have an explicit duty to hold the Board of Directors to account. Ms Greatley to forward presentations. Ms Moseley queried whether a briefing on this would be circulated. Ms Greatley noted that she expected a briefing from Monitor in the next two to three months. Ms Greatley to forward any briefings.

AP3

Ms Greatley also noted a discussion on the proposed future arrangement for workforce development, education and training, which will have critical implications for the Trust. A Government consultation has been issued with a closing date of 31<sup>st</sup> March. The key components of the proposals are: there should be a localised approach to workforce; local "skills" networks will take on Strategic Health Authority workforce functions; the quality of education and training will be under the stewardship of professions in collaboration with education and training providers; health care providers are to lead the new system deciding locally how they will work together; a new expert executive organisation – Health Education England – will bring professional, provider, staff, and patient interests together to provide national leadership. This new system is to be operational from April 2012. Ms Greatley noted her concern about the speed of change. Ms Klauber noted that it was not yet clear who would be represented in the local employer skills networks. It was also not clear how "soft" professions – psychotherapists, dieticians etc. – would be represented. Ms Klauber to brief the Board of Directors on the consultation.

AP4

### ***Mr Richard Strang, Non-Executive Director***

Mr Strang had attended a Mental Health Network (MHN) meeting with

Keith Pearson, Chair of the NHS Confederation. Mr Pearson had confirmed that the Foundation Trust Network (FTN) would separate from the NHS Confederation, but remain an external partner. Steve Shrubbs, the Director of the MHN was working closely with Sue Slipman, the Director of the FTN in determining the roles of the two organisations. Ms Strang noted that the MHN was developing alliances with the Royal College of General Practitioners and the Royal College of Psychiatrists around commissioning guidance and advice. Kathryn Tyson, Director of International Health and Public Health Delivery at the Department of Health had made reference to the link between public health, adult social care, and the NHS. Prof. Louis Appleby, National Clinical Director for Health and Criminal Justice at the Department of Health, had noted that the NHS Commissioning Board would be working with prison mental health services and focusing on diversion.

Mr Strang noted that Steve Shrubbs has made reference to a fear of discrimination of mental health providers in the current contracting round, and would be sending a survey to all mental health organisations. Ms Greatley noted that the FTN were also circulating a survey on differentials in areas of the provider community. It was noted that it was important to respond to these as soon as possible, as the Health and Social Care Bill was currently at the Committee stage. Dr Patrick noted that the FTN's London CEO Group had commissioned some research into differentials between mental health and the acute sector.

Mr Strang also noted that he had attended a meeting on the Gloucester House strategy, which was taking forward the issue of accommodation with external consultants.

## **6. Chief Executive's Report**

Dr Patrick noted there were large changes taking place in the health sector, and the public sector in general. These were detailed in his report.

Mr Strang noted some concern expressed by Steve Shrubbs regarding the Mental Health Strategy and its implementation. Dr Patrick noted that there was a plan to establish an implementation board and to develop more explicit objectives. The Board discussed its input into the Strategy, which it was noted was not always easy. Dr Patrick noted the importance of all Board members representing and promoting the Trust at any given opportunity.

## **7. Finance & Performance Report**

Mr Young noted that overall the Trust's position remains satisfactory. Mr Young highlighted the following points:

- Paragraph 1.1.1 – The Q3 ratings had not yet been confirmed
- Paragraph 2.2.1 – The Trust had received £1.8m from the Strategic Health Authority in January, and so the Trust's cash balance was

higher than usual. This will even out by year-end

- Paragraph 3.1 – Mr Young clarified that not all of the £240k referenced was backdated
- Paragraph 3.2 – Mr Young clarified that not all of the £96k was related to one research post

Mr Young noted that in support of the proposed addition of £30k to the IT Capital Budget, a detailed paper on the installation of wireless networks had been circulated by e-mail for information.

Mr Young noted that waiting times for the Gender Identity Development Service (GIDS) was a significant cause for concern, and the Service was currently seeking to rectify this. Dr Patrick noted that there had been an influx of patients, which was contributing to the waiting times.

Mr Young noted that TCS had fallen below budget after a good Quarter Two, and were expecting to be below for the next two months. This was a cause of some concern, although the Service was already in discussions about this. Mr Bostock queried this fall, noting that the Board had been assured at its January meeting that the Service was expected to remain relatively on budget. Ms Lyon explained that one reason offered from the Service was that one particular piece of business had been deferred to the next financial year. It was suggested that the Trust review the Service's performance and business structure. Mr Strang highlighted that the Service's margins are relatively healthy, and that this should be borne in mind. Dr McPherson queried whether the Service had been affected by the economic downturn. Mr Kara noted that many private consultancies were growing during this period.

The revision of the Capital Budget was approved.

## **8. Non-Executive Director Links to Trust Work**

**AP5** Ms Greatley was working with Miss Carney to deliver a lunch time briefing for Directors on the meaning of NED links.

Directors agreed the following moves:

- Mr Bostock – Complaints
- Ms Moseley – Adolescent Directorate
- Dr McPherson – Portman Directorate (joint with Ms Moseley)
- Mr Strang – Human Resources
- Ms Moseley – CAMHS

- Ms Greatley – Older People

Dr Senior thanked Mr Strang for all his work with the CAMHS Directorate. Ms Lyon suggested CAMHS may want more than one NED link, due to its size. Non-Executive Directors to consider.

**AP6**

### **9. White Paper Update**

**AP7** Nothing to report. This item to come off the agenda as a standing item.

### **10. Academic Health Science Centre and Health Innovation and Education Cluster Updates**

Dr Patrick noted that the Trust was actively involved with UCL Partners, and a number of projects were being developed.

### **11. Any Other Business**

Ms Greatley noted that the Directors Conference on Monday 7<sup>th</sup> March would be used to discuss progress in developing the 2011/12 budget.

### **12. Notice of Future Meetings**

Noted.



## Outstanding Action Part 1

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date
1	Jan-11	7a. Finance & Performance Report	Mr Young to investigate variance in contract base value and report back	Simon Young	Feb-11
2	Feb-10	11. Annual Training Services Report	Miss Carney to schedule discussion on Trust branding in relation to training	Louise Carney	Mar-11
3	Oct-10	11b. Chief Executive's Objectives	Ms Greatley to discuss timetable for objectives with appraisal committees of Board of Governors	Angela Greatley	Mar-11
4	Nov-10	4. Matters Arising	Mr Young to review process for approving contracts and report to Audit Committee	Simon Young	
5	Jan-11	4. Matters Arising	Dr Senior and Ms Lyon to give further consideration to cavassing GP's knowledge of mental health	Rob Senior / Louise Lyon	
6	Jan-11	7a. Finance & Performance Report	Ms Lyon to report back on structure of consultancy work	Louise Lyon	
7	Jan-11	10. Estates & Facilities Report	Ms Key to investigate whether the Public Service Bill affects the public sector	Pat Key	

## Board of Directors : March 2011

**Item :** 6

**Title :** Chief Executive Report

**Summary :**

The report covers the following items:

1. Introduction
2. The Hutton Enquiry
3. Political News and Developments
4. Staff Survey
5. And Finally...

**For :** Discussion

**From :** Chief Executive

## Chief Executive Report

### 1. Introduction

- 1.1 The past month has seen a lot of focus on the preparation of the budget for next year, and the work that underpins this. The contracting round has been drawn out because of deferred PCT and SHA (in relation to training) deadlines, which in turn has meant that certainty around income has also been delayed. In addition the level of detailed preparation is considerable, in part because of the complex nature of many jobs and roles within the organisation which can make tracking the impact of proposed changes difficult.
- 1.2 The contracting round has been difficult across the sector, and I believe across London in general. The co-incidence of major structural change with financial and temporal pressure have been the primary determinants, with many PCTs having to adjust their contracting positions in relation to the unfolding of their own positions within year and forecasts for next.
- 1.3 Inside the organisation, the Finance Directorate have been working closely with Clinical Directors, Associate Clinical Directors, Deans and Central Directors in the preparation of final productivity plans. In some areas this work has been more difficult, in part because, where contracting outcomes has resulted in income losses, these have not been evenly distributed across services within the Trust. I would, however, like to take this opportunity to thank everyone who has contributed.
- 1.4 Alongside this work I and executive colleagues have been working closely with staffside. One outcome of this has been that we have followed other NHS organisations in offering a voluntary redundancy and early retirement scheme. Such a scheme was offered to staff a number of years ago, but few took it up. We are, however, now in very different and more difficult times. The scheme will only be open for a limited period of time, and applications will be judged against a set of agreed criteria to ensure that any awards that are made are in the best interests of the organisation as well as the individual concerned.
- 1.5 The budget proposed to the Board this month still has, within it, areas of continued investment. These include specific areas of service development such as e- and blended learning and the Big White Wall online wellbeing service; alongside investment in key areas of infrastructure including marketing, communications, patient experience and clinical outcomes. It remains of real importance that we retain the capacity for development, linked with clarity about

areas of future opportunity and areas where we need to make improvements in support of the quality of our services.

- 1.6 The development of e- and blended learning will be supported through the creation of a dedicated unit and new strategic university partnerships. Marketing across the organisation will be brought together to create an integrated business development and marketing unit within the Service Development Directorate. This unit will work closely with the communications team that, which is also being strengthened. Ensuring that we communicate effectively and widely about the nature of our work and the range of our training and clinical services is of real importance in a highly competitive marketplace; not least, the message that specialist organisations are able to deliver high quality and flexibility of design and delivery at a competitive price – in effect a level of affordable excellence which should be available to all.
- 1.7 These developments will be supported by a programme of service redesigns, with the aim of ensuring that as a Trust we are best organised to take advantage of the opportunities that will be presented, not least through the implementation of the Health and Social Care bill, the Bradley review and the mental health strategy.

## **2. The Hutton Enquiry**

- 2.1 During the course of the month former Labour cabinet minister, Lord Hutton, reported on his recommendations for public sector pension reform. These recommendations include a move towards career average pensions (as opposed to final salary pensions).
- 2.2 Importantly, however, accrued benefits would be protected (that is those pension benefits that an individual has accrued across their working life up until the date of any change).
- 2.3 In addition the report recommends an increase in the retirement age for most public sector staff.
- 2.4 Unions have been angered by the proposals, indicating that they may pursue a course of strike action to protect benefits. Staff across the public sector are anxious about the potential impact on their own plans and future.
- 2.5 The timetable for reform suggests that a new career average scheme could be implemented by 2015, again for the majority of public sector staff.

### **3. Political News and Developments**

- 3.1 David Nicholson has clarified that the Health Bill will not introduce price competition. A significant amount of concern had been expressed that if tariffs were set to indicate a maximum price only, then this would usher in 'a race for the bottom' in terms of competition on price, with inevitable impacts on quality.
- 3.2 Sue Slipman, Director of the Foundation Trust Network (FTN), has written to David Flory, the NHS Deputy Chief Executive, expressing concern on behalf of providers about the degree of financial pressure within the system. In her letter she warns that a number of organisations could fail given the challenges they face. An FTN survey indicated that the average savings across trusts for 2011-12 was 6.3%, with some having to make savings of up to 15%. The publicly quoted figure for efficiency savings necessary in relation to the NHS financial allocation is only 4%. In her letter Sue Slipman particularly identified mental health trusts as been subject to pressure, given that their services are largely commissioned on the basis of block contracts (as opposed to payment by results) and thus can come to be treated as the 'balancing figure' in PCT budgets.
- 3.3 Within London, PCTs have approved a plan to close Commissioning Support for London (CSL), which was launched as a unit within the London SHA some two years ago. The move is reported as part of the drive to cut management costs within the SHA.
- 3.4 Camden is amongst the latest boroughs to have a primary care consortium. Increasingly it appears that many consortia boundaries will coincide with the boundaries covered by the PCTs they are replacing, retaining co-location with local authorities. To date 177 pathfinder consortia have been announced by the Department of Health.

### **4. Staff Survey**

- 4.1 Each year NHS staff complete a national staff survey. Last year this Trust was rated highest of all NHS organisations on a compound indicator of staff engagement. This is, perhaps, not surprising given that staff come to the Trust because they feel passionately about mental health and about the values and contribution that underpin the organisation's work. In addition we are a small organisation (in NHS terms) which means that communicating with one another can be (though not always is!) somewhat more straightforward.
- 4.2 The Care Quality Commission has recently released the findings of the 2010 staff survey and once again the Trust been rated very

highly by the people who work here. This includes again a very high score in comparison with other Trusts in terms of overall staff engagement (detailed national comparators are not yet available).

- 4.3 Other areas where the Trust did well in comparison with the national average include:
  - 4.3.1 The number of staff reporting good communication between senior management and staff.
  - 4.3.2 The number of staff using flexible working options.
  - 4.3.3 The number of staff reporting good health and wellbeing at work.
- 4.4 The Trust also showed improvements in a number of areas in comparison to the previous survey, including:
  - 4.4.1 A reduction in the numbers of staff experiencing work-related stress.
  - 4.4.2 An increase in the number of staff indicating that the Trust is committed to their work life balance.
  - 4.4.3 And a further increase in the number of staff stating that they feel motivated in relation to their work.
- 4.5 Areas where we score less well, and where we clearly have more work to do include:
  - 4.5.1 The numbers of staff indicating that they are working extra hours.
  - 4.5.2 The numbers of staff undertaking mandatory training such as Health and Safety and Equal opportunities training.
  - 4.5.3 And a reduction, this year, in the number of staff indicating that the Trust provides equal opportunities in career progression.
- 4.6 We will be discussing the full findings in various committees and groups across the Trust, and with staff representatives. This will take place over the next few months with a view to implementing action plans to address the areas of difficulty identified. A fuller report on the survey will also be presented to the Board at a later date. I would like to take the opportunity to thank all staff that participated in the survey for taking the time to complete their questionnaires.

## 5. And Finally...

- 5.1 On Friday the 11<sup>th</sup> March the Adult Directorate hosted a very successful conference on Medically Unexplained Symptoms (MUS). This area of work is of increasing public importance; not least because it is recognised as an area in which effective mental health service development could yield significant savings, both in primary and in secondary care. The conference provided a useful platform for discussion of the Trust's service in City and Hackney which is focused on the management of MUS and other complex cases in primary care settings. There is a strong argument that increased investment in mental health services at this time, in support of the implementation of the mental health strategy, could actually reduce long term psychological and physical morbidity and reduce costs across the NHS.
- 5.2 I would also like to take the opportunity to thank Philip Stokoe, Clinical Director of the Adult Directorate, who is standing down at the end of March. Philip has made a very significant contribution to the development of the Directorate and organisation more widely, not least in his leadership around the work described above. Philip will be continuing to work in the Directorate in a part time capacity.

Dr Matthew Patrick  
Chief Executive Officer  
18 March 2011

## Board of Directors : March 2011

**Item :** 7a

**Title :** Finance and Performance Report

### **Summary:**

After eleven months, a surplus of £346k is reported. There continue to be cumulative income shortfalls on Consultancy and Clinical income which have been offset by Training income and by under spends across the organisation. In Month 11, the surplus increased by £89k.

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

The cash balance at 28 February was £4,599k, well above Plan due to income being received in advance for March. Cash is expected to remain ahead of Plan for the rest of the year and for 2011/12, subject to achievement of planned income and expenditure.

**For :** Discussion

**From :** Director of Finance



## 1. External Assessments

### 1.1 Monitor

- 1.1.1 Monitor has confirmed our Financial Risk Rating of 3 and Green Governance Rating for the third quarter, as planned. Both ratings are also expected to remain unchanged for the final quarter.

## 2. Finance

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

- 2.1.1 After eleven months, income is £699k below budget, and expenditure £577k below budget. The Trust's surplus year-to-date is £346k, and we are still well in line to achieve the full year budget of £150k. Potential provisions at year-end are being reviewed.
- 2.1.2 After 11 months, £103k of the overall adverse income variance is offset by directly related under spends. There are some smaller phasing differences both positive and negative in other areas.
- 2.1.3 Apart from these differences, the income shortfall includes £396k for Consultancy, with TCS under target by £120k and departmental consultancy under by £276k. There is also a shortfall in Clinical but Training is in surplus (see sections 3 and 4 below).
- 2.1.4 Research income is below budget by £131k and the income target for 2011/12 has been reduced to reflect this.
- 2.1.5 There is an under spend of £576k, of which some £159k is directly related to lower activity and income (2.1.2 above). The majority of the remainder can be attributed to vacancies in the Child & Family Directorate (£97k), the Portman Clinic (£140k), and the Adolescent Directorate (£60k). These under spends have been offset by an over spend in TCS of £87k (as reported previously) due to delayed 2009/10 payments for associate consultants and termination costs.
- 2.1.6 The forecast outturns for income and expenditure, shown in the right-hand columns of Appendix B and summarised in Appendix A, show that we expect to achieve our budget and that there remains a contingency reserve to cover unexpected changes.

### 2.2 Cash Flow (Appendix C)

- 2.2.1 The actual cash balance at 28 February 2011 was £4,599k, compared to the Plan of £2,126k. The balance is £2,473k above Plan, a reduction of £352k in month due to the release of the NMET and MADEL funding for February which had been paid in advance in January. This was offset by receipts from General Debtors being above Plan in month due higher than usual receipts from our university partners. Salaries remained below Plan, as reported above.

	Cash Flow year-to-date		
	Actual £000	Plan £000	Variance £000
Opening cash balance	3,645	3,645	0
Operational income received			
NHS (excl SHA)	9,957	10,608	(651)
General debtors (incl LAs)	7,210	6,293	917
SHA for Training	11,212	9,917	1,295
Students and sponsors	2,273	2,500	(227)
Other	443	198	245
	31,095	29,516	1,579
Operational expenditure payments			
Salaries (net)	(13,384)	(13,715)	331
Tax, NI and Pension	(9,883)	(10,069)	186
Suppliers	(6,465)	(6,313)	(152)
	(29,731)	(30,097)	366
Capital Expenditure	(228)	(630)	402
Interest Income	10	18	(8)
Payments from provisions	0	(103)	103
PDC Dividend Payments	(192)	(223)	31
Closing cash balance	4,599	2,126	2,473

- 2.2.2 The details by month are given in Appendix C, which also shows the forecast for the remainder of this year which has been modified due to the prepayment of the NMET and MADEL funding. The forecast balance at 31 March is now increased to £3.0m.
- 2.2.3 Capital expenditure in the current year is now estimated at £382k, reduced from the forecast of £467k reported last month due to the boiler work now being scheduled for early in the new financial year.
- 2.2.4 The cash projections for 2011/12 were updated for the November report. With the higher opening balance now expected, cash balances are still projected to remain satisfactory throughout the year, subject to achieving the productivity improvements needed to deliver a small surplus in 2011/12.
- 2.2.5 The Trust's liquidity, using Monitor's formula and including the £2m financing facility, remains satisfactory.

### 3. **Training**

- 3.1 Training income is £228k above budget in total after eleven months, mainly due to university income over-performing by £247k.
- 3.2 CPD income is also overachieving cumulatively. These gains have been offset by a shortfall of £66k on Conferences.

### 4. **Patient Services**

#### 4.1 **Activity and Income**

- 4.1.1 As reported previously, total contract income for the year is below

budget. This includes a shortfall on the CQUIN elements; one contract being £33k below budget; and deferral of £60k income to next year. These variances have been offset by a small favourable variance on cost and volume activity.

- 4.1.2 The CQUIN element of the contracted income is currently forecast to underachieve by £30k by the end of the year, though there may be some revision to this.
- 4.1.3 There are significant variances, both positive and negative, in the other elements of clinical income, as shown in the table below.
- 4.1.4 GIDS are forecast to deliver an additional £50k cost & volume increase.
- 4.1.5 After eleven months, named patient agreements (NPAs) actual income is £22k below budget, which is spread across the service lines.
- 4.1.6 Court report income was £5k below budget after eleven months. The majority of the under-performance was from the Portman, which has been offset by C&F over-performance.
- 4.1.7 Monroe income is £118k below budget after eleven months. The income was just below budget in February.
- 4.1.8 The Day Unit is currently over performing by £64k cumulatively due to high pupil numbers earlier in the year.
- 4.1.9 Project income is forecast to be £200k below budget for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	8,729	8,693	-0.4%	-36	-53	CQUIN also expected to be £30k down.
Cost and vol variances	3	58		55	61	£50k GIDU
NPAs	235	213	-9.3%	-24	-30	
Projects and other	2,325	2,118		-	-200	Income matched to costs, so variance is largely offset.
Day Unit	929	993	6.9%	70	60	
Monroe	712	605	-15.1%	-118	-120	£34k relates to prior year adjustment
FDAC	304	342	12.3%	41	39	
Court report	234	229	-1.9%	-5	-5	
Total	13,471	13,251		-17	-248	

5. **Consultancy**

- 5.1 TCS income was £51k in February, below budget by £26k. The cumulative income of £533k is £120k behind budget. Our forecast for the year is a shortfall on income of £153k which takes into account the work booked so far for March.
- 5.2 Departmental consultancy is £276k below budget after eleven months. This is offset by higher income in other areas in the same departments; and/or by savings. As discussed previously, the 2011/12 budget aims to avoid a recurrence of these variances.

Simon Young  
Director of Finance  
18 March 2011

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST

INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2010-11

APPENDIX A

		Feb-11			CUMULATIVE			FULL YEAR 2010-11		
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST OUTTURN £000	BUDGET VARIANCE £000
INCOME										
1	CLINICAL	1,198	1,308	110	13,471	13,251	(220)	14,669	14,421	(248)
2	TRAINING	1,276	1,265	(11)	14,789	15,018	228	16,065	16,294	228
3	CONSULTANCY	149	94	(56)	1,465	1,070	(396)	1,615	1,157	(458)
4	RESEARCH	28	10	(18)	303	173	(131)	331	182	(149)
5	OTHER	53	50	(3)	560	378	(182)	613	431	(182)
TOTAL INCOME		2,704	2,726	22	30,588	29,889	(699)	33,293	32,484	(808)
OPERATING EXPENDITURE (EXCL. DEPRECIATION)										
6	CLINICAL DIRECTORATES	1,492	1,514	(22)	16,629	16,366	263	18,122	17,895	226
7	OTHER TRAINING COSTS	483	510	(27)	6,092	5,768	325	6,575	6,250	325
8	OTHER CONSULTANCY COSTS	53	54	(1)	578	670	(92)	630	722	(92)
9	CENTRAL FUNCTIONS	538	479	59	5,956	5,875	81	6,494	6,403	91
10	TOTAL RESERVES	0	0	0	0	0	0	386	123	263
TOTAL EXPENDITURE		2,566	2,556	9	29,256	28,679	577	32,207	31,394	813
EBITDA		139	170	31	1,333	1,211	(122)	1,085	1,091	5
ADD:-										
12	BANK INTEREST RECEIVED	2	1	1	18	12	6	20	14	(6)
LESS:-										
11	DEPRECIATION	42	44	(2)	467	468	(1)	509	509	0
13	FINANCE COSTS	0	0	0	0	0	0	0	0	0
14	DIVIDEND	37	37	(0)	409	409	(0)	446	446	0
RETAINED SURPLUS		61	89	30	476	346	(129)	150	150	(1)
EBITDA AS % OF INCOME		5.1%	6.2%		4.4%	4.1%		3.3%	3.4%	

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

**APPENDIX B**

	Feb-11			CUMULATIVE			FULL YEAR 2010-11		
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST £000'S	REVISED BUDGET VARIANCE £000
<b>INCOME</b>									
NHS LONDON TRAINING CONTRACT	623	623	0	6,856	6,857	1	7,479	7,480	1
TRAINING FEES & OTHER ACA INC	405	434	29	5,211	5,458	247	5,616	5,863	247
POSTGRADUATE MED & DENT'L EDUC	6	(0)	(6)	64	21	(43)	70	27	(43)
JUNIOR MEDICAL STAFF	86	62	(25)	951	999	49	1,037	1,086	49
CHILD PSYCHOTHERAPY TRAINEES	155	146	(9)	1,708	1,683	(25)	1,863	1,838	(25)
R&D	28	10	(18)	303	173	(131)	331	182	(149)
CLINICAL INCOME	997	1,110	114	11,291	11,082	(209)	12,288	12,067	(196)
DAY UNIT	84	70	(14)	929	993	64	1,014	1,074	60
MONROE	68	66	(2)	712	605	(107)	780	660	(120)
FDAC	28	33	6	304	342	38	332	370	38
TCS INCOME	77	51	(26)	653	533	(120)	730	577	(153)
DEPT CONSULTANCY INCOME	73	43	(29)	812	536	(276)	885	579	(305)
COURT REPORT INCOME	21	28	6	234	229	(4)	255	251	(4)
EXCELLENCE AWARDS	10	10	(0)	108	106	(2)	118	116	(2)
OTHER INCOME	43	40	(3)	452	272	(180)	495	315	(180)
<b>TOTAL INCOME</b>	<b>2,704</b>	<b>2,726</b>	<b>22</b>	<b>30,588</b>	<b>29,889</b>	<b>(699)</b>	<b>33,293</b>	<b>32,484</b>	<b>(783)</b>
<b>EXPENDITURE</b>									
EDUCATION & TRAINING	301	337	(36)	4,094	3,974	120	4,395	4,275	120
PORTMAN CLINIC	135	115	20	1,485	1,321	164	1,620	1,450	170
ADULT DEPT	258	244	13	2,854	2,795	59	3,112	3,062	50
MEDNET	18	34	(15)	202	216	(13)	221	234	(13)
ADOLESCENT DEPT	129	129	(0)	1,432	1,403	29	1,561	1,531	29
C & F CENTRAL	736	746	(10)	8,288	8,154	134	9,024	8,900	125
MONROE & FDAC	82	93	(11)	897	929	(32)	979	1,022	(43)
DAY UNIT	64	59	5	704	723	(19)	768	787	(19)
SPECIALIST SERVICES	62	75	(13)	670	752	(82)	732	827	(94)
COURT REPORT EXPENDITURE	9	20	(11)	96	74	22	105	83	22
TRUST BOARD & GOVERNORS	10	10	(1)	105	95	10	115	105	10
CHIEF EXECUTIVE OFFICE	26	24	1	283	293	(10)	308	318	(10)
PERFORMANCE & INFORMATICS	79	63	17	851	811	40	930	880	50
FINANCE & ICT	91	77	14	1,002	1,057	(55)	1,093	1,143	(50)
CENTRAL SERVICES DEPT	181	177	4	2,016	2,159	(144)	2,197	2,367	(170)
HUMAN RESOURCES	56	47	9	653	591	62	709	638	71
CLINICAL GOVERNANCE	31	45	(14)	343	331	12	374	362	12
TRUST DIRECTOR	28	30	(2)	320	293	27	348	321	27
PPI	15	12	3	151	141	10	166	156	10
SWP & R+D & PERU	31	7	24	344	227	117	375	247	128
R+D PROJECTS	0	0	0	0	(0)	0	0	(0)	0
PGMDE	9	11	(2)	100	69	31	109	78	31
NHS LONDON FUNDED CP TRAINEES	155	151	4	1,708	1,565	143	1,863	1,720	143
TAVISTOCK SESSIONAL CP TRAINEES	9	7	2	101	79	23	111	88	23
FLEXIBLE TRAINEE DOCTORS	8	4	4	89	81	8	97	89	8
TCS	49	49	(0)	539	625	(87)	587	674	(87)
DEPARTMENTAL CONSULTANCY	4	4	(1)	39	44	(5)	43	48	(5)
DEPRECIATION	42	44	(2)	467	468	(1)	509	509	0
PROJECTS CONTRIBUTION	(10)	(13)	3	(111)	(124)	13	(121)	(134)	13
IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	0	0	0	0	0
CENTRAL RESERVES	0	0	0	0	0	0	386	123	263
<b>TOTAL EXPENDITURE</b>	<b>2,608</b>	<b>2,600</b>	<b>8</b>	<b>29,722</b>	<b>29,146</b>	<b>576</b>	<b>32,716</b>	<b>31,903</b>	<b>813</b>
<b>OPERATING SURPLUS/(DEFICIT)</b>	<b>96</b>	<b>126</b>	<b>29</b>	<b>866</b>	<b>743</b>	<b>(123)</b>	<b>576</b>	<b>582</b>	<b>(491)</b>
INTEREST RECEIVABLE	2	1	(1)	18	12	(6)	20	14	(6)
UNWINDING OF DISCOUNT ON PROVISION	0	0	0	0	0	0	0	0	0
DIVIDEND ON PDC	(37)	(37)	(0)	(409)	(409)	(0)	(446)	(446)	0
<b>SURPLUS/(DEFICIT)</b>	<b>61</b>	<b>89</b>	<b>28</b>	<b>476</b>	<b>346</b>	<b>(129)</b>	<b>150</b>	<b>150</b>	<b>(497)</b>

## Cash Flow 2010/11

## Appendix C

### 2010/11 Plan

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

### 2010/11 Actual/Forecast

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	3,645	3,787	3,488	3,566	3,504	3,095	2,784	4,653	3,586	2,775	4,951	4,599	3,645
Operational income received													
NHS (excl SHA)	892	1,017	829	785	805	1,109	677	1,184	218	1,352	1,088	917	10,874
General debtors (incl LAs)	709	387	588	610	369	178	1,761	426	654	440	1,087	410	7,620
SHA for Training	874	854	1,015	970	911	959	1,935	87	983	2,625	0	0	11,212
Students and sponsors	277	102	86	126	165	315	538	143	174	269	78	50	2,323
Other	24	35	29	35	53	32	69	59	42	13	51	18	461
	2,776	2,396	2,547	2,526	2,304	2,593	4,979	1,900	2,070	4,699	2,304	1,395	32,490
Operational expenditure payments													
Salaries (net)	(1,206)	(1,192)	(1,198)	(1,184)	(1,198)	(1,173)	(1,232)	(1,264)	(1,263)	(1,223)	(1,252)	(1,247)	(14,631)
Tax, NI and Pension	(859)	(889)	(895)	(905)	(876)	(893)	(896)	(926)	(918)	(919)	(907)	(921)	(10,804)
Suppliers	(570)	(615)	(377)	(502)	(640)	(543)	(965)	(696)	(687)	(377)	(494)	(510)	(6,975)
	(2,635)	(2,695)	(2,470)	(2,591)	(2,713)	(2,608)	(3,092)	(2,885)	(2,868)	(2,519)	(2,653)	(2,678)	(32,409)
Capital Expenditure	0	0	0	0	0	(105)	(19)	(83)	(13)	(4)	(4)	(90)	(318)
Interest Income	1	0	1	3	1	1	1	1	0	1	1	2	12
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	0	0	0	0	0	(192)	0	0	0	0	0	(223)	(415)
Closing cash balance	3,787	3,488	3,566	3,504	3,095	2,784	4,653	3,586	2,775	4,951	4,599	3,005	3,005

## Board of Directors : March 2011

**Item :** 7c

**Title :** Capital Budget 2011/12 & Plan

### **Summary:**

The three-year Estates Capital Plan focuses on:

- Environmental improvements
- Consolidation of space for seminar rooms
- Continuation of toilet improvement programme

The IT programme will also include enhancements to our IT facilities as well as the routine replacement of equipment.

The Board of Directors is asked to approve a total Capital Budget of £659k for 2011/12, in the context of the three-year programme set out here.

**For :** Approval

**From :** Director of Corporate Governance and Facilities  
Director of Finance



## Three-Year Capital Programme Proposal

### 1. Introduction

- 1.1 The Estates Capital Plan proposal builds on work to date to meet the Trust's commitment on energy and also to make the best use of the Trust's sites in order to deliver a high quality service.

### 2. Capital Projects 2011/12

#### 2.1 Day Unit and CAMHS Relocation

- 2.1.1 Work has begun to relocate the Day Unit service and some of our CAMH services. This follows a thorough options appraisal and will be focussed on either a new build on a new site, or a refurbished building either within the public or private sector. A separate business case will be presented to the Board when a suitable site has been located. The relocation will be linked to the sale of 33 Daleham Gardens. However, capital funds will be required initially to ensure that suitable professionals (e.g. architects, planning consultants and quantity surveyors) can be appointed to assist the Trust in taking forward this project

- **Day Unit and CAMHS relocation: £50k**

#### 2.2 Consolidation of seminar rooms on ground floor and relocation of student common room

- 2.2.1 The current common room facility is tired and dated in appearance and lacking in facilities. As a consequence, the current common room is under utilised by the student body. Space is always at a premium and by the conversion of the existing space, and relocation of the common room for the students, will enable the Trust to meet their needs and enable all the seminar rooms to be located on the ground floor. The current 5<sup>th</sup> floor meeting room has been upgraded within the last two years, and requires a minimum amount of project conversion to bring the area up to a level that meets the needs of the students and staff.

- 2.2.2 The existing student common room is the only space on the Fitzjohns wing of the ground floor that is not currently a seminar room. This project will also include the development

of the corridor to the standard of the main ground floor corridor. An additional resource will be the opening up of a one way screen and small viewing area.

- **Consolidation of seminar rooms on ground floor and relocation of student common room: £44k**

## 2.3 Toilets

2.3.1 A programme to upgrade the toilet facilities has been ongoing for the last 3 years. Facilities on the 2<sup>nd</sup> and 4<sup>th</sup> floors will be upgraded during the year

- **2<sup>nd</sup> and 4th floor toilets: £95k**

## 2.4 Replacement of Electrical Boards

2.4.1 The existing electrical infrastructure is in keeping with the original design of the building and the building services are solid and robust, if somewhat dated. Due to the frequent changes in the Electrical Installation Regulations within the last five years, where the reduction in energy consumption is the main driver, there is an opportunity for the Trust to replace the existing consumer boards without the necessity to replace the entire wiring infrastructure. As part of the overall strategy to manage the energy used within the Trust, replacement of the remaining floor consumer boards will enable metering without the need to fit separate meters between floors. The latest IEE Regulations require a meter to be an integral part of all new installations of consumer boards.

- **Replacement consumer boards on the second, third and fourth floors: £45k**

## 2.5 Boiler Replacement

2.5.1 A revised capital plan for the boiler replacement project was agreed in October 2010.

- **Boiler replacement: £175k**

### **3. Capital Projects 2012/13**

#### **3.1 Lecture Theatre**

3.1.1 The Lecture Theatre is the primary location for Trust conferences. The space itself is in a good decorative order and additional cloakroom facilities were added in 2010.

3.1.2 The existing heating and cooling within the Lecture Theatre is a combination of surface cooling and wet heating. Both systems are dated and are limited in the amount of effective localised control available to the end users. It is proposed to upgrade the current facility improving the internal heating to allow better energy control of the space. As part of the project the ceiling will be replaced to allow better acoustic capability plus a reconfiguration and upgrade of the audio and visual aids, including the existing induction loop.

- **Lecture Theatre: £80k**

#### **3.2 Roof Insulation**

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

3.2.2 Typically a similar type of building to the Tavistock Centre, built in the 60's, can generate energy savings of between 15 and 28% following thermal imaging energy performance reports and installation. This would enable the Trust to reduce its carbon footprint.

- **Roof insulation: £94k**

### 3.3 Building Management System

3.3.1 The current building management system is designed to manage the occupancy of the building primarily in the winter period by controlling the heating throughout the Trust. The installation of a new and additional BMS, linked to the various electrical plant of high energy consumption, would enable better energy management. This could also make additional energy savings in the region of 2-5%.

- **Building Management System: £25k**

### 3.4 Goods Lift

3.4.1 Due to the age of the current goods lift, and to ensure compliance, updated replacement is recommended as stipulated in the previous capital plan. The project was deferred.

- **Goods Lift: £112k**

### 3.5 Toilets

3.5.1 Facilities on the 2<sup>nd</sup> and 3<sup>rd</sup> floors will be upgraded.

- **Toilets on 2<sup>nd</sup> and 3<sup>rd</sup> floors: £95k**

## 4. Capital Projects 2013/14

### 4.1 Replacement Windows to the End Staircases

4.1.1 The single glazed windows are typical of 60s buildings and have poor thermal performance. Changing the windows to the two end staircases will have an immediate impact on the temperature throughout the building during the winter months. This project would not cause major disruption to service delivery and would be the first phase of the overall window replacement work.

- **Replacement windows to the end staircases: £80k**

## 4.2 Ground Floor Windows

4.2.1 As with the staircase windows, replacement of the ground floor windows would have an impact throughout the building. The work would have to be completed after the end of the academic year to minimise the inevitable disruption to staff and visitors.

- **Ground floor windows: £250k**

## 4.3 Garden Office Space:

4.3.1 Currently the Trust is accommodating a small number of staff in a purpose built mobile office unit. The current accommodation is nearing the end of its useful life. In addition a further planning application will need to be submitted. At this time, indications are that an application is unlikely to be successful. In order to address the issue of office space, and to replace this portacabin, a purpose built office could be erected in the garden of the Portman Clinic similar in style to the wooden office in the garden of 33 Daleham Gardens, which was until recently used by the Monroe service. This type of structure, located in the garden area, is likely to be viewed more favourably by planners.

- **Garden office space: £44k**

## 4.4 Toilets

4.4.1 Remaining toilets on the 1<sup>st</sup> and 5<sup>th</sup> floors.

- **Toilets: £95k**

## 5. IT network

5.1 The previous annual plan included capital costs of £220k per year for IT hardware and network software.

5.2 A slight increase to £250k per year is now proposed. As well as covering the routine replacement of PCs, servers and other equipment (the annual depreciation charge is currently £165k), this also allows for further development of our IT facilities.

5.3 As in 2010/11, the Board is asked to approve delegation of the £250k IT capital budget for 2011/12 to the Chief Executive. Project

proposals within this total will be submitted to the CEO for authorisation.

**Table 1: Capital Proposals**

Project	2011/12 £000	2012/13 £000	2013/14 £000
Day Unit Relocation <sup>1</sup>	50		
Seminar Room / Common Room	44		
Toilets	95	95	95
Electrical Boards	45		
Boiler Replacement	175		
Lecture Theatre		80	
Roof Insulation		94	
Building Management System		25	
Goods Lift		112	
Replacement Windows			330
Garden Office Space			44
<b>Total</b>	<b>409</b>	<b>406</b>	<b>469</b>
<b>IT</b>	<b>250</b>	<b>250</b>	<b>250</b>
<b>Total Capital Programme</b>	<b>659</b>	<b>656</b>	<b>709</b>

<sup>1</sup> Rebuild/Refurbishment Project to be subject of separate proposal



## Board of Directors : March 2011

**Item : 8**

**Title :** Health and Social Care Bill Update: Governance in NHS Foundation Trusts

**Summary :**

The Health and Social Care bill proposes some fundamental changes to the way in which NHS Foundation Trusts are governed and managed. These changes are introduced at the same time as the safety nets for foundation trusts put in place by Monitor are largely removed.

One of the most significant aspects of the proposals is the move away from collective responsibility of the Board of Directors to individual responsibility for each Director, at the same time as an increase in the responsibilities of Governors.

The paper below outlines the proposed changes and how these will affect the Trust. Also attached is a briefing from a legal firm on the proposed governance changes. It is important to note that these proposed changes are not yet final.

**For :** Noting

**From :** Trust Secretary



## Health and Social Care Bill Update Governance in NHS Foundation Trusts

### 1. Introduction

- 1.1 Much has been made of the changes the Health and Social Care bill proposes to the way in which NHS Foundation Trusts are governed and managed. However, although the proposals sound like a marked departure from current requirements, in practice, much of what is proposed was already implicit under existing structures.

### 2. Governors

- 2.1 The Board of Governors, who will be known as the “*Council of Members*” will have explicit statutory duties to hold Non-Executives to account, both individually and collectively, for the performance of the Trust. In practice, Governors already have this power through their existing powers of appointment of Non-Executives.
- 2.2 Governors will be able to require Directors to attend a meeting to obtain information about the Trust’s performance and that of its Directors. This Trust already has a system in place for agenda-setting where the Deputy Chair of the Board of Governors meets informally with Governors prior to each meeting to discuss the draft agenda, and Governors are welcome to put forward suggestions. Governors at this Trust often request papers on certain topics from Directors. In addition, Governors attend Board of Directors’ meetings on a rotation system, and stay for both Parts 1 and 2, so are aware of all relevant matters. The Trust will need to give consideration as to what constitutes a formal request for information, as this will have to be recorded in the Annual Report.
- 2.3 It is suggested that Governors will require significant training to understand and be able to discharge their duties. The Trust Secretary’s office, in conjunction with the Trust Chair and the Human Resources Directorate, will give consideration to this.

### 3. Directors

- 3.1 Directors will have individual liability as addition to collective responsibility for the running of the Trust. The purpose of this change is to encourage Directors to think carefully before entering into transactions. This is the first time FT Directors’ duties have been

written into law, but it has been suggested that underlying case law on which the codification is based would probably already apply.

#### **4. Constitution and Members**

- 4.1 Monitor will no longer approve changes to a Constitution, but the Boards of Directors and Governors will be required to approve amendments. This is already practice at this Trust, in addition to requiring Members to approve changes at the Annual General Meeting. However, amendments that affect the powers and duties of Governors must be approved by half the Members of a foundation trust. This poses a problem for this Trust, as the Trust does not get significant numbers of Members attending the AGM.
- 4.2 Foundation trusts will be required to hold an annual public meeting for Members, presenting the Annual Report and Accounts. The Trust holds such a meeting annually, so this should not present a significant departure from current practice.



# Who's the governor?

## *A changed governance regime for NHS foundation trusts*

*The Health and Social Care bill proposes fundamental changes to the way NHS foundation trusts are governed and managed.*

The changes mark a move away from collective responsibility of a board to individual responsibility for each director. At the same time, the duties and responsibilities of governors are significantly increased.

These changes in responsibility are introduced at the same time as the financial safety net for foundation trusts and Monitor's Compliance Framework is removed. In the future, there will be no soft landings or loans on favourable terms.

This will mean a radical shift in management dynamics and responsibility as board members and governors take real responsibility for the direction and transactions of their NHS foundation trust.

### Governors – their new role

In future, Monitor's compliance framework will be removed (except for a two year transitional period for some foundation trusts).

To balance this change, governors are given significant duties and real approval powers.

The most important change is that the council of governors is given express statutory duties to hold the non-executive directors individually and collectively to account for the performance of the board and to represent the interests of the foundation trust's members and the public as whole.

Under the current Act, governors appoint the chair and non-executive directors of a foundation trust. The new express duty to "hold non-executives to account" will encourage governors to use their existing powers so as to performance manage non-executives. This raises interesting questions about the role of the chairman as chair of both the council of governors and board of directors and whether this dual role could give rise to conflicts.

There are no express provisions about how non-executives are to be held to account. So, constitutions may need to be changed to allow for ongoing monitoring to allow governors to discharge their new duties.

Governors will be able to require directors to attend a meeting to obtain information about their organisation's performance and that of its directors. They may (like shareholders in a company) vote on motions at such meetings. If, for example, governors pass

a motion of "no-confidence" in directors, then they would (using their existing powers) be entitled to remove the non-executives.

Governors do not currently have powers to remove executive directors but any vote about the performance of the directors will need to be published in the annual report (and might encourage executive directors to resign if they have been criticised).

This extended role for governors raises interesting questions around fiduciary duties, liability and insurance. Many governors are likely to require significant training in order to understand and be able to discharge their duties. Indeed, the impact assessments published in relation to the bill suggest significant initial and ongoing training and advice needs – and this is no surprise in the context of Monitor's devolved duties.

Monitor will be one source of guidance, establishing an independent panel to give advice to governors. The proposals envisage this as "an authoritative source of advice" in response to governors' concerns about constitutional and governance issues.

More than half the governors' council would need to approve a referral to this panel, so referrals would likely occur only in relation to material areas of concern. This might mean that the foundation trust will need to provide much more by way of ongoing support and advice to its council of governors.

### Constitution and members

Monitor will neither check whether a constitution complies with statutory requirements nor need to approve changes. This means that a foundation trust (like any private sector provider) will need to make sure that its constitution is and remains legally compliant.

Again to balance the loss of this oversight role, governors and members gain approval rights in relation to constitutional changes.

For example, the governors and the board of directors must approve any proposed changes to a constitution (the approval of more than half of each forum being required to implement a change). In addition, if a change to a constitution affects the powers and duties of governors, more than half of the members of a foundation trust must approve the change at the next meeting. If they don't approve the change, the change will be ineffective and must be reversed.

All foundation trusts will be required to hold an annual public meeting for their members. This marks a significant change from

current practice. At that meeting, the board of directors must present the accounts, auditor's report and annual report. This move of power back to governors and members might mean that NHS foundation trusts 'look and feel' much more like the mutual or co-operative form on which they were initially modelled.

## Transactions

In the new world, Monitor will no longer review significant or material transactions.

NHS foundation trusts may choose to state that some types of transaction are "significant" in their constitution. If a foundation trust chooses to do this, then it will need the consent of more than half of the council of governors to proceed with the transaction.

Bearing in mind the hurdle this consent will impose upon complicated transactions, it will be interesting to see how many foundation trusts decide to include this right for governors.

However, the consent of more than half of the governors will always be required for any merger, acquisition or separation of the NHS foundation trust. Unlike "significant transactions", this is not an optional requirement. This means that, in practice, responsibility for signing off any merger or acquisition moves to the directors and governors.

## Directors

At the same time, directors will have individual responsibility to promote the success of the foundation trust so as to maximise the benefits for the members as a whole, and the public. This duty echoes statutory duties of directors of companies.

This is a move away from collective responsibility of boards and will mean that each board member will have individual duties. More importantly, board members may also face personal liability (with claims for financial losses) under insolvency legislation where a non-designated provider continues to trade when likely to become insolvent. The awareness of this will make directors stop and think even more than before when entering into transactions.

There are also express duties for each director to avoid conflicts of interest but, importantly, there is a carve-out from the duty if the issue in question has been authorised in accordance with the constitution. It will be important to make sure that constitutions are written so as to take advantage of this provision.

## A new but familiar landscape?

The emphasis on internal governance and governors is interesting. Compare it to the regulation of listed companies or charities of similar size to foundation trusts. In contrast to the proposals

for foundation trusts, both listed companies and charities are subject to significant ongoing external compliance requirements. This only throws into sharp focus the importance of the role of governors, and their training and resourcing, from here on.

Despite these changes in governance, NHS foundation trusts move firmly back within the Department of Health's 'line of sight' in relation to their forward plans and accounts. These must be sent to the Secretary of State and fall outside Monitor's new remit. In addition, the Secretary of State may make orders about the content of annual reports of foundation trusts.

This new reporting requirement is coupled with the right of the Secretary of State to make changes (by statutory order) to the voting rights of directors, members and governors. This means the Department of Health retains the power to change all of these new governance arrangements at any time.

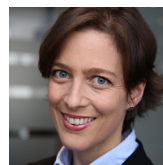
## Conclusion

These monumental changes mean that the central checks and balances for transactions – historically provided by Monitor – will be removed. This, at the same time as the financial safety net for foundation trusts that run into financial difficulties becomes unavailable. What remains unclear is whether Monitor (or even the Secretary of State) will impose additional requirements or special approvals as part of its licensing regime or by order.

Please click [here](#) for further commentary on NHS foundation trust financial powers and central control, and here for further discussion of the implications of the proposed failure regime for NHS providers.

The Bill also proposes significant changes to competition law and NHS services. Capsticks is hosting a conference on this topic. For more information please [click here](#).

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## Board of Directors : March 2011

**Item : 9**

**Title : Clinical Quality, Safety, and Governance Committee  
Quarter 3 Report**

### **Summary :**

This report gives a comprehensive overview of outcomes and performance for each of the Workstream Leads as reviewed by the Committee.

Having worked through three cycles of reporting, some themes are emerging from Workstream Leads.

Positive themes include:

- moving towards a risk enabled culture as demonstrated by the achievement of NHSLA Level 2; and
- improved communication between clinical and corporate work areas.

Areas being addressed include developing systems for:

- quality, eg to achieve CQUIN targets;
- ensuring mandatory training is undertaken;
- integrating information governance into all work areas; and
- compliance with a stricter information governance regime.

Risk is well managed from a non-clinical and clinical perspective.

**For : Discussion**

**From : Medical Director**

## Clinical Quality, Safety, and Governance Committee Quarter 3 Report

### **1. Introduction**

- 1.1 The report is based on the work of the Workstream Leads and is validated by the Management Committee before scrutiny at the CQSG. The CQSG assurance contained in this report is based on substantial and accepted that adequate action plans were in place where it was not, though in some cases proposed action would not result in short term change.

### **2. Findings**

- 2.1 The Trust will have been externally assessed for governance, NHSLA, and information governance (IG) by the end of Quarter 4. Concerns about progress for all areas but NHSLA were noted. One theme was that systems for outcome monitoring, quality reports, and IG, are far from complete, let alone mature and delivering a steady state. It has not been possible for the Committee to review the Assurance Framework due to incompatible scheduling constraints and this task has been undertaken at the Management Committee.

### **3. Conclusion**

- 3.1 The Committee was content to accept the assurance and action plans, recognising the Trust had some work to do in order to fully establish systems and structures to enable work to happen at a later stage. The Management Committee will be overseeing work plans where assurance had not yet been provided, and considering the development of systems and structures where necessary.

### **4. Recommendations**

- 4.1 That the Board of Directors acknowledge the report gives satisfactory assurance, and where this was yet to be provided, that an action plan was in place to generate the assurance through the delivery of improvements to systems.
- 4.2 That areas for development are included in the Annual Plan and that on an ongoing basis any risk of not achieving goals is captured on the Assurance Framework.

- 4.3 That the Terms of Reference for the Committee are changed to transfer responsibility for the oversight of the Assurance Framework from the CQSG to the Management Committee

## Appendix

### Reports from Workstream Leads

#### a) Work stream: Corporate Governance and Risk Lead: Pat Key

Reporting topic	Assurance received	Trend since last	curr RAG	Follow up on tracker Yes/no	Risk Register Yes/no	Comments	CQSG response
CQC compliance	Each lead updated their elements to include details of outcome evidence that can be relied on for 2010-11; updated compliance schedule was considered.	►	G	Yes	No	No areas of concern found (with exception of mandatory training which is addressed below)  Slight decrease in level of risk noted.	-
Non-financial report to Monitor	Report submitted via BD January 2011	►	G	No	No	Q3 report was submitted in advance of work stream meeting and therefore not reviewed.	-
Human Resources Training report	Q3 figures for Induction, Local Induction and Mandatory training and action plan	►	R	Yes	Yes	Q3 figures show below targets outcomes for both induction and mandatory training. CEO support required to oversee implementation of action	The implementation of the sanctions procedure was noted.



Reporting topic	Assurance received	Trend since last	curr RAG	Follow up on tracker Yes/no	Risk Register Yes/no	Comments	CQSG response
						plan. Sanctions procedure now approved and to be implemented.	
Estates and Facilities CQC compliance and NHSLA compliance	Environmental risk assessments have been completed for all sites except Barnet YPDAS. These showed no evidence of risks that could not be tolerated.  CQC compliance schedule populated with details of in year evidence	►	G	Yes	No		-
Responses to recommendations and Requirements of External Bodies	Updated schedule.	►	G	No	No	No deadlines missed.	-
Progress towards NHS Level 2	Verbal report on progress for assessment (due to nearness of assessment and daily	►	A	Yes	Yes	Though good progress has been made overall, there remains a number of challenges remain relating to column 2 standards in	The committee was pleased to receive news that the Trust had attained level 2.

Reporting topic	Assurance received	Trend since last	curr RAG	Follow up on tracker Yes/no	Risk Register Yes/no	Comments	CQSG response
	change to preparedness)					particular the robustness of our process evidence on training, Trust needs 7/10 passes in column 2 and 40/50 passes overall to achieve Level 2). If 7/10 training related standards are not reached the Trust will not achieve level 2.	
Non-clinical incident reports	Summary report on all non-clinical incidents for Q3, graded to show actual harm level, no incident was graded above 8, and details of local management provided in each case.	►	G	No	No	No further action required	-
Specific case reports (serious incidents / SUIs)	No new serious incidents were reported in Q3, there are no outstanding open serious incident cases under review	►	G	No	No	-	-
Central alert broadcast advice	CAB issued 40 alerts in Q3, none of which	►	G	No	No		-

Reporting topic	Assurance received	Trend since last	curr RAG	Follow up on tracker Yes/no	Risk Register Yes/no	Comments	CQSG response
	were relevant to the Trust.						
Board Assurance Framework (strategic risks)	Updated version presented to February BD	►	G	No	No	Recommended that this be considered by MC rather than the Board of Directors .	Recommended that this task be transferred to MC.
Operational Risk Register	Updated version received and reviewed; noted that IG only red risk	►	G	No	No	Action plan for IG discussed as a separate agenda item (see below)	-
Information Governance	Report and action plan.	►	R	Yes	Yes	An action plan to be presented to MC by SIRO. Internal auditors to undertake audit WC 7.2.11	Report findings noted. Final report and recommendations for action will be put to MC in March

**Action Tracker : Corporate Governance and Risk**

Date item added	Action	Lead	Target completion date	Progress review/closed (date and comment)
27.8.10	<p>HR (training compliance)</p> <ul style="list-style-type: none"> <li>➤ Need for directors to ensure attendance at training to be emphasised at MC.</li> <li>➤ CE to be made aware of attendance performance by directorate for addressing at 1:1s.</li> <li>➤ Report metrics to be refined and accompanying narrative in future</li> <li>➤ Complete and final data sets to be completed and forwarded to PK by Friday.</li> </ul>	<p>ST</p> <p>ST</p> <p>ST</p> <p>NN</p>	<p>30.11.10</p> <p>30.9.10</p> <p>27.8.10</p> <p>27.8.10</p>	<p>Complete, 30.9.10</p> <p>Complete, 1.11.10</p> <p>Complete, 27.8.10</p> <p>Complete, 27.8.10</p>
27.8.10	Progress to NHSLA level 2: work with leads to see how gaps can be closed	JC	30.9.10	Complete, 30.9.10
27.8.10	<p>Information governance</p> <ul style="list-style-type: none"> <li>➤ The Information Governance Group will monitor and support IG compliance</li> <li>➤ An action plan will be put to the MC</li> <li>➤ A meeting between PK, LL, SY and NN to look at a co-ordinated approach to training to include RiO, IG, finance system, mandatory training etc will be held</li> </ul>	<p>SY</p> <p>JM</p> <p>JM</p>	<p>15.10.10</p> <p>16.9.10</p> <p>31.8.10</p>	<p>Ongoing</p> <p>Plan not agreed</p> <p>Meeting held, long term solution to be finalised</p>

29.10.10	<p>Outstanding RMC action: <i>Lone Worker Policy Implementation Audit</i></p> <ul style="list-style-type: none"> <li>➡ Assurance that delivery plan has been implemented to be obtained</li> </ul>	PK	30.11.10	Complete
29.10.10	<p>HR (training compliance)</p> <ul style="list-style-type: none"> <li>➡ Directors to be prompted to manage this situation more effectively</li> <li>➡ Performance figures to be supplied to directors monthly (IG performance figures are already being supplied weekly)</li> </ul>	<p>ST</p> <p>ST</p>	<p>30.11.10</p> <p>30.11.10</p>	Discussed at JSCC, MC to consider feedback
29.10.10	<p><b>Estates and Facilities: Health and Safety and Facilities Risks 2010-11</b></p> <ul style="list-style-type: none"> <li>➡ Devise a definition of 'trust sites' and ensure liaison between Business Development and Facilities</li> </ul>	PK	30.11.10	Complete
29.10.10	<p><b>General corporate governance and risk compliance</b></p> <p><i>Risk assessment grading</i></p> <ul style="list-style-type: none"> <li>➡ Eg Access to roof incident risk rating to be reviewed</li> </ul>	PK	30.11.10	Complete

	<b>Stress Management Policy</b> ➡ A review to simplify is indicated	ST	30.11.10	Plan to review in place
29.10.10	<b>Information Governance</b> ➡ 2010/11 plan and resources to be finalised and approved by CEO.	SY	30.11.10	Complete
3.2.11	<b>Assurance Framework</b> ➡ Pat Key to propose change to the CGR TOR to the CQSG to make MC responsible for review	PK	10.2.11	Agreed 10.2.11
3.2.11	<b>Mandatory Training</b> ➡ Performance figures to be supplied to directors monthly ➡ Performance reports of clinical directorates to be copied to Louise Lyon ➡ MC will be invited to review progress ➡ Optimum presentation of data to be explored with Namdi Ngoka	ST	28.2.11	
3.2.11	<b>Trust sites</b> ➡ Review list of 'trust sites' and eliminate entries to Trust site database that are obsolete	PK	28.2.11	
3.2.11	<b>Health &amp; Safety</b>			

	<ul style="list-style-type: none"> <li>➡ Review frequency of fire warden training and update records.</li> </ul>	PK	28.2.11	
3.2.11	<b>Complaints monitoring</b> <ul style="list-style-type: none"> <li>➡ Options for consideration to be explored with MD</li> </ul>	PK	28.2.11	Complete
3.2.11	<b>Information Governance</b> <ul style="list-style-type: none"> <li>➡ Priority plan to be put to MC</li> </ul>	SY	28.2.11	

<b>b) (i) Work stream : Clinical Audit</b>	<b>Lead</b>	<b>Caroline McKenna</b>
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Reporting topic	Assurance received		RAG	Follow up on tracker Yes/no	Risk Register Yes/no	Comments	CQSG response
Development of Clinical Audit Process and Clinical Audit Annual plan	<p>Partial – Evidence available of local audits occurring in all directorates.</p> <p>Clinical Audit Annual plan being written up fro 2011/12 in consultation with Clinical Governance Leads and Clinical Directors.</p> <p>Process for clinical audit in place across all directorates.</p>			Yes	No	<p>Standard: every clinician participating in clinical audit.</p> <p>Clinical audit procedure in place.</p> <p>Planning meeting to develop annual plan in diary</p> <p>Annual audit plan to reflect national priorities, trust annual plan and service needs but will include audit NICE guidelines implementation, compliance with case notes standards, patient experience including within service lines, compliance with audit standard re clinician participation in audit.</p>	<p>Noted that the Clinical Audit Committee will oversee work.</p> <p>Analysis of clinical supervision audit awaited.</p>
NICE compliance	All gap analyses with action plans			No	No	Quarterly report to be compiled from updated plans and sent to	-



Reporting topic	Assurance received		RAG	Follow up on tracker Yes/no	Risk Register Yes/no	Comments	CQSG response
	have been reviewed and updated by leads					Commissioners, no issues identified. Note recent new NICE guideline issued and allocated as lead to complete gap analysis ( Looked After Children - CMcK, Anxiety Disorders-MD, Schizophrenia – Aripiprazole-CMcK )	
Confidential inquiries	Gap Analysis completed			No	No	NHSLA have confirmed that the Trust is only required to review and consider the Confidential inquiry report on Homicide and Suicide when published. The most recent report was published in July 2010 . Review and gap analysis has been completed by C McK.	-

Date item added	Action Tracker Clinical Audit	Lead	Target completion date	Progress review/closed (date and comment)
9.9.10	No evidence to suggest non compliance but formal methods for Trust wide audit to be agreed and implemented with target date of end Q2	CM	Dec 2010	Completed
30.10.10	Complete Gap analysis on NCE	CM	Dec 2010	Completed

<b>b) (ii) Work stream : Clinical Outcome</b>	<b>Lead</b>	<b>Caroline McKenna</b>
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Reporting topic	Assurance received		RAG	Follow up on tracker Yes/no	Risk Register Yes/no	Comments	
Outcome monitoring	None			YES	YES	A proposal to the MC to address the	The committee noted areas for attention and that extra resource had been given to this area.

Date item added	Action Tracker Clinical Audit	Lead	Target completion date	Progress review/closed (date and comment)
-	-	-	-	-

<b>C) Work stream : Patient Safety and Risk</b>	<b>Lead</b>	<b>Jessica Yakeley</b>
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Reporting topic	Assurance received		RAG	Follow up on tracker	Risk Register	Comments/Actions	CQSG response
Clinical incidents	Summary report on all clinical incidents for Q3, graded to show actual harm level. No incident was graded above 8 , no further action required	▶	G	No	No	-	-
Specific case reports (serious incidents / SUIs)	No new serious incidents were reported in Q3, there are no outstanding open serious incident cases under review	▶	G	No	No	-	-
Hospital Acquired Infection	No incident reports relating to infection control were received in Q3. Hand washing techniques and	▶	G	No	No	-	-

Reporting topic	Assurance received		RAG	Follow up on tracker	Risk Register	Comments/Actions	CQSG response
	management of body fluid contamination injuries were covered in induction in this quarter.						
New Clinical claims	The Trust has no clinical claims of negligence	►	G	No	No	-	-
Complaints report	Updated complaints schedule for 2010-11	▼	A	Yes	No	3 complaints received in Q2. One complaint was considered serious enough for investigation under the serious incident policy. The Director of Nursing has been appointed lead investigator and the Trust has engaged the assistance of an external adviser. The complaint is under detailed investigation and an outcome report is	Improvements to the oversight of complaints were noted.

Reporting topic	Assurance received		RAG	Follow up on tracker	Risk Register	Comments/Actions	CQSG response
						expected by the end of February 2011. The external investigator has met with both the complainant and all staff named in the complaint.	
Progress towards NHS Level 2	<p>Following the interim visit of the NHSLA assessors in October work has been progressing towards the formal assessment scheduled for 21/22<sup>nd</sup> February.</p> <p>Please note that the date of the assessment coincides with that of the CQSG meeting</p>	►	A	Yes	Yes	<p>Work has progressed to close the gap on areas of risk of non compliance and this has been reviewed by the Work stream lead during the quarter. Due to the proximity of the assessment to this reporting cycle a detailed action plan will not be presented. A snap shot progress report on 20.1.11 shows that we will be fully compliant at the policy level i.e. Level 1 and that data is available and uploaded</p>	Noted.

Reporting topic	Assurance received		RAG	Follow up on tracker	Risk Register	Comments/Actions	CQSG response
						for all but 6 of the standards. A specific plan is in place to address each of the gaps.	
Central alert broadcast advice	CAB issued 40 alerts in Q2, none of which related to clinical practice relevant to the Trust	►	G	No	No	-	-
Supervision of clinicians	The revised clinical supervision procedure documenting each clinician's supervisors and types of supervision has been sent to all clinicians in the Trust by AMD Risk lead via the heads of discipline.	►	A	Yes	Yes	Data collection is proceeding currently, but is not yet complete due to some clinicians not sending back the form, despite a number of reminders.  Data collection will be analysed, and reviewed thereafter on an annual basis to ensure that the Trust can identify each	Good progress in data collection noted; need for thorough analysis of data and report recommendations to be considered also noted.

Reporting topic	Assurance received		RAG	Follow up on tracker	Risk Register	Comments/Actions	CQSG response
						clinician's named supervisor (in line with CQC and NHSLA requirements).	
Revalidation	Updated report received from Revalidation Lead regarding Trust's preparation for revalidation with action plan and progress in last quarter	►	G	No	No	<p>We continue to work internally on systems and processes so that we will be ready for revalidation when it is implemented in 2012.</p> <p>NHS London will carry out a second assessment exercise for organisational readiness in May/June 2011.</p>	-



Reporting topic	Assurance received		RAG	Follow up on tracker	Risk Register	Comments/Actions	CQSG response
Safeguarding children	The safeguarding lead met with the work stream lead to review progress on the action plans from the two audits (July and Aug 2011)  An updated action plan has been prepared.	▼	A	Yes	No	One area of concern from review is the lack of progress with identifying children with CP plans so that we cannot report on number, or audit compliance with procedure or assess quality of care.  This was to be dealt with as part of the Rio project but as only the admin section is being used currently this has not closed the gap.  The issue has been added to the risk register.	Will review next meeting.
Safeguarding adults	Incident report shows 2 LCDS and 1 adult referral of vulnerable adults have been made in the quarter	►	G	No	No	All 3 incidents reviewed by JC and JY, and confirmed that actions taken are recorded on the incident form..	-

Reporting topic	Assurance received		RAG	Follow up on tracker	Risk Register	Comments/Actions	CQSG response
	and in each case the procedure was followed. One further vulnerable adult incident was reported and reviewed but a decision was taken not to make a referral						
Operational Risk Register (clinical risks)	<p>The risk register has been reviewed and updated by risk owners.</p> <p>The risks identified on the Register are being handled appropriately by the identified leads.</p> <p>2 new risks added in Q3, both regarding RiO:</p> <ul style="list-style-type: none"> <li>- post go-live risk</li> </ul>	▲	G	No	No	<p>Of 8 risk on register scoring 9 +, 3 relate to implementation of RiO</p> <p>Risk assessment has been undertaken for risk of entering clinical notes on RiO to patient safety. Report to go to management committee.</p>	-

Reporting topic	Assurance received		RAG	Follow up on tracker	Risk Register	Comments/Actions	CQSG response
	<p>of drop in quality data which could impact on income</p> <ul style="list-style-type: none"> <li>- Risk of RiO implementation to patient safety due to inadequate record keeping</li> </ul>						

**Action Tracker: Patient Safety and Clinical Risk**

Date item added	Action	Lead	Target completion date	Progress review/closed (date and comment)
Oct 2010	Supervision of clinicians to undertake audit of supervision arrangements	JY	End Jan 2011	Data collection in progress, new target date for completion Feb 2011, with report to MC on findings of audit
Oct 2010	NHSLA -progress towards NHS Level 2	JC/JY	Feb 2011	Progress towards assessment ongoing Assessment due Feb21/22
4.11.10	Formulate clinical safety entry for risk register	JY/JC	End Nov 2010`	Added to risk register , completed Clinical risk assessments to be completed
24.1.11	Receive report from complaint investigation	LJ	End Feb 2012	
24.1.11	Receive progress report on capturing children with CP plan	SA	End March 2011	

d) Work stream name	Quality	Lead	Justine McCarthy Woods				
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Reporting topic	Assurance received	prev RAG	Curr RAG	F/U on tracker	Risk Register	Comments	CQSG response
Quality accounts are produced to a high standard	No current assurance as plans are still be finalised as to approach to be adopted for 2010-11	►	R	Yes	Yes	A Framework for Data Quality and Procedures is currently in the process of being completed. This will be used to confirm data sources and procedures for assurance of data quality, which will be required for the Quality Accounts/Report. Nevertheless, concerns remain about the quality and reliability of some of the data, particularly for Outcome Monitoring. However, an interim Draft Quality Report has been completed, and the feedback provided by KPMG and stakeholders will be used to improve the quality and standard of the final Quality Accounts/Report.	A tracking system is needed.
Arrangements to deliver CQUIN are fit	No formal assurance available	►	R	Yes	Yes	There are a number of problems with delivering information on our CQUIN	A tracking system is needed.

Reporting topic	Assurance received	prev RAG	Curr RAG	F/U on tracker	Risk Register	Comments	CQSG response
for purpose						<p>targets these include</p> <ul style="list-style-type: none"> <li>a) information has not been entered onto RiO</li> <li>b) changes in team strategy about which information systems they are going to use.</li> <li>c) The challenge of services/outcome monitoring encapsulating complex outcome processes in queries, which informatics can then use to generate reports.</li> <li>d) The RiO workload &amp; priorities for informatics which mean there have been slight delays in producing information from IEYS, which we have agreed will be dealt with in a different format and for Q3 reworking the adult long waiters report.</li> </ul> <p>In addition, because RiO</p>	

Reporting topic	Assurance received	prev RAG	Curr RAG	F/U on tracker	Risk Register	Comments	CQSG response
						does not include a tracking system for outcome monitoring forms for patients, it has not been possible to systematically monitor the return rates. As a result, we are not in a position to accurately compare the return rates for Q3 both with Q1 and Q2 and the return rates from previous years.	
That data quality is improving	As the data quality assurance processes are not yet in place at this time, this will need to be carried forward to Q4.						
That data to be collected has been agreed	CQUIN data for 2010-11 agreed and is being collected, reports provided to Commissioners as required.  Mandatory data sets for Quality Report externally set	▼	R	Yes	Yes	As above, the lack of reliability of some of the data included in the CQUINs report is of concern and needs to be addressed as a priority-	Plans to address were noted.
That guidelines on	Few written	►	R	Yes	Yes	There are no guidelines	A policy is required and a

Reporting topic	Assurance received	prev RAG	Curr RAG	F/U on tracker	Risk Register	Comments	CQSG response
the nature of data are satisfactory	guidelines available on nature of data currently available					available to address the current issues concerning:  Data quality and reliability; consistency between the information collected on Carenotes and Rio (particularly how this will affect comparison between the Q1 & Q2 reports and those generated for Q3 & Q4; the decision of outcome monitoring that the tracking system on RiO does not meet their needs, and the lack of agreed systems and infrastructures, along with admin support, for data collection and extraction.	proposal will be put to the March BD meeting.
That non-financial SLM reports are fit for purpose and that communication with SLMs on quality matters is effective	It is recommended that this work stream provide advice and support to SLMs in preparing their reports to confirm that 'quality' entries and accurate and fit for purpose and that issues are reported to CQSG by exception					Note if recommendation in 'assurance' column is accepted then the ToR for the quality work stream will be updated to reflect this approach. To be carried forward for discussion at February CQSG Meeting.	



## Action Tracker Quality

Date item added	Action	Lead	Target completion date	Progress review/closed (date and comment)
9.9.10	Develop and action plan for preparation of Quality Report to include lead for supplying evidence and arrangement for sign off of entry in the report to confirm accuracy Action plan to include method for agreeing non mandatory content of report	JMcCW	31.3.2011	A Framework for Data Quality Procedures is in the process of completion. This will include the Lead for providing evidence and assurance concerning the accuracy and completeness of data, along with identifying gaps and risks.
9.9.10	Seek approval for proposal to prepare quality CQIUN report with action plans for any targets that are not being met and then develop an action plan to ensure its timely production.	JMcCW	31.3.2011	As indicated above, because of the delays caused by the migration to RiO, and with the need to rely on manual data collection and reporting systems, it was not possible to ensure the CQUINs reports were completed and submitted to meet specified deadlines for Q3. The difficulties created by migration to RiO in meeting the CQUINs report deadlines have been conveyed to commissioners. In addition, as an interim measure, Informatics plan to design a temporary OM tracking system for use in Q4.
9.9.10	Update ToR if recommendation for emphasis of work stream activity in relation to SLMs is agreed	JC	31.3.2011	Deferred from Q1 Report
2.11.10	There will be a need to monitor the systems for data collection and data extraction with the implementation of RiO. An interim report to be completed following Quarter 3.	JMcCW	29.4.2011	The difficulties associated with the migration to Rio have been reported above. Further monitoring is required.

e) Work stream name	PPI	Lead	Sally Hodges
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Reporting topic	Assurance received	Trend since last	Curr RAG	Action tracker	Risk Register	Comments	CQSG response
CQC compliance PPI	Core evidence schedule updated for Q2, Annual plan for PPI activity	►	G	No	No	no issues of non compliance identified	PPI LEAD will develop and implement action plan to establish a documented link between PALS and complaints
Adhering to key PPI policies and procedures (PALS, Patient Information)	PALS supervision from PPI lead Updated approved patient information procedure	►	G	Yes	No	PALS lead receives supervision for this work and any issues are discussed at supervision, a link between a PALS and complaint case was reviewed this quarter and lessons learned.  Patient information leaflet review in progress to be	-

Reporting topic	Assurance received	Trend since last	Curr RAG	Action tracker	Risk Register	Comments	CQSG response
						completed by end Nov 2010	
Coordination of PPI activities across the Trust	Scheduled team meeting PPI /communication (new) now meeting fortnightly  PPI Lead meetings with Outcome monitoring/Audit lead re activities around patient experience of consent and treatment	►	G	Yes	No	Ongoing	-
Responding to PPI issues arising from PALS, complaints or other forms of PPI input	Report delayed to Q3 due to sickness	▲	G	Yes	No	This has now been discussed with the PALS officer who has worked closely with the complaints officer to ensure that both	Assurance of reporting due to next meeting.

Reporting topic	Assurance received	Trend since last	Curr RAG	Action tracker	Risk Register	Comments	CQSG response
						complaints and PALs feed into PPI	
Responding to survey findings from 2009-10	PPI committee minutes PPI action plan includes specific projects arising from patient survey	►	G	No	No		-
Action plan for patient survey 2010-11	Included in PPI annual plan	►	G	Yes	No		-
PPI involvement in promotion of members activities including recruitment	Discussed at Governors meeting 8.9.10, plan to set up a working group agreed New Quality /PPI group to include patients established, first meeting date set	►	G	No	No		-

Reporting topic	Assurance received	Trend since last	Curr RAG	Action tracker	Risk Register	Comments	CQSG response
	Discussed in Board of Governors meeting following paper for annual plan on 27.1.11. Smaller group of governors to convene in march with the new assistant psychologist with responsibility for this area.						

## Action Tracker for PPI

Date item added	Action	Lead	Target completion date	Progress review/closed (date and comment)
8.9.10	Update Patient Information Procedure to ensure in line with current practice, undertake review of core patient information and update as required (all on 2 year review cycle)	SB	Dec 2010	Oct 2010 Procedure fully updated Oct 2010, 2 yearly review of all leaflets in progress
8.9.10	Complete review of PPI structure for presentation at MC	SH	Oct 2010	New action
8.9.10	Revise TOR for PPI committee	SH	Oct 2010	Oct 2010 complete
8.9.10	Set out an annual plan for PPI activity across the trust	SH	Oct 2010	Oct 2010 plan completed to be presented to CQSG for information
1.11.10	Prepare a review of PALS activity for Q1 and 2 (postponed from Q2)	DL	Dec 2010	Post poned to Q4
1.10.10	Review and reissue patient information leaflets	SB	Dec 2010	Oct 2010 in progress

## Board of Directors : March 2011

**Item :** 10

**Title :** Annual Schedule of the Board of Directors 2011/12

**Summary:**

Attached is the Annual Schedule of the Board of Directors for 2011/12.

**For :** Approval

**From :** Trust Secretary

## Board of Directors' Annual Schedule 2011/12

Item	Responsible	Action	Apr	May	Jun	Jul	Sep	Oct	Nov	Jan	Feb	Mar	Extra
Part 1													
Reports & Finance													
Trust Chair's & Non-Executive Directors' Reports	TC / NEDs	Noting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Chief Executive's Report *	CEO	Noting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Finance & Performance													
Finance & Performance Report	FD	Discussion	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Budget	FD	Approval										✓	
Capital Budget	FD	Approval										✓	
Quarterly Monitor Governance Declarations	FD / DCGF	Approval	✓			✓		✓		✓			
Charitable Fund Accounts	FD	Approval						✓					
Annual Report & Account													
Annual Report	CEO / TS	Discussion / Approval	✓ζ	✓ζ		✓‡							✓
Annual Accounts	FD / AC Chair	Discussion / Approval	✓ζ	✓ζ		✓‡							✓
Management Representations Letter	FD	Approval											✓
Board of Directors' Committee's Annual Reports													
Charitable Fund Committee	CC	Discussion		✓									
Clinical Quality, Safety, & Governance Committee §	CC	Discussion		✓									
Patient & Public Involvement Committee §	CC	Discussion		✓									
Remuneration Committee	CC	Discussion		✓									
Gloucester House Steering Group Annual Report	CC	Discussion		✓									
Annual Safeguarding Arrangement Review Report §	MD	Discussion					✓						
Responsible Officer's Report	MD	Discussion					✓						
Corporate Governance													
Corporate Governance Report	TS		✓			✓		✓		✓			
Record of Sealings		Noting					As appropriate						
Board of Directors' Committee's Terms of Reference		Approval							✓				
Registers of Interest		Noting	✓										
Annual Schedule		Approval										✓	
Code of Conduct Compliance Review		Discussion / Approval	✓										
Clinical Quality, Safety, & Governance Committee Report §	MD	Discussion		✓			✓		✓		✓		
Information Governance Report §	IGL	Noting	✓										
Constitutional Amendments	TS	Approval	✓		(✓)		(✓)						
Standing Financial Instructions	TS	Approval										✓	
Scheme of Delegation of Power	TS	Approval										✓	
Annual Review of Internal Trust Links	TC / CEO	Discussion / Approval									✓		
Annual Review of External Trust Links §	TC / CEO	Discussion / Approval									✓		
Objectives													
Board of Directors	TC	Approval			✓								
Board of Governors	TC	Noting							✓				
Trust Chair	TC	Approval							✓				
Chief Executive	TC	Approval			✓								
Trust Policies	Appropriate Lead	Approval					As appropriate						
Committee Minutes													
Charitable Fund Committee	CC	Noting					As appropriate						
Quality & Development													
Annual Plan §	CEO / FD	Discussion / Approval	✓ζ	✓					✓	✓ζ	✓ζ	✓ζ	
Quality Report §	TD	Discussion / Approval	✓ζ	✓								✓ζ	
Quality Accounts §	TD	Discussion / Approval	✓ζ	✓								✓ζ	





## Board of Directors' Annual Schedule 2011/12

[illegible]

# Board of Directors' Annual Schedule 2011/12

## Key to Symbols Acronyms

Key to Symbols	
§	Items link to Care Quality Commission Standards
*	Key issues from the Management Committee to be summarised in Chief Executive's Report
ζ	Draft
†	Summary financial accounts for publication, if required
(✓)	If necessary
±	Full Risk Register

Key to Acronyms	
TC	Trust Chair
NEDs	Non-Executive Directors
CEO	Chief Executive
FD	Finance Director
MD	Medical Director
TD	Trust Director
D	Dean
TS	Trust Secretary
DCGF	Director of Corporate Governance & Facilities
DHR	Director of Human Resources
DSDS	Director of Service Development & Strategy
DRD	Director of Research & Development
PPICL	Patient & Public Involvement and Communications Lead
IGL	Information Governance Lead
SLD	Service Line Director
AC Chair	Audit Committee Chair
CC	Committee Chair
TCFC	Tavistock Clinic Foundation Chair

## Links to CQC Standards

Links to Care Quality Commission Essential Standards	
Agenda Item	Standard
<b>Reports &amp; Finance</b>	
Finance & Performance	
Assurance Framework	
Operational Risk Register §	All outcomes where risks to compliance are identified
Board of Directors' Committee's Annual Reports	
Clinical Quality, Safety, & Governance Committee §	All outcomes
Patient & Public Involvement Committee §	Outcome 1
Annual Safeguarding Arrangement Review Report §	Outcome 7
<b>Corporate Governance</b>	
Clinical Quality, Safety, & Governance Committee Report §	All outcomes
Information Governance Report	Outcome 21
Annual Review of External Trust Links §	Outcome 6
<b>Quality &amp; Development</b>	
Annual Plan §	All outcomes
Quality Report §	Outcome 16
Quality Accounts §	Outcome 16
Service Line Reports	
CAMHS, Camden §	Outcome 16
CAMHS, Developmental §	Outcome 16
CAMHS, Looked After Children §	Outcome 16
CAMHS, Training §	Outcome 16
Adolescent §	Outcome 16
Adult §	Outcome 16
Portman §	Outcome 16
Tavistock Consultancy Service	Outcome 16
Education & Training Report	Outcome 14
Staff Survey Report §	Outcome 14
Annual Meeting with Staff	Outcome 14
Estates & Facilities §	Outcomes 10
Workforce Statistics §	Outcomes 13
Equalities Report §	Outcomes 1; 14

Care Quality Commission Essential Standards
Outcome 1: Respecting and involving people who use the service
Outcome 2: Consent to care and treatment
Outcome 3: Fees
Outcome 4: Care and welfare of people using the service
Outcome 5: Meeting nutritional needs
Outcome 6: Co-operation with other providers
Outcome 7: Safeguarding vulnerable people who use the service
Outcome 8: Cleanliness and infection control
Outcome 9: Management of Medicines
Outcome 10: Safety and suitability of premises
Outcome 11: Safety, availability, and suitability of equipment
Outcome 12: Requirements relating to workers
Outcome 13: Staffing
Outcome 14: Supporting workers
Outcome 15: Statement of purpose
Outcome 16: Assessing and monitoring the quality of service provision
Outcome 17: Complaints
Outcome 18: Records (systems and processes)
Outcome 19: Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983
Outcome 20: Notification of other incidents
Outcome 21: Records (clinical content)

## Board of Directors : March 2011

**Item :** 11a

**Title :** Trust Policies – Data Quality Policy

**Summary :**

Attached is the Data Quality Policy, for approval. This Policy has been sent to the Trust's External Auditors, KPMG, for feedback.

**For :** Discussion

**From :** Chief Executive

# Data Quality Strategy & Policy

Version:	1 (new policy)
Approved by:	Board of Directors
Date ratified:	Mar 2011 [TBC]
Name of originator/author:	Jane Chapman Governance and Risk Adviser
Name of responsible committee/individual:	Chair of CQSG
Date issued:	Apr 2011 [TBC]
Review date:	Mar 2011 [TBC]

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6	Duties & Responsibilities
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9	Promotion of Policy and Training Requirements
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Appendix A	Equality Impact Statement

## **1 Introduction**

The Trust recognises the importance of having in place systems and processes to ensure that the data on which it bases its decisions, whether clinical, managerial, or financial, is of the highest quality. It also recognises the importance of having robust data definitions and systems of validation in place to assure data quality and the financial implications of poor data quality following the introduction of Honos PBR and Care Quality Indicators (CQUINS). The Trust recognises that complete and accurate data is essential to support effective decision making across the spectrum of Trust functions, including: -

- a)** Patient Care – in the delivery of effective, relevant and timely care, thereby minimising clinical risk.
- b)** Good Clinical Governance –a pre-requisite for minimising clinical risk and avoiding clinical error and misjudgement.
- c)** Disclosure –ensuring that clinical and administrative information provided to the patient and authorised health partners is of the highest quality.
- d)** Business planning –ensuring management can rely on the information to make informed and effective business decisions.
- e)** The measurement of activity and performance to ensure effective distribution and use of Trust resources.
- f)** Regulatory reporting –to ensure compliance with the standards and targets as laid down in measures such as CQUIN, IG Toolkit and Monitor Assessments.
- g)** Good corporate governance –which, as above, has data quality as a pre-requisite to ensure effective business management.
- h)** Legal compliance –ensuring that the Trust conforms to its legal obligations as laid down in relevant legislation, such as Data Protection Act.

## **2 Purpose**

The purpose of this policy is to provide an overarching framework to ensure that the Trust operates with accurate and complete data and can meet its various legal and regulatory responsibilities with regards the quality and accuracy of the data it holds.



### 3 Scope

Although data quality is relevant to all aspects of the Trust's business, this policy is primarily focussed upon systems and process to ensure the highest standards of data quality in relation to the collection, recording and reporting of clinical based activity. It applies to all staff, clinical and non-clinical, that record, collate, or handle data in the course of their work.

### 4 Definitions

**Data quality** is a measure of the difference between data collected on information systems or manually, against the true experience of the subject (eg for patient data), or the true occurrence of an event (eg for financial data). Data quality is 'high' if the data accurately portrays what actually took place.

**Data validation** is defined as systems and processes that are employed to verify the accuracy and completeness of data that is collected.

### 5. Strategic approach –data quality principles

The Trust utilises the following principles:-

- a Trust-wide culture that recognises the importance of accuracy in recording data
- clear accountability for data quality across the Trust, supported by effective groups and committees specifically responsible for supporting the delivery of assurance of data quality
- established procedures that ensure that the Trust is aware of changes, developments and additions to services and standards that have an effect on data collection and data quality including Information Standards Board Notifications
- agreed active methods of data validation and a culture that responds to identified errors promptly
- effective expertise in and training for staff who are required to input, extract, or interpret data.

## 6 Duties and Responsibilities

### 6.1 Chief Executive

The Chief Executive has overall responsibility for data quality systems and processes in the Trust. The CE is responsible for signing the statement of assurance of data quality included in the annual Quality Report.

The responsibility for data quality is delegated through the Trust management structure, with specific responsibilities allocated as below.

### 6.2 Senior Information Risk Owner (SIRO)

The Trust's Senior Information Risk Owner (SIRO) is an executive director appointed by the Board of Directors (BD). The SIRO reports to the BD through the Corporate Governance and Risk work stream. The SIRO is an executive who is familiar with and takes ownership of the organisation's information risk policy, acts as advocate for information risk on the Board.

### 6.3 Medical Director

The Trust's Medical Director, in his role as Chair of CQSG<sup>1</sup>, is responsible to the Board for assurance that systems and processes for data quality are in place and working effectively, and alerting the Management Committee (and the Board of Directors, if appropriate) of any significant risks to data quality.

The Medical Director will be supported in this role by data quality leads as shown in the list below:

Data set	Data Quality Assurance Lead
Financial data	Director of Finance
RiO data	Director of Service Development
Paper medical records	Trust Director
HR records (paper and electronic)	Director of HR
Membership records data	Trust Secretary
Student records	The Dean

### 6.4 Quality Reports Lead

<sup>1</sup> Clinical Quality, Safety, and Governance Committee

Working to the Trust Director, the post holder has operational responsibility for the completion and submission for all quality based reporting for the Trust.

#### **6.5 Information Governance (IG) Manager**

The IG Manager has responsibility for ensuring effective policies and procedures are in place in relation to information governance and to promote staff compliance with IG standards.

#### **6.6 Caldicott Guardian**

The Caldicott Guardian has a role, with a specific emphasis on ensuring security and confidentiality are maintained, to act as an adviser to the Trust in relation to the use and storage of patient identifiable information.

#### **6.7 Departmental Directors**

Departmental directors have an operational responsibility, often delegated within their directorate, for ensuring that their staff comply with this policy and other related policies and procedures on data handling and to take action where required to address areas of concern.

#### **6.8 Head of Informatics**

The Head of Informatics is responsible for advising on tools and processes to monitor and measure the level of data quality within electronic patient systems. This responsibility extends to providing an early warning system of potential risks and actively monitoring and commenting on performance trends.

#### **6.9 All staff**

Staff recording data either manually or electronically are responsible for ensuring that it is timely, accurate, complete, complies with legal requirements (in particular the Data Protection Act) and Trust policies and procedures, and that any error that is identified is rectified in the correct way .

### **7. Processes for Ensuring and Improving Data Quality**

The Trust has a number of interrelated processes to support high levels of data quality, the main ones are:-

- Setting data standards
- Undertaking data validation

- Acting on inconsistencies.

## 7.1 Setting of Data standards

Data standards ensure that there is consistency in data collection by having agreed and implemented data definitions for key data items. The Trust will seek to establish agreed data standards for key data items where an agreed standard is not in place.

## 7.2 Undertaking data validation

Trust is committed to developing and implementing data validation techniques for all key data sets where a data validation method is not already in place. Data validation will be undertaken by a variety of methods depending on the way in which the data is stored; this will include:

- **Direct checks of demographic data** by administration staff by direct questioning of the patient to ensure that the data we have on file is accurate, complete and up to date.
- **Monitoring and reviewing electronic data held on RiO via the data warehouse** - reports will be available to designated management and departmental staff on a daily basis, these will be up to date to the close of business on the previous evening
- **Local audit and sampling** for checking accuracy where data warehouse checks are not possible local sampling for accuracy should be carried out by the department/team responsible
- **Independent audit (by internal and/or external auditors)** all aspects of the Trust's business, including data quality are subject to periodic internal and external audit as detailed in the Trust's quality assurance procedures. Findings and recommendations from these audits, and subsequent action plans to address deficiencies are monitored by both the relevant Trust committee and overseen by the Audit Committee which reports directly to the BD.

## 7.3 Acting of data inconsistencies

In any data system inconsistencies will arise. To promote the highest data quality any member of staff identifying a data inconsistency should either correct it (if in the scope of their role/responsibility) or draw it to the attention of an appropriate administrator or manager without delay.

Any errors/ inconsistencies identified will be investigated to ascertain whether this is as a result of processing, programming, or IT issue.

# 8. Management Arrangements for Assuring Data Quality

## 8.1 Management via the Clinical Quality, Safety, and Governance Committee (CQSG)

Day to day management of data quality lies with the information asset owners. The information asset register is updated and held by the Information Governance Manager.

Ongoing assurance of data quality is managed via the relevant work stream lead reporting to the CQSG. For a detailed description of the CQSG see the terms of reference.

The CQSG reports to the Board of Directors quarterly and will flag data quality risks via this report and via the operational risk register. The CQSG will assure the quality of the final Annual Quality Report in advance of presentation to the Board for approval.

**8.2 Management Committee** – this is the principal operational management group; it receives updates against key targets and standards. Members are responsible for reviewing and challenging any reported data that does not reflect members' understanding of practice/outcomes.

**8.3 Information Governance Tool Kit**

The Trust uses the DH Information Governance Toolkit as a way of providing assurance of its management of information including assurance of data quality. Performance against the IG toolkit standards are considered by the CQSG on a quarterly basis

<b>9 Promotion of the Policy and Training Requirements</b>
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The importance of data quality will be included in Trust INSET programme, as part of the IG presentation, and within RiO System training.

Training issues with other systems and/or other specific processes should be addressed on an individual basis as they arise

<b>10 Monitoring Compliance</b>
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The Trust's compliance with this policy will be monitored by the CQSG on an annual basis as part of the review of the sign off process for the Annual Quality Report, and on an ongoing basis through interrogation of data validation methods in place for data sets presented as evidence by the work streams presenting the CQSG

On a rolling basis the trust will instruct its auditors (both internal and external) to conduct reviews of different aspects of data quality and reports will be considered by the Audit Committee, and relevant action plans monitored by the CQSG

<b>11. Related Policies and Procedures</b>
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This policy should also be considered in conjunction with all the policies and legislation, especially those highlighted below:

- Clinical Records Standards & Audit Procedure
- Code of Conduct on Patient Identifiable Information
- Data Protection policy

- Health Records Procedure
- Information Asset Registration Procedure
- Information Governance Policy
- Privacy Impact Assessment Procedure
- Risk Strategy

## **12 Equality Impact Statement**

This policy has been screened using the Trust's Equality Impact Tool and has been found not to discriminate against any group of persons (see appendix 1).

## **13 References**

Data Protection Act <http://www.legislation.gov.uk/ukpga/1998/29/contents>  
NHS Information Governance Toolkit <https://www.igt.connectingforhealth.nhs.uk/>

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

**YES** (*go to Section 5.*)

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

**NO**

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

**Negative / Adverse impact: Low.....**

**Positive impact: Low.....**

Date completed 10.1.11

Jonathan McKee

draft



## Board of Directors : March 2011

**Item :** 12

**Title :** Quality Report

### **Summary :**

The Draft Quality Report is not complete as it only covers quarters 1 & 2. In addition, the 2011/12 quality priorities need to be finalised, following consultation with relevant stakeholders. The report includes the comments provided by the External Auditors, KPMG, and Jane Chapman, Governance and Risk Advisor. It is requested that the report is reviewed and feedback is provided for the following:

- Accuracy
- Completeness
- Suggestions of any way that we can increase the reporting of 'quality' under the relevant headings

Feedback is invited by e-mail or hardcopy to Justine McCarthy Woods, Quality Standards and Report Lead, by April 6, 2011 ([JMcCarthyWoods@tavi-port.nhs.uk](mailto:JMcCarthyWoods@tavi-port.nhs.uk)).

**For :** Discussion

**From :** Quality Standards and Report Lead

## Draft Quality Report 2010 - 2011



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## Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) is a specialist mental health trust which provides psychological, social and developmental approaches to understanding and treating emotional disturbance and mental ill health, and uses these approaches to promote mental well-being. It has a national and international reputation based on excellence in service delivery, clinical innovation, and high quality clinical training and workforce development. The Trust provides specialist out-patient services, offering assessment, a full range of psychological therapies, an integrated health and social care for children and their families, which are provided on an out patient basis both on site and in many different community settings. It does not provide in-patient treatment, but has a specific expertise in providing assessment and therapy for complex cases including forensic cases. It offers expert court reporting services for individuals and family cases. The Trust has a national role in providing mental health training, where its training programmes are closely integrated with clinical work and taught by experienced clinicians. One of its strategic objectives is that trainees and staff should reflect the multi-cultural balance of the communities where the Trust provides services. A key to the effectiveness and high quality of its training programmes are its educational and research links with its university partners, University of East London, the University of Essex and Middlesex University.

### Core Purpose

The Trust is committed to improving mental health and emotional well-being. We believe that high quality mental health services should be available to all who need them. Our contribution is distinctive in the importance we attach to social experience at all stages of people's lives, and our focus on psychological and developmental approaches to the prevention and treatment of mental ill health. We make this contribution through:

- Providing relevant and effective patient services for children and families, young people and adults, ensuring that those who need our services can access them easily
- Providing education and training aimed at building an effective and sustainable NHS and Social Care workforce and at improving public understanding of mental health
- Undertaking research and consultancy aimed at improving knowledge and practice and supporting innovation
- Working actively with stakeholders to advance the quality of mental health and mental health care, and to advance awareness of the personal, social and economic benefits associated with psychological therapies

## Part 1: Statement from the Chief Executive



The Trust is 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. We have valued the opportunity provided by the Quality Report to work closely with patients, the public, staff, the Board of Governors, the Board of Directors, our commissioners and other stakeholders in our efforts to ensure that we continue to provide the highest quality services and innovative ways of improving mental well-being.

Building on our achievements from last year, where we introduced a quality programme which was strongly supported by senior management and the Board of Directors and locally owned in each clinical service line, this year we have implemented an integrated system of Clinical Quality, Safety and Governance (CQSG). The CQSG Committee includes the *Patient Safety and Clinical Risk; Corporate Governance and Risk; Clinical Outcomes and Clinical Audit; Patient and Public Involvement* and the *Quality* work streams. The CQSG Committee, which is clinically focused and clinically led, meets quarterly and provides assurance to the Board of Directors and ensures that the work streams deliver on their objectives. Each service line within the Trust continues to produce 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 yet been developed which apply either to CAMHS or adult psychological therapies. However, we are committed to finding ways of evaluating and demonstrating the quality of the services we offer whenever possible through the use of national measures, which allow us to benchmark our services. The implementation of our new electronic patient record system RiO with administrative staff has also enabled us to improve our data collection system. In addition, this year through the use of the CQUINs (Commissioning for Quality and Innovation) Framework, in conjunction with our commissioners we have agreed indicators (goals) aimed at encouraging innovative practice and improving the quality of services we provide.

Over the past year we have made significant progress on the five areas we identified as priorities. We have increased return rates within our outcome

monitoring programme; our redesigned website has been launched and the initial feedback has been very positive from patients and students, and we are awaiting the results of our survey in April; we maintain a rolling programme of refurbishments; we are involved in on-going consultation with patients, carers, governors and our Non-Executive directors on the quality of our services through the Patient Public Involvement Committee, and we have provided additional training to support staff.

We continue to work to improve return rates across all clinical services and this year have piloted a number of new outcome measures for use with specific patient groups. We are pleased that over 70% of respondents to our annual survey rated the care they received as "good", "very good", or "excellent". We continue to explore ways of improving the communication with our patients and facilitating engagement in services, through the use of telephone surveys and text messaging.

We believe that well-trained, well-supported staff are essential to delivering high quality services and therefore we are pleased that participation in our induction and training programmes is high. In the past year we have provided training to staff on time and workload management and stress awareness and provided workshops aimed at enhancing clinical learning and development.

We are also pleased to report other innovations and achievements during the year, including the launching of a new Young Person's Drug and Alcohol Service in Barnet; the implementation of our online wellbeing service, delivered in partnership with Big White Wall, which was short-listed for a number prestigious awards and successful in winning the Guardian Public Sector Transformation Award, and the short-listing of the Family Drug and Alcohol Court (FDAC) in the MJ Local Government Achievement Awards.

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

I confirm that I have read this draft quality report which has been prepared on my behalf. I have ensured that whenever possible 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

31st January 2011



## 1.1 Quality Initiatives

The Trust is committed to providing services of the very highest quality and safety. It recognizes the patient experience as a key indicator of quality, and the importance of creating a clear role for patients, the public, Governors, members and the Board of Directors alongside staff in contributing to driving up quality standards.

Over the past year, the Trust has implemented the following quality initiatives:

Established an integrated approach to providing assurance to the Board on Quality Safety and PPI with the establishment of the Clinical Quality, Safety and Governance Committee (CQSG), with work streams reporting on quality and safety issues spanning the Trusts services

- Developed a data validation process to support reported data items in this report, to provide assurance to the Board on the quality of data
- Undertaken a series of stakeholders consultations
- Established a Clinical Quality Forum, to identify and share examples of good clinical practice across the Trust and for the purpose of identifying key factors contributing to effective clinical practice, especially in complex cases
- Appointed a Quality Standards and Reports Lead, who leads the Quality workstream reporting to the CQSG and is a member of the, Trust Patient and Public Involvement (PPI) Committee and Pan-London PPI Mental Health Forum, and involved in selecting the quality priorities for the Quality Report and the quality indicators for the CQUINs (Commission for Quality and Innovation) scheme
- Appointed a staff member with specific responsibility for promoting and developing Trust and Governor links with the Trust membership and improving patient experience
- Participated as a key member of the Pan-London Patient and Public Mental Health Forum, which represents ten mental health trusts across London. The PPI Mental Health Forum, which meets regularly, has a remit to ensure that the involvement of service users, carers and the wider community forms an integral part of mental health services in London, and to share good practice

## Part 2: Priorities for Improvement and Statements of Assurance from the Board

### 2.1 Priorities for Improvement

#### 2.1.1 Progress against 2010/11 Quality Priorities

The following section describes our progress and achievements against the targets set for each quality priority for 2010/11.

#### Priority 1.1: Clinical Outcome Monitoring – CAMHS Outcome Monitoring Programme

Targets for 2010/11	Progress
<b>1. Clinical Outcome Monitoring</b>	
<b>1.1 CAMHS (Child and Adolescent Mental Health Service) Outcome Monitoring Programme:</b>	
1. To increase the return rates for CAMHS to 60% and above.	1. This has been achieved for the SDQ and C-GAS for the combined data for Q1 and Q2, 2010/11.
2. To implement the CORC (CAMHS Outcome Research Consortium) expanded protocol across all CAMHS services within the directorate for every new patient referred.	2. The expanded CORC protocol has been implemented.
3. To pilot the new outcome measures within the Learning and Complex Disabilities Service (LCDS), the Under Fives Service and the Fostering and Adoption Service.	3. LCDS are participating in a national programme to develop the CORE-LD (Clinical Outcomes for Routine Evaluation - Learning Disabilities). The Under 5's and Fostering and Adoption pilots are in progress.
4. To improve data collection in CAMHS across an agreed range of domains.	4. This had been achieved for all of the main CAMHS services/teams by Q2 2010/11.

1. Following on from the achievements last year, the CORC (CAMHS Outcome Research Consortium) protocol has now been implemented across CAMHS, requiring services and teams to utilise the SDQ, C-GAS and Goal-Based Measure as part of the routine Outcome Monitoring Programme. This is in addition to the CHI-ESQ (Experience of Service Questionnaire), which is used to gather information about patient's experience. An improvement in the patient return rates has been achieved for the SDQ and the C-GAS/PIR-GAS compared to previous years. This increase in return rates has been particularly noticeable is for the pre-assessment phase where, rather than posting the pre assessment monitoring forms, they are now handed to the young person and parent/carer to complete while in the waiting



room prior to their appointment. Further work is required to increase the return rates for the Goal-Based Measure. Since the implementation of the new electronic patient administration system (RiO) in November 2010, it has not been possible to accurately track the goal-based measure as there is no outcome monitoring tracking facility incorporated within RiO. However, manual data collection at the end of Q2 indicates that the return rate is approximately 21%.

2. The CORC (expanded) protocol is now used for every new patient referred.

3. The *Learning and Complex Disabilities Services (LCDS)* have been participating in a four year national programme to develop the CORE-LD. The priority for Phase one of the pilot was to ensure that the questionnaire covered all domains, while also assessing the readability and usability of the measure. Phase two ran from September 2008 to July 2010 and incorporated data gathering from clinical use. The LCDS contributed data from 14 patients to the study and are currently awaiting the results from phase two to be published in early 2011.

The *Under Fives Service* is currently piloting a series of outcome measures: The Goal-Based Measures, the PIR-GAS, and the CGAS, according to age, at time 1 and 2. As there are no standard outcome measures for babies under 18 months, the Service is piloting the BCL (Behaviour Checklist) as an OM. The PSI (Parenting Stress Index) is also included at times 1 and 2. In addition, the Service has devised 2 forms: Parent Evaluation Form (times 1 and 2), and the Clinician Evaluation Form (times 1 and 2), which is hoped will provide more information about the intervention process, and its efficacy.

The *Fostering and Adoption Service* are piloting The Assessment Checklist for Children (ACC) (Tarren-Sweeney). Further work is planned in order to evaluate the results, before considering wider implementation.

4. The information required for the CAMHS dataset was collected for all of the children and young people attending the main CAMHS services/teams in Q1 and 2 2010/11.

Table 1: Outcome Monitoring Returns – CAMHS

Department	Outcome Monitoring Instrument	Completed By	Outcome Monitoring Returns for	Treatment Stages			
				Pre-assessment	Post-assessment	6m	End of Treatment
Child and Family (including North and South Camden)	Self report SDQ	Young persons (Age 11 - 17)	2008/09	50.00%	N/A	27.27%	0.00%
			2009/10	21.43%	N/A	43.75%	0.00%
			2010/11 (Q1 & Q2)	65.31%	N/A	20.78%	2.78%
	Parent and Teacher SDQ	Parents / Carers and Teachers	2008/09	68.38%	N/A	40.17%	25.00%
			2009/10	41.32%	N/A	39.36%	29.41%
			2010/11 (Q1 & Q2)	65.97%	N/A	33.02%	18.80%
Child and Family (including North and South Camden)	CGAS (age 4 - 16)	Therapist	2008/09	N/A	63.98%	50.00%	78.13%
	PIR-GAS (under 4's)		2009/10	N/A	71.43%	51.06%	76.67%
			2010/11 (Q1 & Q2)	N/A	62.39%	57.14%	80.68%

In summary, for Q1 and Q2, there has been an improvement in the return rates for the majority of outcome measures, compared to previous years. We have been successful in rolling out the CORC protocol to all the relevant CAMH services and teams, and in gathering all the relevant information required for each patient attending our Service, and we have begun to pilot the use of new specialised outcome measures.

### Priority 1.2: Clinical Outcome Monitoring - Adult Outcome Monitoring Programme

Targets for 2010/11	Progress
<b>1. Clinical Outcome Monitoring</b>	
<b>1.2 Adult Outcome Monitoring Programme:</b>	
1. To further increase the return rates of forms from patients in the Adult Department.	1. Return rates from patients have largely remained consistent throughout Q1 and Q2 2010/11.
2. The data from the new outcome measures currently being piloted within the Adult Brief Therapy Service will be evaluated.	2. Data from the PHQ-9, GAD-7 and the WASAS is being collected for 2 groups of patients within this Service.

1. The outcome measure used by the Adult Department is the CORE (Clinical Outcomes for Routine Evaluation) system. Although the return rates have remained consistently high over the past few years at the pre-assessment stage with over 90% return rate, it was hoped that a change in the protocol, would help to increase the return rates at the post-assessment stage where, rather than post the forms, clinicians hand the CORE forms to patients. However, the response rates in Q1 and Q2 of 2010/11 have largely remained consistent with previous years, except for the end of treatment return rates which have dropped by 4% to 46.7%. It is believed that the reason for this slight decrease in the return rate is due to data capturing difficulties resulting from the implementation of a new electronic patient records system (RiO) in November 2010, and the transfer over from the previous patient activity system, CareNotes. As a consequence, any outcome monitoring forms distributed during Q1 and Q2 2010/11, but returned after this period, will not have been captured as it is not possible to record this return on RiO.

2. In the Adult Brief Therapy Service three new outcome measures (PHQ-9, GAD-7 and the WASAS) have been selected for use in evaluating this service along with a client satisfaction questionnaire. These are currently being piloted in the Service with Interpersonal Therapy and Brief Psychotherapy with a small sample of patients to help evaluate these therapies and benefits for patients presenting with anxiety and depression.

Table 2: Outcome Monitoring Returns - Adult

Department	Outcome Monitoring Instrument	Completed By	Outcome Monitoring Returns for	Treatment Stages		
				Pre-assessment	Post-assessment	End of Treatment
Adult	CORE	Adult patients	2008/09	94.96%	56.10%	51.06%
			2009/10	99.53%	55.68%	50.68%
			2010/11 (Q1 & Q2)	96.92%	55.77%	46.67%
Adult	CORE Therapy Post Assessment Form	Therapist	2008/09	N/A	93.70%	91.88%
	CORE End of Therapy Form		2009/10	N/A	78.65%	86.47%
			2010/11 (Q1 & Q2)	N/A	83.33%	79.25%

In summary, the return rates of the CORE outcome measure for the Adult Department have remained consistent with previous years, and three new outcome measures, along with a client satisfaction questionnaire are currently being piloted for possible use as part of the Brief Therapies Service.

## Priority 2: Access to clinical service and health care information for patients and the public

Targets for 2010/11	Progress
<b>2. Access to Clinical Service and Health Care Information for Patients and Public</b>	
1. In 2009 the Trust website was redesigned to ensure it provided the appropriate access to information. After the site has been live for a year a survey will be conducted through the Members' Newsletter to check that the site is functioning as it should.	1. This survey will be included in the April 2011 Members' Newsletter.
2. The Communications Team will prepare 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. Final amendments to the leaflets are in the process of being completed and the leaflets will be published in February 2011.
3. Following a consultation with People First, the Trust will develop information leaflets suitable for people with learning disabilities and will make these available from 2010/11.	3. These leaflets have been produced.

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 and, in response to feedback from patients, to ensure that the website was organised around the typical questions asked by patients (and our student users). 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. Now that the site has been live for one year the Trust plans to conduct a further survey through the Members' Newsletter in April 2011 to ensure that the site is functioning as planned.

In October 2010, Camden's new children's emotional well-being website was launched. The Project was led by the Trust PPI Lead, supported by Camden PCT and the Local Authority, and included the involvement of other Trust staff.

2. The Communications Team has prepared a series of downloadable leaflets on Life Issues which offer information and advice in relation to common issues encountered across the life span. The series is due to be launched in February 2011 and will make a contribution to promoting public health and well-being.

3. Following a consultation with People First, the Trust has developed information leaflets suitable for people with learning disabilities.

In summary, the redesigned website has been live for a year. In that time, patients have been invited to provide feedback, which have led to further improvements. However, a more comprehensive survey is planned for April 2011. In addition, Camden's new children's emotional well-being website was launched in October 2010. The series of downloadable leaflets on Life Issues will be available from February 2011, and the Trust has developed information leaflets suitable for people with learning disabilities.

### Priority 3: Improvements to the built environment and facilities

Targets for 2010/11	Progress
<b>3. Improvements to the Built Environment and Facilities</b>	
1. To conduct a survey of the improvements to the built environment and facilities.	1. A survey will be included in the April 2011 Members' Newsletter.
2. To maintain a rolling programme of refurbishments, and plans for improvements to the use of the external spaces.	2. The refurbishments are ongoing.

1. In 2009 the Trust focused on the 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, with many patients giving positive feedback about the 'feel' of the building and praise for the artwork.

Further feedback was obtained following the completion of the refurbishment. 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 ground floor areas looked better. In addressing the concerns raised in the post-refurbishment survey, plants and soft furnishing has been added to the waiting area along with a frosted glass screen. In addition, the lighting has been softened in the ground floor corridor and some of the artwork changed. There have been various other improvements made to the building, such as increased capacity of toilet facilities, including access to disabled toilet and shower facilities, more efficient lighting and light sensors have been installed throughout many areas of the building and the seminar room doors have been made acoustically and thermally efficient. Surveys are planned on a yearly basis to ensure that regular feedback on the environment and facilities is obtained. The next survey will be included in the Members' Newsletter in April 2011.

2. As the Patient and Public Involvement (PPI) Lead is a member of the Trust's Design Advisory Group, this 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 on an on-going basis.

In summary, the Trust is engaged in obtaining on-going feedback from patients, Governors, Members and others regarding the physical environment and facilities, and taking forward various improvement programmes in response to the feedback received.

#### Priority 4: Patient and Public Involvement

The Trust places great importance in patient and public involvement and aims to elicit feedback from as wide a range of our service users as possible, including patients and their families, students and professionals who attend conferences and courses. Over the last year we have had the opportunity to be more systematic in our approach to the consideration of patient experience through the Quality Improvement Programme.

The patient and public involvement team consists of PPI leads for all departments within the Trust, representatives from central services, training, education services and research. There are three patient and public involvement representatives from the patient/ local public population as well as two Governors and a Non-Executive

Director. There is a close link with the Communications Team to ensure that communications with patients and the public are optimised.

Targets for 2010/11	Progress
<b>4. Patient and Public Involvement</b>	
1. Complete a stakeholder consultation on the quality of our clinical services in liaison with the Patient and Public Involvement Committee.	1. This process has already begun with one meeting taking place in September 2010 and another planned for February 2011.
2. Complete and report on consultations involving patients and carers.	2. To date we have obtained feedback from patients and carers on RiO. The next planned consultation will be around issues concerning consent.
3. Develop and evaluate more creative ways of obtaining feedback.	3. To plan an 'open meeting' as soon as the new PPI Psychology Assistant is in post.

1. In liaison with the PPI Committee, the Trust Director, PPI Lead and the Quality Standards and Reports Lead completed a Stakeholder Consultation in September 2010 with patient and public representatives, exploring the ways the Trust could improve the quality of its clinical services. The main three areas which were discussed included the need for patients to be provided with adequate information about the treatments/therapies offered by which ever service the patient attends; the possibility of patients being offered a follow-up appointment, to help evaluate the outcome of treatment; and the different aspects of the patient experience from the time they walk into the building until the time they leave. It was agreed that the issues explored would be considered further by the Trust, along with the PPI Team, and followed up at the next Stakeholder Consultation meeting planned for February 2011.

2. Over the past year, The Patient and Public Involvement Team (Committee) have been consulted about various initiatives, including patient information leaflets, updating the Trust website, developing a scheme to fund membership projects and also for feedback following the implementation of these initiatives. In addition, the PPI Team has obtained feedback from patients and carers on RiO (electronic patient record system), and the Trust is currently seeking feedback on the various issues around consent.

3. The plan to develop more creative ways of obtaining feedback, including themed open meetings is to be taken forward by the new PPI Psychology Assistant, who will be in post in February 2011.

In summary, over the past year the Trust has undertaken a series of stakeholder consultations around improving the quality of clinical services; the PPI Team has obtained feedback from patients and carers on RiO (electronic patient record system), and is currently seeking feedback on the issues around consent, and when the new Psychology Assistant is in Post in February, he will take forward the plan to develop more creative ways of obtaining feedback.



## Priority 5: Maintaining a High Quality Effective Workforce

The Trust performed extremely well in the most recent staff survey which was conducted in 2009, and showed better than average scores for a large number of survey questions especially those relating to staff job satisfaction; staff recommending the Trust as a place to work and receive treatment; staff motivation; being able to use flexible work options; the Trust's commitment to work-life balance, and with staff feeling that they are able to contribute towards improvements at work. In fact in many areas the results show that The Tavistock and Portman NHS Foundation Trust ranks in the top 20% of mental health trusts.

There has also been an increase in the number of staff taking part in the survey as compared with previous years, with the Trust having a response rate of 57% in 2009, compared with a national response rate of 55%. The Trust's response rate in 2008 was 55% and 53% in 2007. The 2009 results also show improvements in nearly all areas with a higher number of positive responses overall, compared with 2008.

Targets for 2010/11	Progress
<b>5. Maintaining a High Quality, Effective Workforce</b>	
1. To put in place a range of measures to reduce work related stress.	1. Training has been provided to staff on time and workload management, along with stress awareness training and briefing sessions.
2. 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.	2. A comprehensive action plan was developed in response to the Annual Staff Survey, where many of the actions identified have been completed, and other actions are in the process of being completed.

1. There has been an improvement in the 2009, compared to the 2008 Staff Survey, with fewer staff reporting that they work extra hours for the Trust, but also a reduction for the percentage of staff reporting work-related stress, with 26% of staff reporting this in the 2009 Staff Survey, compared to 46% in 2008. However, the Trust continues to remain committed to providing support to staff to maintain their health and well-being, as a consequence, some of the initiatives arising from the 2008 Staff Survey have been carried forward to 2010. These have included providing staff with time and workload management and stress awareness training and briefing sessions. In response to one of these workshops "Managing Pressure Positively", the feedback was largely positive, ranging from 6-9, in responding to the question: 'From a scale of 1 to 10 how confident and motivated do you feel in taking these steps with 10 being very motivated and confident?'. Some of the feedback indicated that there was "not enough time to cover all the topics", but other feedback included the staff member stating that they would "Tackle difficulties, with more confidence and conviction than I am currently experiencing".

2. The Trust is also very committed to maintaining a well-trained and flexible workforce. The Trust performed particularly well on the 2009 Staff Survey for the section of the survey related to staff training and the support provided from the line management structure for staff, with the Trust ranking in the top 20% of mental health trusts for most of the questions. In the past year, as part of the comprehensive action plan developed in response to the 2008 Staff Survey, the Trust has provided appraisal training for managers, providing an extended Management Development Program for middle and senior managers and training in improving communication. The use of Personal Development Plans (PDPs), which in 2009/10 were completed for 93% of staff, has contributed to the identification of training needs for the majority of staff and enabled the Trust to establish a coherent training programme for 2010/11, which is relevant to the needs of its staff group.

Table 3: Staff Survey Feedback

	2008	2009
Percentage of staff working extra hours	84%	75%
Well-structured appraisals received	34%	49%
Work-related stress	46%	26%
Job satisfaction	-	3.98*
Recommend the Trust as a place to work and receive treatment	-	4.30*

\*Scale is from 1-5. 1 is a low score and 5 is a high positive score.

In summary, the trust has provided providing staff with time and workload management and stress awareness training and briefing sessions, which has helped to reduce work-related stress reported by staff. In addition, a Management Development Program has been put in place for middle and senior managers, along with training for conducting appraisals and improving communication.



### 2.1.2 Quality Priorities for 2011/12

It is clear from the span and the number of quality priorities achieved for 2010/11, that the Trust is both committed to quality improvement at every level of service delivery, and for all Trust staff to be involved in its quality improvement initiatives.

Feedback from patients is essential for the process of selecting quality priorities for 2011/12. Patient surveys, information from the Experience of Service Questionnaire completed with patients, feedback from the PPI Team, and consultation with stakeholders and with Camden LINKs, has been an important part of the process for selecting the priorities this year. In addition, we have been actively involved in seeking contributions from our Board of Directors, the Board of Governors, staff and members as part of this process, along with our commissioners when agreeing CQUIN targets for 2011/12. Liberating the NHS: Greater Choice, Greater Control (DoH, 2010), with its focus on patient experience, choice and outcomes has been important for determining our direction of travel. In addition, the recent MIND et al survey, 'We Need to Talk: Getting the Right Therapy at the Right Time' (MIND, 2010) has pointed to the enhanced perceived helpfulness of treatments where choice was available.

In response to the feedback we have received over the year to our 2010 Quality Report, we have decided to refine our priorities for 2011/12. However, this is not to say that the priorities identified in previous years for quality improvement will be dropped. For example, where improvement to the built environment and facilities had been identified as a priority for 2009/10 and 2010/11, it is clear that there are now structures and systems in place to oversee the plans for on-going maintenance and improvements to the building and facilities.

The Trust is able to offer some choice of when and where patients may be seen and increasingly a wider range of treatments are available. During the year, a consultation with a group of stakeholders, including patients, led to the Trust taking further action to ensure that patients are aware of and understand the range of treatments available and suitable for different patient problems

This includes our plan to revise our information leaflets and work further on issues of consent, capacity and confidentiality. This is a priority which has been identified for the coming year, where training will be developed for staff to increase their capacity to present and identify choices with patients.

The PPI Team are keen to develop relationships between governors and members of the foundation trust. This will be a key priority for work over the coming year. We aim to do this through encouraging members and patients to contribute to the members' newsletter and to increase the numbers of events that patients and public attend and contribute to.

In 2011-12 we plan to develop and evaluate more creative ways of obtaining feedback from the patients, the public and carers.

Targets for 2011/12	
1. Clinical Outcome Monitoring	2. Access to Clinical Service and Health Care Information for Patients and Public
<b>1.1 CAMHS Outcome Monitoring Programme:</b>  1. Achieve robust return rates for time 1 and time 2 (at 6 months) for goal-based measures.  2. Determine the percentage improvement rate.  3. Improve return rates on the CHI-ESQ.	1. <b>TBC</b> following receipt of feedback from survey in April 2011.  2. <b>TBC</b> - To obtain feedback on the downloadable leaflets on Life Issues launched on the Trust Website in 2011.
<b>1.2 Adult Outcome Monitoring Programme:</b>  1. To further increase the return rates of forms from patients in the Adult Department.	3. Patient and Public Involvement
	1. Continue with stakeholder consultations to assess the quality of our clinical services in liaison with the Patient and Public Involvement Committee.  2. To continue to complete and report on consultations involving patients and carers.  3. Continue to develop and evaluate more creative ways of obtaining feedback.

## 2.2 Statements of Assurance from the Board

During 2010/11 The Tavistock and Portman NHS Foundation Trust provided and / or sub-contracted four NHS services.

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

The income generated by the NHS services reviewed on 2010/11 represents x% (to be provided in May 2011) of the total income generated from the provision of NHS services by The Tavistock and Portman NHS Foundation Trust for 2010/11.

### Participation in Clinical Audits and National Confidential Enquiries

During 2010/11 x (TBA) national clinical audits and x (TBA) national confidential enquiries covered NHS services that The Tavistock and Portman NHS Foundation Trust provides.

During 2010/11 The Tavistock and Portman NHS Foundation Trust participated in x% (TBA) national clinical audits and x% (TBA) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust was eligible to participate in during 2010/11 are as follows: (list TBA)

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust participated in during 2010/11 are as follows: (list TBA)

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust participated in, and for which data collection was completed during 2010/11, 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 (list and %s TBA).

The reports of x (TBA) national clinical audits were reviewed by the provider in 2010/11 and The Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (description of actions TBA).

The reports of x (TBA) local clinical audits were reviewed by the provider in 2010/11 and The Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (description of actions TBA).

### **Participation in Clinical Research**

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 36.

### **The use of the CQUIN Framework**

A proportion of The Tavistock and Portman NHS Foundation Trust's income in 2010/11 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 2010/11 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](mailto:rbonner@tavi-port.nhs.uk); postal address: The Tavistock and Portman NHS Foundation Trust, 120 Belsize Lane, London, NW3 5BA).

The total financial value was £7.8m and the Trust expects to receive 100% of the £118k that is available. However, this is only a forecast and the achievement of goals requires ratification at year end.

### **Registration with the Care Quality Commission (CQC) and Periodic / Special Reviews**

The Tavistock and Portman NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is full registration without conditions, for a single regulated activity "treatment of disease, disorder or injury"

The Care Quality Commission has not taken enforcement action against The Tavistock and Portman NHS Foundation Trust during 2010/11.

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

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

### **Information on the Quality of Data**

The Tavistock and Portman NHS Foundation Trust did not submit records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The Tavistock and Portman NHS Foundation Trust score for 2010/11 for Information Quality and Records Management, assessed using the Information Governance Toolkit was X (submission of Trust self assessment due end March 2011).

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

## Part 3: Other Information

### 3.1 Quality of Care Overview: Performance against selected indicators

The quality metrics that we have selected to measure the performance of The Tavistock and Portman NHS Foundation Trust are incorporated within the three quality domains of patient safety, clinical effectiveness and patient experience. These indicators include those reported in the 2009/10 Quality Report along with metrics that reflect our quality priorities for both 2010/11 and 2011/12. In addition we have highlighted other indicators outside of our priorities that the Trust is keen to monitor and improve.

#### 3.1.1 Patient Safety Indicators

Quality Domain	Indicator	2008/09	2009/10	2010/11 (Q1 & Q2)
Patient Safety	NHS Litigation Authority Level	-	Level 1 with 100% pass rate	Assessed for Level 2 in Feb '11
	<b>Incidents*:</b>			
	All reported incidents	187	264	163
	Patient Safety Incidents	0	53	21
	Monitoring of Adult Safeguard Alerts	-	2	4
	Electronic Recording of Children in Need	-	-	**
	Attendance at Trust Wide Induction Days	66%	85%	56%
	Attendance at Local Induction	-	-	31%
	Attendance at Mandatory Training***	-	36%	64%
	Safeguarding of Children - Level 3 Training	-	94%	82%

\* Please note that in the 2009/10 Quality Report due to a data definition error the number of incidents reported related to 'all incidents' and not 'patient safety' incidents. This error has been corrected in the table above.

\*\* The Trust has introduced RiO as an administration system. Within RiO it has not been possible to establish an electronic recording system for 'children in need'. We are investigating alternative solutions.

\*\*\* Staff are expected to attend training every 2 years. In order to achieve this 100% attendance is expected over a 2 year period.

#### 3.1.1.1 NHS Litigation Authority Level

In March 2011, the NHS Litigation Authority (NHSLA) awarded the Trust a Level 2 for demonstrating compliance with its policies and procedures covering all aspects of risk management. This assessment is valid for three years.

#### 3.1.1.2 Patient Safety Incidents

In this report the Trust has taken the definition of 'patient safety incident' to be an incident reportable to the National Patient Safety Agency (NPSA) data base National Reporting and Learning System (NRLS).

The Trust has a very low 'patient safety incident' rate due to the nature of its patient services. The vast majority of the reportable incidents have occurred in the Trust's Specialist Children's Day Unit which includes a school for children with emotional difficulties and challenging behaviour.

Prior to April 2009 the Trust, in consultation with the NPSA, did not update any 'patient safety' incidents to NRLS. Following a discussion with the NPSA in mid 2009 it was agreed that the Trust would begin to upload incidents. The NPSA requested that all 'pupil to pupil' violent behaviour and patient accident incidents were uploaded and these make up almost all the incidents uploaded since April 2009.

The total reported incidents (both clinical and non-clinical) rose in 2009/10, and is on track to rise again in 2010/11 which is considered to be as a result of a general increase in awareness of incident reporting across the Trust, rather than any change in the type or rate of incidents being experienced.

To date in 2010/11 the Trust has not had an incident that has rated more than 8 on the Trust risk matrix, i.e. all incidents have been rated as suitable for no further action or for local review only, and non have triggered an investigation under the Trust's serious investigation procedure.

The Trust continues to promote incident reporting at the Trust-wide Induction, INSET and other risk training events.

#### 3.1.1.3 Monitoring of Adult Safeguards

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 implementation of various education and awareness initiatives, such as the mandatory training provided at the annual Trust INSET day and via induction and team meeting presentations, which ensures that the alert process is

communicated within the Trust. Also, the Clinical Incident Report Form has now been made available on the Trust Intranet, and the permanent position of Vulnerable Adults Advisor has been recruited in early 2011.

#### 3.1.1.4 Attendance at Trust-wide and Local Induction Days

For 2010/11 the Trust has two targets for induction days which is to achieve a high level of attendance of over 75% at both Trust-wide and local inductions.

A possible reason for the drop in attendance during Q1 and Q2 2010/11 is because there are only a limited number of induction days held per year, so new starters are waiting to attend the next available day. A truer reflection of the attendance rate will be evidenced at year end.

#### 3.1.1.5 Attendance at Mandatory Training

The Trust provides its main mandatory training update via its In-Service Education and Training (INSET) day, which staff are required to attend every two years. At the INSET day, staff receive training updates in risk management and assessment, health and safety, infection control, confidentiality and Caldicott guidance, equality and diversity, information governance, safeguarding children level one, safeguarding adults and fire safety.

#### 3.1.1.6 Safeguarding of Children

The trust has made it mandatory for all staff from CAMHS and the Adolescent Directorate to be trained in Safeguarding of Children Level 3. All staff are offered training as required and their attendance is monitored.

A possible reason for the drop in attendance during Q1 and Q2 2010/11 is because one of the training events had to be cancelled, as consequence some staff are waiting to attend the next scheduled training event day. A truer reflection of the attendance rate will be evidenced at year end.

### 3.1.2 Clinical Effectiveness Indicators



Quality Domain	Indicator	2008/09	2009/10	2010/11 (Q1 & Q2)
Clinical Effectiveness	Monitor number of staff with Personal Development Plans	92%	93%	Data available March 2011
	<b>Range of treatment modalities:</b>			
	Systemic Psychotherapy	✓	✓	✓
	Psychodynamic Psychotherapy	✓	✓	✓
	Interpersonal Therapy (IPT)	X	✓	✓
	Dynamic Interpersonal Therapy (DIT)	X	✓	✓
	Mentalisation Based Therapy (MBT)	TBA	✓	✓
	Family and Schools Together (FAST)	X	✓	✓
	Eye Movement Desensitisation and Reprocessing (EMDR)	✓	✓	✓
	Relationship Development Intervention (RDI)	TBA	✓	✓
	Cognitive Behavioural Therapy (CBT)	✓	✓	✓
	<b>Outcome monitoring returns:</b>			
	Child and Family	See Section 2.1.1 (Priority 1.1), Table 1		
	Adolescent	See Section 3.1.2.3, Table 4		
	Adult	See Section 2.1.1 (Priority 1.2), Table 2		
	Portman	See Section 3.1.2.4, Table 5		

### 3.1.2.1 Monitor Number of Staff with Personal Development Plans

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.

The number of staff with personal development plans in 2009/10 was 93%, a slight increase on the 92% achieved for the previous year. For 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.

### 3.1.2.2 Range of Treatment Modalities

Over the years the Trust has increased the range of treatments available, which enables us to offer therapies to a greater range of patients, and also offer a greater choice of treatments to all of our patients. Amongst the therapies we offer are Interpersonal Therapy (IPT), Dynamic Interpersonal Therapy (DIT) and Cognitive Behaviour Therapy (CBT), which have been approved as appropriate treatments to offer within the Improving Access to Psychological Therapies (IAPT) programmes.

During the past year, there has been the opportunity to embed some of the new therapeutic approaches. Leading on from this, our priority for next year will be to train staff to increase their capacity to present and identify choices with patients, when patients are offered a range of treatments and therapies.

### 3.1.2.3 Outcome Monitoring Returns – Adolescent

Table 4: Outcome Monitoring Returns – Adolescent

Department	Outcome Monitoring Instrument	Completed By	Outcome Monitoring Returns for	Treatment Stages						
				Pre-assessment	Post-assessment	6m	12m	18m	24m	End of Treatment
Adolescent	YASR / YSR	Young persons (age 12 - 30)	2008/09	86.52%	20.74%	14.42%	14.81%	20.69%	12.00%	14.29%
			2009/10	98.37%	17.71%	13.48%	13.11%	22.22%	11.11%	10.34%
			2010/11 (Q1 & Q2)	95.35%	15.28%	15.58%	11.54%	30.56%	12.12%	9.52%
	CBCL / YABCL	Significant other	2008/09	82.52%	14.84%	15.53%	14.81%	17.24%	10.00%	11.11%
			2009/10	95.40%	14.11%	13.64%	11.48%	17.78%	8.33%	3.70%
			2010/11 (Q1 & Q2)	84.21%	16.92%	15.58%	7.69%	25.00%	12.12%	9.09%
Adolescent	YABCL (over 18)	Therapist	2008/09	N/A	36.21%	38.83%	38.27%	35.59%	28.00%	48.72%
	2009/10		N/A	29.01%	35.23%	31.15%	33.33%	27.78%	31.82%	
	2010/11 (Q1 & Q2)		N/A	43.86%	36.36%	46.15%	27.78%	21.21%	36.84%	

As indicated in the 2010 Quality Report, the Adolescent Directorate is planning to introduce some new outcome monitoring measures in order to encourage more young people to provide feedback on their mental well-being and increase the rate of returns.

The return rates recorded for Q1 and Q2 for the young people completing the outcome measures was roughly in line with previous years. However, for therapists there was seen to be a slight improvement in the completion of forms at the post-assessment phase. This is thought to be as a consequence of the Adolescent Outcome Monitoring Team working closely with clinicians to encourage them to complete and return the OM forms.

### 3.1.2.4 Outcome Monitoring Returns – Portman

Table 5: Outcome Monitoring Returns - Portman

Department	Outcome Monitoring Instrument	Completed By	Outcome Monitoring Returns for	Treatment Stages		
				Pre-assessment	Post-assessment	End of Treatment
Portman	CORE	Adult patients	2008/09	73.17%	46.15%	18.75%
			2009/10	73.33%	38.24%	12.50%
			2010/11 (Q1 & Q2)	60.00%	53.80%	16.67%
Portman	CORE Therapy Post Assessment Form	Therapist	2008/09	N/A	77.05%	16.67%
	CORE End of Therapy Form		2009/10	N/A	43.59%	0.00%
			2010/11 (Q1 & Q2)	N/A	60.00%	20.00%

As indicated in the 2010 Quality Report, there are limitations to using the CORE as a measure of outcome for a forensic population receiving psychotherapeutic treatment, particularly because of the concerns about the low return rates from both clinicians and patients of completed forms at the end of treatment stage.

For this reason, as part of the CQUINs framework, the Portman has been piloting the use of the Shedler-Western Assessment Procedure (SWAP) with adults. Although the patients numbers have been small, the return rate was 100% at the end of Q2 in 2010/11.

However, there was seen to be a noticeable improvement, at least for Q1 and Q2 in 2010/11 for the completion of forms by patients and clinicians at the post-assessment stage, when compared to the 2009/10 return rates.

In conclusion, from reviewing the outcome monitoring returns for the different services, there is evidence of inconsistencies in the outcome monitoring data. This is due to several reasons.

1. Due to annual changes in the way in which the data is calculated. In 2008/09 the initial numbers are high but we had no method of counting the actual patient cohort and so we were only logging the returns. As a result it is probable that the return rate was overestimated.

2. It is believed that the reason for the slight decrease in some of the return rates for Q1 and Q2 in 2010/11 is due to data capturing difficulties resulting from the implementation of a new electronic patient records system (RiO) in November 2010, and the transfer over from the previous patient activity system, CareNotes. As a consequence, any outcome monitoring forms distributed during Q1 and Q2 2010/11, but returned after this period, will not have been captured as it is not possible to record this return.

3. Throughout the treatment stages the attrition is such that low sample sizes are included, which means that one form can have a large impact on the return rates.

It is also important to note that the new electronic patient records system (RiO) does not include an outcome monitoring tracking facility. As a result, this presents a risk for Q3 and Q4 2010/11 as it is not currently possible to systematically monitor the return rates and thus compare accurately with previous years.

### 3.1.3 Patient Experience Indicators

Quality Domain	Indicator	2008/09	2009/10	2010/11 (Q1 & Q2)
Patient Experience	Complaints received	8	9	8
	<b>Patient feedback:</b>			
	Patients rating care 'excellent' / 'very good' / 'good'	-	70%	Data available March 2011
	Patients who felt they were listened to and treated with respect and dignity	-	73%	Data available March 2011
	Patients who would recommend the Trust	-	69%	Data available March 2011
	Patients rated the Trust's facilities as very good or good	-	82%	Data available March 2011
	Positive feedback received about the environment	-	60%	Data available March 2011
	<b>DNA rates:</b>			
	First Attendances	9.5%	8.8%	9.3%
	Subsequent Appointments	10.4%	10.4%	10.9%

#### 3.1.3.1 Complaints Received

In 2010-11 a total of \*\* formal complaints were received. In accordance with the complaints procedure, all formal complaints were investigated by the complaints manager, in conjunction with the relevant Director, and the final response reviewed and signed by the Chief Executive.

In 2010-11 no complaints were referred by patients to the Ombudsman.

#### 3.1.3.2 Patient Feedback

The feedback from patients, as summarised above, was reported in the 2009/2010 Quality Report. The next patient survey is due to be distributed in Q4 2010/11. The results will be available for the 2010/11 year end.

### 3.1.3.3 DNA Rates

Compared with other mental health trusts, where the DNA (Did Not Attend) rate historically falls at around 14%, the DNA rate for patients for Q1 and Q2 in 2010/11 is below average, and does not exceed the 11% upper limit. However, the DNA

rates for both first attendances and subsequent appointments have increased slightly from 2009/10. In addition, for some of the services the DNA rates exceed 11%. This will require further investigation, especially if we consider that DNA rates can be regarded as a rough indication of patient's satisfaction with their care. But also, high DNA rates can be seen to represent a misuse of NHS resources.

## 3.2 Performance against Key National Priorities and National Core Standards

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

With regard to the mental health indicators on data completeness, the Trust does not expect to comply with the indicator on data identifiers. The Trust is taking steps to improve data quality in 2010/11, particularly with regard to the collection of marital status.

The Trust complies with requirements regarding access to healthcare for people with a learning disability.

The Tavistock and Portman NHS Foundation Trust declared full compliance with all 26 Essential Standards to the 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.

## **Part 4: Statements from our local PCT Alliance, LINKs and Overview and Scrutiny Committee**

draft