The Tavistock and Portman **NHS**

NHS Foundation Trust

Board of Directors

Agenda and papers
of a meeting to be held

2.30pm – 4.30pm
Tuesday 27th September 2011

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

Board of Directors
2.30pm – 4.30pm, Tuesday 27th September 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)*   *p.1*
                                                 For approval

4. Matters Arising

    a. Outstanding Action Update   *(Report attached)*   *p.7*
    Miss Louise Carney, Trust Secretary   *For noting*

Reports & Finance

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

6. Chief Executive's Report   *(Report attached)*   *p.13*
Dr Matthew Patrick, Chief Executive   *For discussion*

7. Finance & Performance   *(Report attached)*   *p.17*
Mr Simon Young, Director of Finance   *For discussion*

8. CQSG Committee Quarter One Report   *(Report attached)*   *p.27*
Dr Rob Senior, Medical Director   *For discussion*

Corporate Governance

9. Audit Committee Terms of Reference   *(ToR attached)*   *p.30*
Mr Richard Strang, Committee Chair   *For approval*

10. Corporate Governance Report   *(Report attached)*   *p.39*
Miss Louise Carney, Trust Secretary   *For approval*

11. Review of Internal Links   *(Report attached)*   *p.44*
Miss Louise Carney, Trust Secretary   *For noting*

12. Review of External Links   *(Report attached)*   *p.49*
Miss Louise Carney, Trust Secretary   *For noting*

Quality & Development

13. Risk Management Strategy   *(Report attached)*   *p.76*
       Dr Rob Senior, Medical Director   *For approval*

14. Health & Social Care Bill Update   *(Report attached)*   *p.109*
       Ms Angela Greatley, Trust Chair   *For discussion*

15. Quality Report Quarter One Review   *(Report attached)*
       Ms Louise Lyon, Trust Director   *For discussion*

Conclusion

16. Any other business

17. Notice of future meetings
       Tuesday 18th October 2011: Directors' Conference (*Strategy*)
       Tuesday 25th October 2011: Board of Directors
       Tuesday 8th November 2011: Directors' Conference (*Plan Review*)
       Tuesday 29th November 2011: Board of Directors
       Thursday 1st December 2011: Board of Governors
       Tuesday 31st January 2012 : Board of Directors
       Thursday 2nd February 2012 : Board of Governors
       Tuesday 28th February 2012 : Board of Directors
       Tuesday 27th March 2012 : Board of Directors
       Tuesday 24th April 2012 : Board of Directors
       Thursday 3rd May 2012 : Board of Governors
       Tuesday 29th May 2012 : Board of Directors
       Tuesday 26th June 2012 : Board of Directors
       Tuesday 31st July 2012 : Board of Directors
       Thursday 13th September 2012 : Board of Governors
       Tuesday 25th September 2012 : Board of Directors
       Tuesday 30th October 2012 : Board of Directors
       Tuesday 27th November 2012 : Board of Directors
       Thursday 6th December 2012 : 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
Meeting Minutes

Part One, 2pm – 4pm, Tuesday 26th July 2011

Present:			
Ms Angela Greatley Trust Chair	Mr Martin Bostock Snr Independent Director	Ms Lis Jones Nurse Director	Ms Trudy Klauber Dean
Ms Louise Lyon Trust 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	Dr Rita Harris CAMHS Director (item 9)	Dr Sally Hodges CAMHS Associate Director (item 9)	Dr Jessica Yakeley Associate Medical Director (item 10)
Apologies:			
Mr Altaf Kara Non-Executive Director			

Actions

AP	Item	Action to be taken	Resp	By
1	**3**	Miss Carney to amend minutes	**LC**	**Immed**
2	**4**	Directors to provide briefing notes on progress with Outstanding Actions	**All**	**Sep 11**
3	**6**	Dr Patrick to update Board on RiO developments	**MP**	**-**
4	**7a**	Ms Klauber agreed to review the Trust's policy on chasing student debt and ensure it is well-publicised	**TK**	**Sep 11**
5	**7b**	Ms Lyon and Mr Young to investigate 13 patients with no registered GP	**LL/SY**	**Sep 11**
6	**9**	All Service Line Reports to start with executive summary	**All**	**-**
7	**10**	Dr Senior to produce materials to send to commissioners on Trust's services	**RSe**	**Aug 11**
8	**10**	Dr Senior and Ms Lyon to prepare briefing on Any Qualified Provider	**RSe/LL**	**Sep 11**

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

1. Trust Chair's Opening Remarks

Ms Greatley welcomed everyone to the meeting.

2. Apologies for Absence

As above.

3. Minutes of the Previous Meeting

AP1   The minutes were approved subject to some minor typographical amendments.

4. Matters Arising

Ms Greatley noted that, in relation to Action Point 5, Mr Ngoka had circulated information that confirmed that the Trust was required to send the staff survey to all staff, due to its size.

AP2 It was agreed that Directors would provide briefing notes on progress with Outstanding Actions.

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

Angela Greatley, Trust Chair
Ms Greatley had attended a meeting of the Foundation Trust Network's mental health group. Ms Greatley noted that implications of the Health & Social Care Bill on Governors were still unclear.

Martin Bostock, Senior Independent Director
Mr Bostock noted that in his role as Board lead for security, he had met with the Director of Corporate Governance & Facilities, and an external security expert. A report would be presented to the Clinical Quality, Safety, and Governance Committee.

Richard Strang, Deputy Trust Chair
Mr Strang noted that he had asked the Trust's Internal Auditors to prepare a report on the workings of the Audit Committee in the context of the new Audit Handbook. The new Handbook places a great deal of emphasis on aspects other than finance, and the Audit Committee needs to ensure that it is operating appropriately.

6. Chief Executive's Report

Dr Patrick noted that RiO was a big issue for all organisations using the software, and continuity plans needed to be developed for post-2015. The taking on of provider arms presented an added complication. The Trust was pushing for users of RiO to form a consortium to address this issue. Mr Strang queried whether this should have been anticipated. Mr Young noted that the Trust may still be using RiO post 2015, and it was just BT's contract to provide RiO that was terminating. There has to be a procurement process at the end of this contract, and these take a significant amount of time, so the Trust needs to be prepared. Dr Patrick noted that there would be two further updates from BT to the software before 2015. Ms Lyon noted that the Trust's requirements of RiO are growing all the time, and are now very
AP3 different to what they were two years ago. Dr Patrick to update Board on progress as appropriate.

Mr Bostock noted that the Trust has appointed to the Communications Manager role.

The Board noted that the Trust had been listed in the top 19 lead performers from all NHS organisations, as judged by the Health Service Journal.

7. Finance & Performance

7a. Finance & Performance Report

Mr Young noted that the results at Month Three, before allowing for restructuring costs, showed the Trust slightly ahead of budget. Mr Young explained that this includes some non-recurrent and timing factors, and the Trust would still need to work hard to ensure that the Trust is able to deliver on budget for the whole year. Mr Young was expecting us to receive a Financial Risk Rating of 3 for quarter 1.

Mr Young noted that some restructuring costs had come slightly earlier than expected. Of the 24 staff taking voluntary redundancy, most would be leaving in Quarter Two, and savings would start from then. As the Trust was aware of the costs of the voluntary redundancies, accounting standards required the Trust to report them in quarter 1. This meant that the Trust appeared to have a deficit, but as noted when the Annual Plan was approved, this would not be reflected in its Financial Risk Rating.

Mr Young highlighted two main risk areas: making sure that the Voluntary Redundancy Scheme savings were delivered – there was some risk of erosion, but this was not expected to be significant; and ensure that income-generation continues at the same time as restructuring – the Financial Directorate were working with Service Line Directors to ensure they remained focused on this.

Mr Young noted that the Trust's cash balance was significantly below budget. Mr Young did not expect this to be a problem, but noted that the Trust must keep working on this. The low cash balance was in large part due to general debtors. Mr Young explained that the £216k that was being negotiated had now been agreed and would be paid. Ms Klauber noted that results were being withheld from students who had not yet paid their fees. Mr Strang suggested the Trust develop clear stages and methods for chasing student debt, which are clearly publicised. These stages might include personal letters to students, withholding of results, and legal action.

AP4   Ms Klauber agreed to review the Trust's policy on this and ensure it is well-publicised. Ms Klauber noted that the Directorate encouraged students to pay before their course begins, or to pay at least half of their fees in the first term. Ms Klauber noted, however, that many students are very naïve about money and underestimate how expensive studying is. Tutors are now having initial meetings with students to gauge whether they have a realistic understanding of their personal finances before they start their course.

Mr Young clarified that the consultancy fees referred to in paragraph 2.1.3 were for external contractors who were helping to deliver a service, not for consultation about Tavistock Consulting.

Ms Moseley noted the over-performance referred to in paragraph 3.1.1 and queried whether this meant that staff were working for nothing effectively, and if so, what controls and monitoring were in place for this. Ms Lyon confirmed that staff were working without charge, but that there was a steady diminution of the number of cases they were taking on, and liaison with commissioners about this matter. Ms Lyon noted, however, that there was an issue of trainees and training opportunities. Dr Patrick noted that in small units the figures could be easily skewed by a small number of patients.

Ms Lyon also noted that some patients taken on had been waiting for treatment for some time, and this was taken into consideration when agreeing to treat them.

7b. Quarter One Finance, Governance, and Quality Declarations

Mr Young explained that the Trust had 99% data completeness on GP registration, but highlighted that the Trust was reliant on the NHS spine to provide this information. Mr Young noted that 99% reflected 13 patients for whom no GP information was available. Ms Lyon and Mr Young to investigate. Mr Young suggested that some of these patients may be refugees with unsecured residence status in the UK. Ms Moseley queried whether the Trust may decide not to see patients who are not registered with GPs. Mr Young confirmed this was not the case.

AP5

Mr Young highlighted that Monitor expects FTs to aim to comply with all elements of the Compliance Framework; but if in any quarter the Trust could not achieve required levels of data completeness for GP registration, it would only lose ½ mark, and would still achieve a Green Governance Rating.

Mr Strang noted that the Audit Committee was responsible for reviewing the underlying assurances that form the basis of the declarations. The Audit Committee, with the help of the Trust's Internal Auditors, would be looking into what the Committee needs to be in order to be adequately assured. The Board noted that the Audit Committee's relationship with the Clinical Quality, Safety, & Governance Committee was key to understanding assurance.

The Finance, Governance, and Quality Declarations were all approved.

8. Education and Training Report

Ms Klauber noted that recruitment for courses highlighted green in Appendix 2 was on track or better than plan. However, Ms Klauber noted that the Trust's statistics were more reliable this year than in previous years, so this may skew results.

Ms Klauber noted that higher education funding for "soft" sciences (which is what the Trust provides) will be removed by 2014. HEFCE is currently reviewing whether the Trust's research is "soft" (the Trust's Professional Doctorates count as research). The Trust will need to raise its fees in order to counter this reduction in funding.

A manager had been appointed to the E-Learning Unit. The Trust was focusing on developing e-learning for the lower end of the health and social care markets. Ms Moseley queried what the take-up of e-learning was amongst Trust staff noting that it was a significant change in style. Ms Klauber noted that it was a steep learning curve, but the some interest had been generated. Ms Lyon noted that as part of the Trust's Productivity Programme, time had been identified that could be dedicated to e-learning.

Mr Strang queried how the Trust was generating interest in e-learning, highlighting that the paper Ms Klauber had prepared was more focussed on supply rather than demand. Ms Klauber explained that the Trust must have products and resources ready and available before it undertakes a large marketing project. The Open University had offered to undertake a market research exercise on behalf of the Trust. Ms Klauber noted that there was enthusiasm for e-learning, but cautioned that this does not always translate into commission.

Ms Jones noted, with regards to recruitment for D65 that this reflects patterns for other training organisations. Ms Klauber noted that the Trust had attempted to counter this with the creation of a BSc.

9. Service Line Report – Developmental CAMHS

Dr Hodges noted that there was a large structural reorganisation underway in the CAMHS Directorate. The Trust was identifying growth areas, to ensure that it was able to meet demand. However, Dr Hodges noted that developing in new markets requires a great deal of time dedicated to developing relationships with commissioners, which is time consuming, and particularly difficult at the same time as restructuring.

Mr Strang highlighted paragraph 10.1, which noted a decline in other teams' scores in clinical audit. Dr Hodges noted that there was an action plan in place to address this, but also explained that the case note audit was an audit of case note standards, not outcomes.

Dr Hodges clarified that comments in Appendix 1 relate to all points, and apologised for the unclear structure of this.

Ms Moseley queried the relationship between court work and the Monroe Family Assessment Service. Dr Hodges noted that work was underway to try to bring these together.

Ms Moseley queried whether the Trust had any connections with The Place2Be. Dr Harris noted that there were several staff members across the Trust who had connections to The Place2Be, and she was in the process of pulling them all together in a single corporate approach. Dr Harris noted that the Trust also did a lot of work with many different primary schools across the Sector. Dr McPherson suggested that there may be opportunities to combine the Trust's training expertise with schools to focus on early intervention projects.

AP6   Mr Strang commended the executive summary, and the Board agreed this should be rolled out to all Service Line Reports.

10. Payment by Results Implementation

Dr Yakeley noted that the deadline for clustering patients is 31st December 2011, but the Trust hopes to have this completed by the end of September

2011. Dr Yakeley noted that the patients included in the clustering project were adolescents over 18 years of age, adult patients excluding those in the MedNet service, and Portman Clinic patients. Patients in the Learning and Complex Disability Service would not be included in this project. Mr Young noted that Cluster 7 accounts for 25% of the Trust's patients, whereas in many other mental health trusts, Cluster 7 accounted for 2%.

Dr Yakeley explained that all patients are currently subject to a termly review, but this would now occur every sixmonths to coincide with cluster reviews at the end of June and the end of December.

Dr Yakeley noted that PbR implementation wasa large project. Whilst PbR was common for acute services, it had only been trialled once before for mental health services, in Australia, and had failed.

Mr Strang noted that the system appeared to be payment by activity, rather than payment by results. Mr Young explained that tariff-based commissioning was likely to be introduced if PbR is successful. Mr Strang queried the implications on future income for the Trust, noting that tariffs for in-patient mental health services may affect the Trust's specialist status. Dr Patrick explained that the Trust's costs compare favourably with other mental health organisations. Dr Patrick noted that in the acute sector there are adjusted tariffs for specialist services. Ms Moseley queried whether there would be any remuneration difference between psychotic and non-psychotic patients. Dr Yakeley confirmed that there should not be.

Dr McPherson noted the importance of the Trust being proactive in this project because of its a-typical nature.

AP7
AP8
Non-Executive Directors queried how this related to Any Qualified Provider (AQP). Mr Young noted that AQP may in future be extended into Payment by Results, but this would not happen at this stage. Dr Senior noted that the Trust needed to be talking to clinical commissioners about what the Trust *AQP* can offer immediately. Dr Senior to develop materials for GPclinical commissioning groups by the end of September. Dr Senior and Ms Lyon to prepare Board briefing for September.

The Board noted that this was an important project and good progress was being made in its implementation.

11. Any other Business
None.

12. Notice of Future Meetings
Noted.

The Tavistock and Portman **NHS**
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No.	Action	Minutes	Director / Manager	Due Date	Progress Update
1	Ms Lyon to include target date column	*Data Assurance Overview (item 12b, April 2011)* The board commended the format of the report, but suggested Ms Lyon include a target date column	Louise Lyon	Apr-11	We now have action plans and SMART objectives in place for all quality objectives
2	Dr Patrick to update Board of Directors on Big White Wall contract	*Matters Arising (item 4, April 2011)* Mr Strang queried whether the Big White Wall contract had yet been signed. Dr Patrick noted that it had not, but that there were no outstanding matters of substance in dispute. Dr Patrick to update Board of Directors in May.	Matthew Patrick	May-11	The contract was signed on 26th July 2011
3	Ms Moseley to forward Loughton Report to Dr Graham	*Service Line Report - Adolescent Directorate (item 14, June 2011)* Ms Moseley noted Tim Loughton MP had set up a cross-Government group, comprising of Ministers from seven major departments and charity CEOs to look into the needs of vulnerable 16-25 year olds	Joyce Moseley	Jun-11	This was done in July 2011
4	Ms Lyon to liaise with Dr Hodges on communicating Quality Report to patients and public	*Quality Report (item 12a, April 2011)* Dr McPherson suggested that the Trust should take care to explain quality to its patients and the public, and queried how the content of the Report could be communicated in a clear way. Ms Lyon to liaise with Dr Sally Hodges, Patient & Public Involvement and Communications Lead.	Louise Lyon	Jun-11	A notice was published on the Trust's website and across the Trust's building in July 2011 with details of how to access the Quality Report
5	Management to address bullying and harassment in Staff Survey Action Plan	*Equalities Report (item 17, May 2011)* Mr Strang highlighted that the number of staff reporting experience of bullying and harassment was surprisingly high, and suggested that a small organisation such as the Trust ought to have a better handle on this. Dr Patrick noted that this was unacceptable. Trust to address this in next Staff Survey action plan.	Management Committee	Jun-11	

Red denotes actions overdue
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6	Dr Senior to liaise with auditors to align terminology	*Matters Arising (item 4, April 2011)* CQSG Report: Dr Senior presented an updated version of this report, and noted that the language was now consistent throughout. Dr Senior to liaise with auditors to work towards aligning terminology. The report was approved.	Rob Senior	Jun-11	This has been done
7	Mr Young to give consideration to preparing Board paper on performance management	*Operational Risk Register (item 7c, April 2011)* Mr Kara raised the issue of performance management. Mr Young to give consideration to preparing a Board paper on this.	Simon Young	Jun-11	This has not yet been done but is being scheduled
8	Miss Carney to investigate insurance policies for Directors	*Health & Social Care Bill Update (item 8, March 2011)* Mr Strang queried the need for Directors' indemnity insurance in light of the proposed changes. Miss Carney noted that Directors' were probably already covered by the Trust's existing insurance policies, but would investigate further.	Louise Carney	Jul-11	Waiting for final version of Health & Social Care Bill before further work is undertaken
9	Ms Lyon to report back on structure of consultancy work	*Finance & Performance Report (Item 7a, January 2011)* Mr Kara queried the set-up of departmental consultancy and requested a paper on structural issues. Ms Lyon explained that departments and Tavistock Consultancy Service were meeting to consider ways in which to pull the Trust's consultancy work together, mitigating internal competition and re-allocating work. Ms Lyon to report further when details are clearer. Mr Young explained that departmental consultancy was one element within a much bigger market structure and budget, as opposed to TCS, where consultancy was its sole remit.	Louise Lyon	Jul-11	Extensive discussions have taken place on the pros and cons of bringing together all consultancy across the Trust. For the present, it has been decided that Tavistock Consulting needs the freedom to operate independently of the rest of the Trust, especially given the difficult climate in relation to public sector consultancy work. However, mutual cooperation will continue, e.g. where a Trust consultant outside Tavistock Consulting may be asked to work on a TC project, and vice versa.
10	Ms Lyon to provide quarterly updates on the Quality Report	*Quality Report (item 12a, April 2011)* Ms Lyon agreed to provide quarterly updates on the Quality Report.	Louise Lyon	Jul-11	A report on progress on quality priorities is being presented to the Board of Directors in September 2011. The Quarter One quality workstream report to the CQSG Committee outlined progress on preparing the 2011/12 quality report.

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11	Dr Senior to produce materials to send to commissioners on Trust's services	*Payment by Results Implementation (item 10, July 2011)* Non-Executive Directors queried how Payment by Results related to Any Qualified Provider (AQP). Mr Young noted that AQP may in future be extended into Payment by Results, but this would not happen at this stage. Dr Senior noted that the Trust needed to be talking to clinical commissioners about what the Trust can offer immediately. **Dr Senior to develop materials for GP clinical commissioning groups by the end of September.**	Rob Senior	Aug-11	This is underway and meetings have already been held with some clinical commissioners
12	All Service Line Reports to start with executive summary	*Service Line Report - Developmental CAMHS (item 9, July 2011)* Mr Strang commended the executive summary, and the Board agreed this should be rolled out to all Service Line Reports.	All	Sep-11	A new paper proforma is being developed and will be sent to all staff preparing Board papers
13	Dr Senior and Ms Lyon to prepare briefing on Any Qualified Provider	*Payment by Results Implementation (item 10, July 2011)* Non-Executive Directors queried how Payment by Results related to Any Qualified Provider (AQP). Mr Young noted that AQP may in future be extended into Payment by Results, but this would not happen at this stage. Dr Senior noted that the Trust needed to be talking to clinical commissioners about what the Trust can offer immediately. Dr Senior to develop materials for GP clinical commissioning groups by the end of September. **Dr Senior and Ms Lyon to prepare Board briefing for September.**	Louise Lyon; Rob Senior	Sep-11	This briefing has been prepared by Julia Smith, Director of Service Development & Strategy, for discussion at the September Board meeting

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The Tavistock and Portman **NHS**
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14	Ms Lyon and Mr Young to investigate 13 patients with no registered GP	*Quarter One Finance, Governance, & Quality Declarations (item 7b, July 2011)* Mr Young explained that the Trust had 99% data completeness on GP registration, but highlighted that the Trust was reliant on the NHS spine to provide this information. Mr Young noted that 99% reflected 13 patients for whom no GP information was available. Ms Lyon and Mr Young to investigate. Mr Young suggested that some of these patients may be refugees with unsecured residence status in the UK. Ms Moseley queried whether the Trust may decide not to see patients who are not registered with GPs. Mr Young confirmed this was not the case.	Louise Lyon; Simon Young	Sep-11	This has been done. Mr Young and Ms Lyon are working with Informatics to minimise in Q2.
15	Ms Thomas to give consideration to how responsibilities outside of departments are covered in appraisals	*Data Quality Policy (item 10, May 2011)* The Board queried whether individual discharge of responsibilities for matters not necessarily in listed in a job description, for instance those listed in 6.3, was taken into account when appraisals were undertaken. Ms Thomas to give consideration to facilitation of this.	Susan Thomas	Sep-11	The major line manager will contact and collect feedback from the others engaged in managing various aspects of an indivudal's work so that the appraisal can cover all roles undertaken. This is current practice and works well

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The Tavistock and Portman **NHS**
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16	Ms Klauber to review policy on chasing student debt and ensure it is well-publicised	*Finance & Performance Report (Item 7a, July 2011)* Mr Young noted that the Trust's cash balance was significantly below budget. Mr Young did not expect this to be a problem, but noted that the Trust must keep working on this. The low cash balance was in large part due to general debtors. Mr Young explained that the £216k that was being negotiated had now been agreed and would be paid. Ms Klauber noted that results were being withheld from students who had not yet paid their fees. Mr Strang suggested the Trust develop clear stages and methods for chasing student debt, which are clearly publicised. These stages might include personal letters to students, withholding of results, and legal action. Ms Klauber agreed to review the Trust's policy on this and ensure it is well-publicised. Ms Klauber noted that the Directorate encouraged students to pay before their course begins, or to pay at least half of their fees in the first term. Ms Klauber noted, however, that many students are very naïve about money and underestimate how expensive studying is. Tutors are now having initial meetings with students to gauge whether they have a realistic understanding of their personal finances before they start their course.	Trudy Klauber	Sep-11	Discussions have started and will be complete during September 2011. These will be widely publicised
17	Dr Hodges to develop a PPI mission statement	*Board Committee Annual Review: Patient & Public Involvement Committee (item 8, May 2011)* Dr Patrick suggested the PPI Committee develop a mission statement. Dr Hodges to produce.	Sally Hodges	Sep-11	This is on the agenda for the September 2011 PPI Committee meeting
18	Responsible Officer Report to Board of Directors	*Responsible Officer Nomination (item 9, September 2010)* Dr Senior noted that the Responsible Officer would have to report to the Board annually.	Rob Senior	Sep-11	Responsible Officers are still determining their responsibilities. A report will follow once work has commenced

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19	Tavistock Clinic Foundation to report to Board of Directors with brief of work	*Tavistock Clinic Foundation Constitution Update (item 10, March 2010)* Dr Patrick noted that the new Constitution ensures that the Foundation is properly independent from the Trust. The Foundation will report to the Board of Directors with a full brief of the Foundation's work.	Louise Lyon	As appropriate	A report is not apprporiate at this time.
20	Ms Key to investigate whether the Public Services Bill affects the NHS and FTs in particular	*Estates & Facilities Report (item 10, January 2011)* Ms Moseley noted that the new Public Service Bill currently going through Parliament required contracts for public services to demonstrate both economy and social value. The SHED Unit would be useful in demonstrating this. Ms Key to investigate whether the Bill affects the public sector.	Pat Key	As appropriate	The Trust will need advice from the Secretary of State. We can't get guidance until after the Bill receives Royal Assent
21	Miss Carney to update Board of Directors on Governors' and Directors' responsibilities as appropriate	*Health & Social Care Bill Update (Item 8, March 2011)* Miss Carney to update the Board of Directors as more information becomes available	Louise Carney	As appropriate	A paper has been prepared for the September Board meeting. Further information will be presented when it becomes available

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Board of Directors : September 2011

Item : 6

Title : Chief Executive's Report

Summary :

This paper covers the following items:

1. Introduction

2. Appointment of Dean

3. London Programme for IT (LPfIT)

4. NHS and Public Sector Reforms

5. And Finally…

For : Discussion

From : Chief Executive

Chief Executive Report

1. Introduction

1.1 My last CEO report to the Board was at the end of July, at the tail end of the academic term and year. In that report I highlighted the weariness that people felt; a product, I think, of protracted uncertainty and anxiety within the healthcare system, but more locally of a term focussed on productivity and strategic re-structuring of services.

1.2 My sense of the new term so far is that many people have come back feeling rested, but knowing that we have a lot more work to do. In particular, re-structuring plans have to be consulted upon and then implemented alongside productivity commitments.

1.3 At the same time media attention after the summer was focused on the riots in some of our major cities. I hope that as a Trust and as individual professionals we will be able to contribute to the thinking and debate around understanding the causes of what happened, and to the thinking about how best to respond.

2. Appointment of Dean

2.1 As you all know Trudy Klauber is standing down from her role as Dean at the end of this calendar year. I am delighted to say that we have now appointed a successor, Mr Malcolm Allen.

2.2 Malcolm Allen is currently Chief Executive of the British Psychoanalytic Council (BPC), but comes from a background that includes running Arts Council England's Capital Programme and running the Birmingham Media Development Agency. In his work with the BPC, Malcolm has been highly effective both politically and strategically, and will be known to some of you already.

2.3 I know that he will be very much missed by the BPC, but I am also delighted that Malcolm is joining our Trust. I know that he will bring a great deal to this role, not least passion and intellect.

3. London Programme for IT (LPfIT)

3.1 The RiO IT solution has been delivered within London under a contract with the Local Service Provider, BT. In October 2015 the contract with BT expires. With this in mind, Trusts now need to begin the process of evaluating their future strategic IT options.

3.2 While remaining on RiO may well be one of these options, managing the transition created by the end of the current contract is critical for all organisations using the product and carries with it significant risks.

3.3 Regardless of the post 2015 solution that each trust may opt for, all will need to go through a procurement exercise, either alone or as part of consortia.

3.4 If this exercise, and an associated solution, is not delivered within the time frame of the existing contract, a contract extension with BT may be required. After October 2015 individual trusts will be liable for the costs of such extensions, which could be considerable.

3.5 Failure to manage the transition effectively would also present significant business continuity in terms of unsupported IT infrastructure.

3.6 In order to support the process of transition, the RiO Community and Mental Health Programme Board (CMHPB), a subcommittee of the London Programme Board, has established a 2015 strategy group with the remit of supporting trusts through this process.

3.7 Board members will remember that I am currently chairing the CMHPB on an interim basis.

3.8 Starting work in 2011 for a contract which concludes in 2015 may seem early but taking into account the time it takes to produce a requirements document, undertake the procurement, and the lead in time required by any possible replacement supplier, it is imperative that RiO trusts start to consider their options now with a view to having an agreed Outline Business Case by the end of March 2012.

3.9 As a first step in supporting our strategic thinking, the CMHPB is arranging a series of workshops. The 2015 Strategy Group will then be drafting guidance of the range of options for trusts, including technical guidance on the current contract and procurement exercise.

3.10 Given the importance of this project I will ensure that the Board is updated on a regular basis.

4. NHS and Public Sector Reforms

4.1 The summer recess, coupled with a very real and alternative preoccupation for both politicians and media, has meant that work and noise around the health bill has been much quieter.

4.2 Although a large number of amendments were made to the Bill following the listening exercise, a majority of these were technical points of drafting and the Bill has now passed through the Commons stage

4.3 The Bill is next due to go to the House of Lords. If it is not passed by the Lords, it could return to the House of Commons for further revision.

4.4 One area outside of the Health Bill that has also attracted significant attention has been discussion around pension reviews and the implementation of the Hutton Enquiry.

4.5 A formal consultation on increased employee pension contributions from April 2012 is in progress. There are no detailed proposals beyond that yet.

4.6 A number of unions are now balloting around the possibility of industrial action based on the likelihood that reforms will lead to higher contributions paid over a longer period of time for a lower final pension, based on career average earnings as opposed to final salary.

5. And Finally…

5.1 I am really pleased to let you know that David Armstrong, who retired recently from the Tavistock Consultancy Service, been given the award of 'Distinguished Member' of the International Society for the Psychoanalytic Study of Organisations in recognition of his scholarly work and for his intellectual leadership and world-wide influence as a teacher and mentor. His work (particularly his writing on The Organisation in the Mind) has extended and promoted the Tavistock systems-psychodynamic perspective and has had a hugely significant impact in the field and beyond the consultancy world.

Dr Matthew Patrick
Chief Executive Officer
September 2011

Board of Directors : September 2011

Item : 7

Title : Finance and Performance Report

Summary:

After five months a deficit of £44k is reported (before restructuring costs), £82k below the planned surplus of £38k. Small deficits in July and August have been caused by seasonal factors and by income shortfalls on Directorate Consultancy and "other", offset by under spends in Training and Central Functions. The Trust aims to reach a cumulative surplus again by the end of September; and to achieve the budgeted £150k surplus for the year (before restructuring costs).

Budgeted savings in the second half are expected to be achieved. 25 voluntary redundancy applications have been approved, at a cost close to the planned £1,000k.

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

The cash balance at 31 August was £2,272k, close to Plan. Cash will reduce – as planned – due to the payment of redundancy and early retirement costs, but the balance is projected to remain satisfactory.

This report has been reviewed by the Management Committee on 15 September.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance of progress in this key objective; and where not, whether the Board of Directors is satisfied with the action plans that have been put in place.

This report focuses on the following areas:

- Finance

For :   Information.

From :   Simon Young, Director of Finance

Finance & Performance Report

1. External Assessments

1.1 Monitor

1.1.1 Following Monitor's review of our Annual Plan, the Trust has a green governance rating and a Financial Risk Rating of 3, as expected.

1.1.2 The quarter 1 results should also lead to a rating Financial Risk Rating of 3; and it is currently expected that the actual rating will remain at 3 in subsequent quarters.

1.1.3 This Trust's recent and current ratings are shown in the table below:

	2010/11 Quarter 3	2010/11 Quarter 4	2011 Plan	2011/12 Quarter 1
Governance	Green	Green	Green	Green *
Financial Risk	3	3	3	3 *

* = expected rating, based on our Quarter 1 performance

1.1.4 Monitor has published tables showing the ratings of all 137 Foundation Trusts, based on their 2011/12 Annual Plans. These are summarised below.

Governance Ratings	All Foundation Trusts	Mental Health Foundation Trusts
Green	76	29
Amber-Green	30	5
Amber-red	27	7
Red	4	0
Total	137	41

Financial Risk Ratings	All Foundation Trusts	Mental Health Foundation Trusts
5	4	0
4	35	16
3	87	25
2	8	0
1	3	0
Total	137	41

2. Finance

2.1 Income and Expenditure 2011/12

2.1.1 After five months, the Trust is reporting a deficit of £44k, £82k below Plan. Income is £86k below budget, and expenditure £14k below budget. Some of these variances are due to timing, and the forecast for the year remains in line with Plan. The Trust aims for a surplus in the month of September and a small cumulative surplus after six months.

2.1.2 Consultancy income is £47k under budget; departmental consultancy under by £113k which was offset by Tavistock Consulting over target by £67k. Other income is £99k below target mainly due to under achieved productivity schemes in Adult £75k and Adolescent £36k. Clinical Income is £16k below target: this includes the Day Unit being £24k above Plan, Big White Wall is £46k below and PHP income is £30k below Plan. These main income sources and their variances are discussed in sections 3, 4 and 5 below.

2.1.3 The cumulative expenditure under spend of £4k is due underspends across the organisation offset by over spends in CAMHS £166k and Adolescent £47k primarily as a result of the profile of the vacancy factor. Tavistock Consulting is also over spent by £59k due to associate fees.

2.1.4 Without effective action and controls, forecast income for the year would be £97k below budget as in Appendices A and B. Larger shortfalls than this should be covered firstly by the under spending discussed above; and then by the budgeted contingency reserve. As work on service redesign progresses, attention also needs to focus on delivery of income against Plan.

2.2 Cash Flow (Appendix C)

2.2.1 The actual cash balance at 31 August was £2,272k, close to the revised Plan of £2,366k. The balance would have been significantly higher if it had included a late payment of £974k from one PCT, received on 1 September. The year-to-date receipts and payments are summarised in the table on the next page.

2.2.2 Payments in September will include redundancy and early retirement pension payments. These are included in the forecast (Appendix C), which shows that cash balances are expected to remain satisfactory for the rest of the year, with the balance on 31 March close to Plan. At present, there are no significant revisions to the monthly forecasts for 2012/13, which also remain satisfactory.

	Cash Flow year-to-date		
	Actual	Plan	Variance
	£000	£000	£000
Opening cash balance	4,712	4,712	0
Operational income received			
NHS (excl SHA)	3,231	3,806	(575)
General debtors (incl LAs)	2,550	2,620	(70)
SHA for Training	4,612	4,609	3
Students and sponsors	568	700	(132)
Other	171	90	81
	11,132	11,825	(693)
Operational expenditure payments			
Salaries (net)	(6,201)	(6,047)	(154)
Tax, NI and Pension	(4,551)	(4,475)	(76)
Suppliers	(2,676)	(3,402)	726
	(13,428)	(13,924)	496
Capital Expenditure	(148)	(200)	52
Interest Income	4	4	0
Payments from provisions	0	(51)	51
PDC Dividend Payments	0	0	0
Closing cash balance	2,272	2,366	(94)

2.2.3   Monitor has approved an increase in the Trust's working capital facility from £2.0m to £2.4m. This reflects the increase in annual income and expenditure since the last change in 2008. The facility will be renewed at this higher level, from 1 November. The facility has not been used, and is not expected to be used; but it ensures the Trust's liquidity in the event of temporary cash-flow difficulties such as a delay in receipts.

2.3   Training

2.3.1   Training income is £85k above budget in total; but the majority of this favourable variance is due to £96k bursary income, and the corresponding payments of £96k are an adverse variance in the expenditure budget. Other income lines are close to budget. There is a shortfall on Child Psychotherapy Trainees but this is due to slightly lower numbers, and is offset by lower costs.

2.3.2   Income from university partners is expected to be close to budget. At this stage, there is no reason to expect fee income from students and sponsors to be short of budget; but this will not be known more firmly until October.

3. **Patient Services**

3.1 Activity and Income

3.1.1   All contract values have now been agreed. Total contracted income for the year is in line with budget. After five months, there is a small favourable variance on cost and volume activity of £15k. However, this includes an under performance of £32k with Haringey. The Camden Adult service is currently over performing by 39% but the contract only allows for 2.5% to be paid. Part of the budgeted income for the year is dependent on meeting our CQUIN† targets agreed with commissioners and achievement is reviewed on a quarterly basis. A credit note for £16.2k was raised in August relating to 2010/11 for London Borough of Haringey.

3.1.2   Variances in other elements of clinical income are shown in the table on the next page.

3.1.3   The income for named patient agreements (NPAs) was £79k after five months which is £17k below budget, with £7k shortfalls in Adult and the Portman. The forecast for the year without action would be a shortfall of £80k.

3.1.4   Court report income is budgeted at £285k for the year, of which £210k is for the Portman, and is expected to meet these targets. After five months, however, we are £43k below budget overall; the Portman is £51k below target whilst CAMHS are £12k above target.

3.1.5   Monroe income is above budget by £6k after 5 months. The annual budget was reduced from £780k to £504k this year, with a corresponding reduction in staffing which is now taking place.

3.1.6   Day Unit is £24k above target year-to-date. They were down to 9 pupils at the beginning of the new term, against a budgeted target of 12.5; but this fall is slightly less than expected, and new pupils are due to start during the term.

3.1.7   Project income is £54k above budget year-to-date, including some one-off items (2.1.2 above). The forecast is £50k above budget for the year.

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† Commissioning for Quality and Innovation

	Budget £000	Actual £000	Variance %	Full year		Comments
				Variance based on y-t-d	Predicted variance	
Contracts - base values	3,957	3,857	-2.5%		-33	Small under-achievement on CQUIN, plus old year credit note £16k.
Cost and vol variances	2	14			7	
NPAs	96	79	-17.4%	-40	-80	
Projects and other	836	915		–	50	Income matched to costs, so variance is largely offset.
Day Unit	440	464	5.6%	59	0	
Monroe	180	186	3.4%	17	0	
FDAC 2nd phase	170	162	-4.6%	-18	-31	Income matched to costs, so variance is largely offset.
Court report	119	76	-36.2%	-103	0	
Total	5,800	5,754		-85	-87	

4. Consultancy

4.1 Tavistock Consulting income was £297k up to August, compared to the budget of £231k. Our forecast for the year assumes at present that budget is achieved for the remaining seven months. However, expenditure is also £59k above budget.

4.2 Departmental consultancy is £113k below budget after five months. The majority of the shortfall is within CAMHS which is currently £70k below target. Actions to recover the shortfall will be required to deliver against Plan.

Simon Young
Director of Finance
12 September 2011

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST

INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2011-12

	Aug-11			CUMULATIVE			FULL YEAR 2011-12		
	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									
CLINICAL	1,133	1,058	(74)	5,770	5,754	(16)	13,899	13,840	(59)
TRAINING	1,347	1,429	82	6,634	6,719	85	16,544	16,621	77
CONSULTANCY	100	70	(29)	539	493	(47)	1,351	1,334	(17)
RESEARCH	14	13	(1)	70	60	(10)	167	167	0
OTHER	68	48	(20)	341	242	(99)	818	719	(99)
TOTAL INCOME	**2,661**	**2,618**	**(43)**	**13,353**	**13,267**	**(86)**	**32,778**	**32,681**	**(97)**
OPERATING EXPENDITURE (EXCL. DEPRECIATION)									
CLINICAL DIRECTORATES	1,513	1,452	61	7,330	7,444	(114)	17,298	17,449	(151)
OTHER TRAINING COSTS	514	594	(80)	2,681	2,578	103	7,098	7,041	57
OTHER CONSULTANCY COSTS	50	54	(4)	259	320	(61)	599	658	(59)
CENTRAL FUNCTIONS	532	498	34	2,680	2,590	90	6,356	6,277	79
TOTAL RESERVES	(1)	0	(1)	(3)	0	(3)	393	198	195
TOTAL EXPENDITURE	**2,609**	**2,598**	**10**	**12,947**	**12,933**	**14**	**31,744**	**31,623**	**121**
EBITDA	**53**	**20**	**(33)**	**406**	**334**	**(72)**	**1,034**	**1,058**	**24**
ADD:-									
BANK INTEREST RECEIVED	1	1	0	5	4	0	11	11	(0)
LESS:-									
DEPRECIATION	42	44	(2)	212	222	(10)	509	533	(24)
FINANCE COSTS	0	0	0	0	0	0	0	0	0
DIVIDEND	32	32	0	161	161	(0)	386	386	0
RETAINED DEFICIT BEFORE RESTRUCTURING	**(21)**	**(56)**	**(35)**	**38**	**(44)**	**(82)**	**150**	**150**	**(1)**
RESTRUCTURING COSTS	0	0	0	1,000	993	7	1,000	1,000	0
RETAINED DEFICIT AFTER RESTRUCTURING	**(21)**	**(56)**	**(35)**	**(962)**	**(1,038)**	**(76)**	**(850)**	**(850)**	**(1)**
EBITDA AS % OF INCOME	2.0%	0.8%		3.0%	2.5%		3.2%	3.2%	

	Aug-11			CUMULATIVE			FULL YEAR 2011-12		
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST £000'S	REVISED BUDGET VARIANCE £000
INCOME									
1 NHS LONDON TRAINING CONTRACT	605	612	8	3,023	3,038	15	7,254	7,254	0
2 TRAINING FEES & OTHER ACA INC	484	564	80	2,320	2,448	128	6,028	6,156	128
3 POSTGRADUATE MED & DENT'L EDUC	12	6	(5)	59	40	(18)	141	141	0
4 JUNIOR MEDICAL STAFF	81	90	10	403	413	10	966	966	0
5 CHILD PSYCHOTHERAPY TRAINEES	166	156	(10)	830	779	(51)	2,155	2,104	(51)
6 R&D	14	13	(1)	70	60	(10)	167	167	0
7 CLINICAL INCOME	957	898	(59)	4,823	4,779	(44)	11,554	11,498	(56)
8 DAY UNIT	88	82	(6)	440	464	24	1,055	1,055	0
9 MONROE	23	22	(0)	180	186	6	504	504	0
10 FDAC	42	41	(0)	208	248	40	500	540	40
11 TCS INCOME	27	60	33	231	297	67	613	680	67
12 DEPT CONSULTANCY INCOME	73	10	(63)	309	195	(113)	737	654	(83)
13 COURT REPORT INCOME	24	15	(9)	119	76	(43)	285	242	(43)
14 EXCELLENCE AWARDS	10	10	0	48	48	0	116	116	0
15 OTHER INCOME	58	38	(20)	292	193	(99)	702	603	(99)
TOTAL INCOME	**2,661**	**2,618**	**(43)**	**13,353**	**13,267**	**(86)**	**32,778**	**32,681**	**(97)**
EXPENDITURE									
16 EDUCATION & TRAINING	327	414	(87)	1,742	1,718	23	4,679	4,679	0
17 PORTMAN CLINIC	118	108	10	566	556	10	1,316	1,316	0
18 ADULT DEPT	269	257	12	1,316	1,288	28	3,109	3,109	0
19 MEDNET	21	19	1	103	88	14	246	232	14
20 ADOLESCENT DEPT	155	157	(2)	705	752	(47)	1,717	1,717	0
21 C & F CENTRAL	713	704	10	3,449	3,616	(166)	8,086	8,186	(100)
22 MONROE & FDAC	70	79	(9)	414	439	(25)	905	995	(90)
23 DAY UNIT	64	57	7	320	320	(0)	751	751	0
24 SPECIALIST SERVICES	96	71	25	422	370	52	1,083	1,083	0
25 COURT REPORT EXPENDITURE	7	0	7	35	15	20	85	60	25
26 TRUST BOARD & GOVERNORS	9	10	(1)	44	44	(0)	106	106	0
27 CHIEF EXECUTIVE OFFICE	26	22	4	129	122	8	311	303	8
28 PERFORMANCE & INFORMATICS	58	54	4	302	288	14	708	694	14
29 FINANCE & ICT	101	83	18	506	516	(10)	1,200	1,225	(25)
30 CENTRAL SERVICES DEPT	182	190	(8)	910	902	8	2,165	2,165	0
31 HUMAN RESOURCES	55	52	2	278	301	(23)	646	646	0
32 CLINICAL GOVERNANCE	36	36	(0)	174	164	10	415	405	10
33 TRUST DIRECTOR	31	28	4	166	150	16	398	382	16
34 PPI	19	16	3	96	72	24	231	207	24
35 SWP & R+D & PERU	22	17	5	110	78	32	264	232	32
36 R+D PROJECTS	0	0	0	0	0	0	0	0	0
37 PGMDE	5	5	1	26	21	6	63	57	6
38 NHS LONDON FUNDED CP TRAINEES	166	165	1	829	778	52	2,155	2,103	52
39 TAVISTOCK SESSIONAL CP TRAINEES	7	7	0	36	34	3	88	88	0
40 FLEXIBLE TRAINEE DOCTORS	9	4	6	47	27	20	113	113	0
41 TCS	45	50	(5)	236	295	(59)	542	601	(59)
42 DEPARTMENTAL CONSULTANCY	5	4	1	23	25	(2)	57	57	0
43 DEPRECIATION	42	44	(2)	212	222	(10)	509	533	(24)
44 PROJECTS CONTRIBUTION	(7)	(11)	3	(36)	(47)	11	(87)	(87)	0
45 IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	(0)	0	0	(0)	0
46 CENTRAL RESERVES	(1)	0	(1)	(3)	0	(3)	393	198	195
TOTAL EXPENDITURE	**2,651**	**2,643**	**8**	**13,159**	**13,155**	**4**	**32,253**	**32,156**	**97**
OPERATING SURPLUS/(DEFICIT)	**10**	**(25)**	**(36)**	**194**	**112**	**(82)**	**525**	**525**	**0**
47 INTEREST RECEIVABLE	1	1	(0)	5	4	(0)	11	11	(0)
48 UNWINDING OF DISCOUNT ON PROVISION	0	0	0	0	0	0	0	0	0
49 DIVIDEND ON PDC	(32)	(32)	0	(161)	(161)	(0)	(386)	(386)	0
SURPLUS/(DEFICIT) BEFORE RESTRUCTURING	**(21)**	**(57)**	**(36)**	**38**	**(44)**	**(82)**	**150**	**150**	**(0)**
50 RESTRUCTURING COSTS	0	0	0	1,000	993	7	1,000	1,000	0
SURPLUS/(DEFICIT) AFTER RESTRUCTURING	**(21)**	**(57)**	**(36)**	**(962)**	**(1,038)**	**(76)**	**(850)**	**(850)**	**(0)**

Cash Flow 2011/12

Appendix C

2011/12 Plan

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	4,712	4,770	4,010	3,316	2,872	2,366	1,607	1,401	1,422	1,118	1,572	1,505	4,712
Operational income received													
NHS (excl SHA)	541	623	659	976	1,007	890	877	1,008	888	877	1,009	888	10,243
General debtors (incl LAs)	742	374	560	519	425	650	533	485	450	839	565	472	6,614
SHA for Training	914	934	914	914	933	914	914	934	914	914	934	914	11,047
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
	2,515	2,099	2,301	2,527	2,383	2,672	2,992	2,695	2,370	3,148	2,626	2,392	30,720
Operational expenditure payments													
Salaries (net)	(1,209)	(1,210)	(1,209)	(1,210)	(1,209)	(1,710)	(1,661)	(1,162)	(1,161)	(1,162)	(1,161)	(1,161)	(15,225)
Tax, NI and Pension	(900)	(894)	(894)	(894)	(894)	(894)	(894)	(858)	(858)	(858)	(858)	(858)	(10,554)
Suppliers	(349)	(756)	(849)	(761)	(687)	(576)	(584)	(595)	(605)	(614)	(615)	(613)	(7,604)
	(2,458)	(2,860)	(2,952)	(2,865)	(2,790)	(3,180)	(3,139)	(2,615)	(2,624)	(2,634)	(2,634)	(2,632)	(33,383)
Capital Expenditure	0	0	0	(100)	(100)	(60)	(60)	(60)	(50)	(60)	(60)	(109)	(659)
Interest Income	1	1	1	0	1	1	1	1	1	0	1	1	10
Payments from provisions	0	0	(45)	(6)	0	0	0	0	0	0	0	0	(51)
PDC Dividend Payments	0	0	0	0	0	(193)	0	0	0	0	0	(193)	(386)
Closing cash balance	4,770	4,010	3,316	2,872	2,366	1,607	1,401	1,422	1,118	1,572	1,505	963	963

2011/12 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	4,712	3,376	3,516	2,536	2,445	2,272	1,732	1,427	1,447	1,144	1,598	1,530	4,712
Operational income received													
NHS (excl SHA)	691	725	341	871	603	1,450	877	1,008	888	877	1,009	888	10,228
General debtors (incl LAs)	618	238	279	691	724	650	533	485	450	839	565	472	6,544
SHA for Training	0	1,707	968	876	1,061	914	914	934	914	914	934	914	11,050
Students and sponsors	198	92	162	39	77	200	650	250	100	500	100	100	2,468
Other	4	22	30	68	47	18	18	18	18	18	18	18	297
	1,511	2,784	1,780	2,545	2,512	3,232	2,992	2,695	2,370	3,148	2,626	2,392	30,587
Operational expenditure payments													
Salaries (net)	(1,243)	(1,210)	(1,202)	(1,255)	(1,291)	(1,710)	(1,661)	(1,162)	(1,161)	(1,162)	(1,161)	(1,161)	(15,379)
Tax, NI and Pension	(900)	(917)	(926)	(906)	(902)	(894)	(894)	(858)	(858)	(858)	(858)	(858)	(10,630)
Suppliers	(705)	(497)	(542)	(463)	(469)	(876)	(684)	(595)	(605)	(614)	(615)	(613)	(7,278)
	(2,848)	(2,624)	(2,670)	(2,624)	(2,662)	(3,480)	(3,239)	(2,615)	(2,624)	(2,634)	(2,634)	(2,632)	(33,287)
Capital Expenditure	0	(21)	(91)	(13)	(23)	(100)	(60)	(60)	(50)	(60)	(60)	(121)	(659)
Interest Income	1	1	1	1	0	1	1	1	1	0	1	1	10
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	0	0	0	0	0	(193)	0	0	0	0	0	(193)	(386)
Closing cash balance	3,376	3,516	2,536	2,445	2,272	1,732	1,427	1,447	1,144	1,598	1,530	977	977

Board of Directors : September 2011

Item : 8

Title : CQSG Committee 2011/12 Quarter One Report

Summary:

The work stream's objectives had been updated to reflect the 2011/12 Annual Plan. Quarter One outcomes indicate that the Trust has been able to achieve its objectives to date, or where objectives were not achieved, noted that action plans that would deliver by the deadline were in place. Issues addressed included: mandatory training; plans for clinical audit; plans for clinical outcomes; clinical incident reporting. Overall, the committee indicated satisfaction with the assurance provided to date and was pleased with the overall administrative and managerial performance.

This report focuses on the following areas:

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

For : Discussion

From : Rob Senior, Chair CQSG

CQSG Committee 2011/12 Quarter One Report

1.   Quarter One Key Issues

1.1   The Committee explored the assurance from each Lead and accepted all reports and action plans. Issues that were highlighted are below.

2.   Corporate Governance and Risk

2.1   The Trust maintains a good governance rating with the regulator

2.2   A discussion on whether to work towards NHSLA level 3 will be held in June

3.   Clinical Audit

3.1   There is a need to re-engage clinicians and sustain their involvement

4.   Clinical Outcomes

4.1   There had been some slippage on the project plan timescale but this was getting back on track

4.2   RAG ratings indicated objectives were being delivered

4.3   Phase One of the project had delivered its objectives; Phase Two of the project would soon begin

4.4   How to get good data from remote sites/ services was being explored

5.   Patient safety and clinical risk

5.1   A procedure for medical revalidation was being developed

5.2   Work to support child protection and protection of vulnerable adults was being undertaken in order to address weaknesses

6.   Quality reports

6.1   data validation procedures were being developed

6.2   a draft report will be available in Quarter Three

6.3   as a public document, there is a need to use plain English

6.4   CQUIN results should be delivered as required

7.   PPI

7.1   Activity was being delivered as planned

7.2   The development of communications through new social media is to be planned

8.   IG

8.1   Work had begun to deliver the new requirements

9.   Draft Internal Audit Report

9.1   This had been received quite some time after the audit; a response was being prepared by the Director of Corporate Governance and Facilities in consultation with the Chair of the CQSG Committee

10.   Relationship with the Audit Committee

10.1   A briefing is to be sent to members on the relationship and function of the respective committees.

11.   Quality of assurance

11.1   The Committee were satisfied with the quality of reports given to them to date and decided to discontinue the cycle of close examination of supporting evidence.

Jonathan McKee
Governance Manager
14th September 2011

Board of Directors : September 2011

Item : 9

Title : Audit Committee Terms of Reference

Summary:

The Committee is recommending the removal of paragraph 9.4.4 from the Terms of Reference.

The Terms of Reference, with tracked changes, are attached.

The Board of Directors is asked to approve this change.

This proposal is of relevance to the following areas:

• Quality
• Risk
• Governance

For : Approval

From : Audit Committee Chair

Audit Committee
Terms of Reference

Ratified by:	Board of Directors
Date ratified:	30th November 2010
Name of originator/author:	Richard Strang, Committee Chair
Name of responsible committee/individual:	Audit Committee / Committee Chair
Date issued:	July 2007; June 2009; November 2010
Review date:	October 2011

Audit Committee
Terms of Reference

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Committee to be known as the Audit Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

2. Membership

2.1 Membership of the Committee shall be as follows:

2.1.1 Non-Executive Director (Committee Chair)

2.1.2 Not less than two other Non-Executive Directors

2.2 The Trust Chair shall not be a member of the Committee.

3. Attendance

3.1 The Director of Finance and appropriate External and Internal Audit representatives shall normally attend meetings.

3.2 At least once a year the External and Internal Auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers.

3.3 The Chief Executive and other Executive Directors should be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

3.4 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control.

3.5 The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.

4. Quorum

4.1 This shall be two members.

5. Frequency of meetings

5.1 The Committee will meet not less than three times per year.

6. Agenda & Papers

6.1 Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.

6.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

7. Minutes of the Meeting

7.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

7.2 Approved minutes will be forwarded to the Board of Directors for noting.

8. Authority

8.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

9. Duties

9.1 Governance, Risk Management and Internal Control

9.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

9.1.2 In particular, the Committee will review the adequacy of:

9.1.2.1 all risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the Care Quality Commission's *Judgement Framework*), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors

9.1.2.2 the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

9.1.2.3 the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Clinical Quality, Safety, and Governance Committee

9.1.2.4 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service

9.1.2.5 the financial systems

9.1.2.6 the Internal and External Audit services, and counter fraud services

9.1.2.7 compliance with *Board of Directors' Standing Orders* (BDSOs) and *Standing Financial Instructions* (SFIs)

9.1.3 The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

9.1.4 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, the Local Counter-Fraud Service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness

9.1.5 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it

9.2 Internal Audit

9.2.1 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by:

9.2.1.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

9.2.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

9.2.1.3 consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources

9.2.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

9.2.1.5 annual review of the effectiveness of internal audit

9.3 External Audit

9.3.1 The Committee shall review the work and findings of the External Auditor appointed by the Board of Governors, and consider the implications and management's responses to their work. This will be achieved by:

9.3.1.1 consideration of recommendations to the Board of Governors relating to the appointment and performance of the External Auditor

9.3.1.2 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy

9.3.1.3   discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

9.3.1.4   review all External Audit reports and any work carried out outside the annual audit plan, together with the appropriateness of management responses

9.4   Other Assurance Functions

9.4.1   The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust

9.4.2   These will include, but will not be limited to, any reviews by Monitor, Department of Health Arms Length Bodies or Regulators / Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

9.4.3   In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. This will particularly include the Clinical Quality, Safety, and Governance Committee

9.4.4   ~~In reviewing the work of the Clinical Quality, Safety, and Governance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function~~

9.5   Management

9.5.1   The Committee shall request and review reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control

9.5.2   They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements

9.6   Financial Reporting

9.6.1   The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

        9.6.1.1   the wording in the Statement on Internal Control and other disclosures relevant to the Terms of Reference of the Committee

        9.6.1.2   changes in, and compliance with, accounting policies and practices

        9.6.1.3   unadjusted mis-statements in the financial statements

        9.6.1.4   major judgemental areas

        9.6.1.5   significant adjustments resulting from the audit

    9.6.2   The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors

9.7   Appointment, reappointment, and removal of external auditors.

    9.7.1   The Committee shall make recommendations to the Board of Governors, in relation to the setting of criteria for appointing, re-appointing, and removing External Auditors

    9.7.2   The Committee shall make recommendations to the Board of Governors, in relation to the appointment, reappointment, and removal of the External Auditors, providing the Board of Governors with information on the performance of the External Auditor

    9.7.3   The Committee shall approve the remuneration and terms of engagement of the External Auditors

10. Other Matters

10.1 At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

11. Sources of Information

11.1 The Committee will receive and consider minutes from the Clinical Quality, Safety, and Governance Committee. The Committee will receive and consider other sources of information from the Director of Finance.

12. Reporting

12.1 The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Audit Committee or the Board of Directors to any issues in the minutes that require disclosure or executive action.

12.2 The Committee will report annually to the Board of Directors on its work in support of the Statement on Internal Control, specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements, and the appropriateness of the self-assessment against the Care Quality Commission's *Judgement Framework*.

12.3 The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

13. Support

13.1 The Committee will be supported by a Secretary from the Director of Finance's team.

Board of Directors : September 2011

Item : 10

Title : Corporate Governance Report

Summary:

This report covers the following items:

- Board of Governors Updates
- Constitutional Amendments
- Monitor Updates
- Health & Social Care Bill
- Mid-Staffordshire NHS Foundation Trust Public Inquiry
- Foundation Trust Network

This report focuses on the following areas:

- Quality
- Equality
- Risk

For : Noting

From : Trust Secretary

Corporate Governance Report

1. Board of Governors Update

1.1 We currently have six vacancies on our Board of Governors:

- Public: Camden (1 seat)
- Public: Rest of England & Wales (2 seats)
- Staff: Representatives of Recognised Staff Organisations and Trade Unions (1 seat)
- Stakeholder: Primary Care Trusts (1 seat)
- Stakeholder: Specialist Commissioning (1 seat)

1.2 By-Election for Public: Rest of England & Wales seats

1.2.1 Learning from the previous round of elections to the Board of Governors, the Trust decided to extend its proceeding time (the time taken to undertake the formal election, from notice of election to the return of ballot papers, to allow for a greater period of time for the submission of nomination papers (27 days instead of 12 days) and ballot papers (27 days instead of 14 days). Nominations were received from four candidates for the two seats.

1.2.2 As of 14th September, only 165 members, out of a possible 2,042, have returned their ballot papers. As recommended following the previous election, reminder notices were sent out for the return of ballot papers a little over a week before the deadline.

1.2.3 The poll closes on Wednesday 21st September. The Trust will announce the result shortly afterwards.

1.3 Election to the Public: Camden seat

1.3.1 Adam Elliott has resigned from the Board of Governors, leaving a vacant seat in the Camden class of the Public Constituency.

1.3.2 According to the Trust's Constitution, where vacancies arise during a term of office, the unsuccessful candidate with the highest number of votes at the last stage of the count of the previous election shall be deemed elected.[1]

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[1] Tavistock & Portman NHS Foundation Trust, Constitution, Election Rules, Standing Orders, Paragraph 10.4

1.3.3   The Trust is at this stage trying to contact the candidate referred to above, to confirm that they are still eligible to take up the seat. Should there be no eligible candidates, the seat shall remain vacant for the remainder of the term (see 4.4.2, for explanation).

1.4   Election to the Staff: Representatives of Recognised Staff Organisations and Trade Unions seat

1.4.1   Robin Bonner steps down from the Board of Governors when he retires from the Trust on 19th September, leaving a vacant seat in the Representatives of Recognised Staff Organisations and Trade Unions class of the Staff Constituency.

1.4.2   The Trust's Constitution stipulates that if there is less than a year and a day from the announcement of the result to the end of the term of office, a by-election will not be held. The Trust's minimum proceeding time is 40 days, which would mean that if there was less than a year and a day to serve. Therefore, the Trust will not be holding a by-election for this seat.

1.5   Stakeholder Vacancies

1.5.1   John Carrier stepped down as representative of Primary Care Trusts. The Trust has written to the Chief Executive of the North Central London Cluster, asking her to consider making another appointment. The Trust is waiting to hear back about this.

1.5.2   The Specialist Commissioning seat remains vacant.

1.6   Appointments of University of East London Stakeholder Governor

1.6.1   The University of East London have appointed Prof. John Joughin as its representative to our Board of Governors. Prof. Joughin is Deputy Vice Chancellor at the university, and we are very pleased that he has joined our Board of Governors.

2.   Trust Constitutional Amendments

2.1   The Trust has held off on amending its Constitution until the passage of the Health & Social Care Bill is complete. Once the Bill receives Royal Assent, the Constitution will be reviewed in light of the new requirements of foundation trusts.

3. Monitor Updates

3.1 Monitor's review of foundation trusts

3.1.1 Monitor has published *NHS foundation trusts: review of twelve months to 31 March 2011*. There were 136 foundation trusts at the end of 2010/11. Monitor's report is based on the data submitted by FTs on a quarterly basis.

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

Table 1: NHS Foundation Trust Statistics at 31 March 2011[2]

Type of FTs		
Total	136	
Acute	77	57%
Mental Health	**41**	**30%**
Specialist	16	12%
Ambulance	2	1%
FTs by Strategic Health Authority[3]		
North West	28	74%
South West	17	65%
Yorkshire & The Humber	16	62%
London	**16**	**73%**
East of England	15	39%
West Midlands	12	44%
North East	10	91%
South Central	9	53%
South East Coast	7	47%
East Midlands	6	46%
Governance Risk Ratings		
Green	**83**	**61%**
Amber-Green	17	13%
Amber-Red	24	18%
Red	12	9%
Financial Risk Ratings		
5 (lowest risk)	13	10%
4	58	43%
3	**55**	**40%**
2	7	5%
1	3	2%
FTs in significant breach of terms of authorisation		
Total	9	7%
Combined actual net surplus Q3		
Total	£406m	
EBITDA margin		
Total	6.7%	

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[2] As at April 2011, there were 138 Foundation Trusts
[3] Percentages are of foundation trusts out of potential foundation trusts in each Health Authority

3.1.3   All of the red rated trusts are acute foundation trusts; ten of these are in significant breach of their terms of authorisation.

3.1.4   Monitor's document can be found at http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/reports-nhs-foundation-trusts/nhs-foundation-trusts-quarterly--29

3.2   In July, Monitor announced that they had decided not to appoint a new Chief Executive at this stage. They have decided to wait for Parliament's view on the Health & Social Care Bill to become clearer before restarting the recruitment process. This is likely to happen sometime in 2012. In the meantime, David Bennett will continue as interim Chief Executive, alongside his role as Chair.

4.   Health & Social Care Bill

4.1   The Health and Social Care Bill has cleared its House of Commons stages and is now passing through the House of Lords. The second reading is scheduled for 11th October.

5.   Mid-Staffordshire NHS Foundation Trust Public Inquiry

5.1   The public inquiry into the care provided by Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 recommenced on 5th September after a summer recess. Inquiry hearings are expected to finish by 1st December, after which the final report will be written. Monitor gave evidence to the Inquiry hearings in week 24 (23rd – 26th May) and week 25 (31st May – 2nd June). Transcripts can be found on the Inquiry's website http://www.midstaffspublicinquiry.com.

6.   Foundation Trust Network

6.1   The Foundation Trust Network became an independent organisation on 1st June 2011, separating from the NHS Confederation. The FTN will continue to work with the NHS Confederation and its other networks by sharing information, whilst at the same time providing a strong independent voice for foundation trusts.

6.2   Chief Executive Sue Slipham has said the FTN will focus on persuading the Government to keep FTs independent.

Louise Carney
Trust Secretary
16th September 2011

Board of Directors : September 2011

Item : 11

Title : Review of Internal Links 2011/12

Summary:

Internal Trust links were reviewed by the Board of Directors in February 2011. The updated spreadsheet details all current Director links to Trust work. There is one vacant link and one possibility for a further link, which NEDs are asked to consider prior to the meeting.

The information is presented in two formats, the first with all members of the Board of Directors and Trust staff, ordered by the areas of work, and the second with only Non-Executive Directors links.

This report focuses on the following areas:
(delete where not applicable)

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

For : Noting

From : Trust Secretary

Review of Internal Links 2011/12

1. Updates

1.1 When these links were previously reviewed, the following amendments were made;

- Martin Bostock is now the NED link for complaints
- Joyce Moseley is now the NED link for the Adolescent Directorate
- Ian McPherson is now the NED link for the Portman Directorate
- Richard Strang is now the link with the Human Resources Directorate
- Joyce Moseley is now the link with the CAMHS Directorate
- Angela Greatley is now the link with Older People.

1.2 There is currently one NED vacancy for a link to Estates. Any volunteers to fill this vacancy would be welcomed. It was also suggested that the CAMHS Directorate may want another NED link due to their size. NEDs are asked to consider this.

Louise Carney
Trust Secretary
16th September 2011

Director Links to Trust Work

	Name	Title	Responsibility
Audit Committee	Altaf Kara	Non-Executive Director	Member
	Ian McPherson	Non-Executive Director	Member
	Richard Strang	Deputy Trust Chair	Committee Chair
	Simon Young	Finance Director	Attendance
Business Development & Investment Committee	Richard Strang	Deputy Trust Chair	Committee Chair
	Altaf Kara	Non-Executive Director	Member
	Joyce Moseley	Non-Executive Director	Member
	Angela Greatley	Trust Chair	Member
	Matthew Patrick	Chief Executive	Member
	Louise Lyon	Trust Clinical Director	Member
	Simon Young	Finance Director	Member
Charitable Fund Committee	Angela Greatley	Trust Chair	Committee Chair
	Matthew Patrick	Chief Executive	Member
	Simon Young	Finance Director	Member
CQSG	Matthew Patrick	Chief Executive	Committee Chair
	Rob Senior	Medical Director	Member
	Lis Jones	Nurse Director	Member
	Louise Lyon	Trust Director	Member
	Joyce Moseley	Non-Executive Director	Member
	Martin Bostock	Senior Independent Director	Member
NED Appraisal & Appointment Committee	Angela Greatley	Trust Chair	Committee Chair
Patient & Public Involvement Committee	Martin Bostock	Senior Independent Director	Non-Executive Lead
	Lis Jones	Nurse Director	Executive Lead
	Sally Hodges	Patient & Public Involvement and Communications Lead	Committee Chair
Remuneration Committee	Martin Bostock	Senior Independent Director	Member
	Altaf Kara	Non-Executive Director	Member
	Joyce Moseley	Non-Executive Director	Member
	Ian McPherson	Non-Executive Director	Member
	Angela Greatley	Trust Chair	Committee Chair
	Richard Strang	Deputy Trust Chair	Member

Director Links to Trust Work

	Name	Title	Responsibility
Gloucester House The Tavistock Children's Day Unit	Rita Harris	CAMHS Director	Trust Lead
	Richard Strang	Deputy Trust Chair	Non-Executive Lead
Security Management	Martin Bostock	Senior Independent Director	Non-Executive Lead
	Pat Key	Director of Corporate Governance & Facilities	Management Lead
	Matthew Patrick	Chief Executive	Trust Lead

Areas where NED involvement is helpful			
	Name	**Title**	**Responsibility**
Adolescent Directorate	Joyce Moseley	Non-Executive Director	Non-Executive Lead
Adult Directorate	Ian McPherson	Non-Executive Director	Non-Executive Lead
CAMHS Directorate	Joyce Moseley	Non-Executive Director	Non-Executive Lead
Consultancy Directorate	Altaf Kara	Non-Executive Director	Non-Executive Lead
Finance Directorate	Richard Strang	Deputy Trust Chair	Non-Executive Lead
Portman Directorate	Ian McPherson	Non-Executive Director	Non-Executive Lead
Training Directorate	Altaf Kara	Non-Executive Director	Non-Executive Lead
Safeguarding	Sonia Applyby	Consultant Social Worker	Clinical Lead (Child)
	Elisa Reyes-Simpson	Consultant Social Worker	Clinical Lead (Adult)
	Angela Greatley	Trust Chair	Non-Executive Lead
	Rob Senior	Medical Director	Trust Lead
Committee for Clinical Excellence Awards	Matthew Patrick	Chief Executive	Committee Chair
	Angela Greatley	Trust Chair	Lay Member
	Richard Strang	Deputy Trust Chair	Lay Member
Communications	Martin Bostock	Senior Independent Director	Non-Executive Lead
	Sally Hodges	Patient & Public Involvement and Communications Lead	Trust Lead
Complaints	Lotte Higginson	Complaints Manager	
	Pat Key	Director of Corporate Governance & Facilities	Management Lead
	Martin Bostock	Senior Independent Director	Non-Executive Lead
Counter Fraud Policy / Measures	Simon Young	Finance Director	Trust Lead
	Richard Strang, NED	Deputy Trust Chair	Non-Executive Lead
	David Foley	Local Counter Fraud Specialist	
Disability Issues	Pat Key	Director of Corporate Governance & Facilities	Trust Lead
	Ian McPherson	Non-Executive Director	Non-Executive Lead
	Susan Thomas	Director of Human Resources	Trust Lead
Estates	Pat Key	Director of Corporate Governance & Facilities	Trust Lead
Equality	Ian McPherson	Non-Executive Director	Non-Executive Lead
	Julia Smith	Director of Service Development & Strategy	Trust Lead
Human Rights	Susan Thomas	Director of Human Resources	Trust Lead

Director Links to Trust Work

	Name	Title	Responsibility
Human Rights	Ian McPherson	Non-Executive Director	Non-Executive Lead
Human Resources	Richard Strang	Deputy Trust Chair	Non-Executive Lead
Older People	Angela Greatley	Trust Chair	Non-Executive Lead
	Name	**Title**	**Responsibility**
Legal Issues	Pat Key	Director of Corporate Governance & Facilities	Trust Lead
	Ian McPherson	Non-Executive Director	Non-Executive Lead
Mental Health Act	Ian McPherson	Non-Executive Director	Non-Executive Lead
	Rob Senior	Medical Director	Trust Lead
Research Committee	Andrew Cooper	Director of Research & Development	Trust Lead
	Joyce Moseley	Non-Executive Director	Non-Executive Lead
Research Ethics	Jessica Hobson	Research Fellow	
	Biddy Youell	Head of Child Psychotherapy	

Board of Directors : September2011

Item : 12

Title : Review of External Links 2011/12

Summary:

The Board of Directors is responsible for ensuring that the Trust co-operates with other NHS bodies, Local Authorities and other relevant organisations with an interest in the local health economy. Monitor's Code of Governance suggests that the Board should maintain a schedule of the specific third party bodies to which the Trust has a duty to cooperate. The Board should be clear of the form and scope of cooperation required for each body. The Board should ensure that mechanisms are in place to cooperate with relevant third party bodies and that collaborative and productive relationships are maintained. The Board should review the effectiveness of these processes and relationships.

This schedule is attached. It draws in large part from the list of third parties with roles in relation to foundation trusts found in Monitor's Compliance Framework. In addition to this, other organisations such as professional bodies, the Police, and HM Coroner have been added to this list. The schedule is clear about the scope of, and the mechanisms for, cooperation, as well as highlighting key contacts.

Both those listed as contacts and management has reviewed this schedule, highlighting the mechanisms that are in place to cooperate with relevant third party bodies, and has ensured that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority.

This report has been reviewed by the following Committees:
- Management Committee, 8th September 2011

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance that the Trust is appropriately prepared to co-operate with external parties, and where not, whether they are satisfied with the action plans that have been put in place.

This report focuses on the following areas:
(delete where not applicable)

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

For : Approval

From : Trust Secretary

Annual Review of External Trust Links

Party[1]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with statutory enforcement powers over NHS foundation trusts				
Care Quality Commission	The CQC is the independent regulator of healthcare and adult social care in England. It monitors providers' compliance with Essential Standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 on an on-going basis It has a range of enforcement powers available to it to address failure to maintain compliance with these requirements up to removing registration to practice In the case of an NHS Foundation Trust failing to meet these standards, the CQC will liaise with Monitor and, taking account of their respective powers, Monitor and the CQC will work together to ensure these requirements are met www.cqc.org.uk	All care providers in England must be registered with the CQC. In order to be registered, each provider must show they meet essential standards of quality and safety in all of their regulated services The CEO must ensure that the Board of Directors is informed of any declaration of compliance with Essential Standards The Trust must cooperate with any request for information and/or spot check visit that the CQC may choose to conduct The Trust must inform the CQC of any significant changes to practice and through relevant agencies (e.g. NPSA) of any significant adverse events	The Trust has fully completed registration processes and is currently fully registered The Trust has a nominated CQC Inspector who will approach the Trust directly with any concerns and/or requests for information The Trust will contact the Inspector directly in the event of changes or other information that it is required to inform the CQC of.	**Pat Key, Director of Corporate Governance & Facilities** (Nominated Manager registered with CQC) Matthew Patrick, Chief Executive Officer Jane Chapman Governance and Risk Adviser (co-ordinated CQC liaison)

[1] This list is partially informed by Appendix A to Monitor's Compliance Framework 2011/12 (published March 2011)

* Lead contact appears in bold and underlined

Party[1]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with statutory enforcement powers over NHS foundation trusts				
Charities Commission	The Charities Commission is a statutory regulator and registrar for charities in England & Wales http://www.charity-commission.gov.uk/	Submission of annual returns, Annual report and Accounts Response to any other enquiries		**Simon Young, Director of Finance**
Environment Agency	The Environment Agency is the leading public body for protecting and improving the environment in England and Wales. It grants licences for waste management services, including clinical waste http://www.environment-agency.gov.uk/	The Trust must ensure that any waste it produces is handled safely and in accordance with the law according to the Duty of Care legislation	The Trust receives certification to verify safe and legal disposal of all electrical and electronic equipment under WEEE regulations	**Pat Key, Director of Corporate Governance & Facilities**
Equality and Human Rights Commission	The Equalities and Human Rights Commission is an independent statutory body established to promote and monitor human rights, and to protect, enforce and promote equality across the nine "protected" grounds – age; disability; gender; race; religion and belief; pregnancy and maternity; marriage and civil partnership, sexual orientation, and gender reassignment http://www.equality humanrights.com/	The Trust has no formal link with the Equality and Human Rights Commission and is not required to do so	The Website and Helpline are used on an ad hoc basis for information and/or advice	**Julia Smith, Director of Service Development & Strategy**

Party[1]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with statutory enforcement powers over NHS foundation trusts				
Fire Authorities	Fire Authorities are responsible for fire fighting and fire safety, and may require NHS Foundation Trusts to make changes to buildings or operations to prevent fires	Trust is required to ensure risk assessments are carried out regularly on all buildings All staff must be appropriate trained on fire safety The Trust must cooperate with any request for information and/or spot check visit that the Fire Authorities may choose to conduct	Risk Assessments for all buildings the Trust owns (updated if changes to fabric or usage of building) Fire training; INSET; and local induction with Manager Annual Fire warden training and evacuations	**Pat Key, Director of Corporate Governance & Facilities** Lisa Tucker, Health & Safety Manager Dave King, Fire Safety Consultant
General Medical Council	The GMC registers doctors to practise medicine in the UK. Their purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine http://www.gmc-uk.org/	All doctors must be registered with the GMC to practice medicine in the UK Doctors are required to maintain their registration and licence to practice through payment of an annual fee The Trust is required to respond to any requests for information made by the GMC under their investigation of complaints and/or disciplinary procedures The Trust is required to be in a state of readiness for new procedure for re-validation process	HR maintains a system of checking registrations at employment and annually thereafter Re-validation Lead nominated and preliminary work underway	**Rob Senior, Medical Director** Dr Jessica Yakeley , Associate Medical Director (Lead on Revalidation Process)

Party[1]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with statutory enforcement powers over NHS foundation trusts				
General Social Care Council	The GSCC is the regulator of the social work profession and education in England The GSCC protects the public by requiring high standards of education, conduct, and practice of social workers by ensuring that only those who are properly trained and committed to high standards practise social work. The GSCC is the body that registers Social Workers The GSCC also accredits practice placements http://www.gscc.org.uk/	All staff using the title *Social Worker* register with the GSCC. It is illegal to use the title without registration Social Workers are required to maintain their registration through payment of fees set by the GSCC The Trust is required to respond to any requests for information made by the GSCC under their investigation of complaints and/or disciplinary procedures	HR maintains a system of checking registrations at employment and annually thereafter	**David Lawlor, Trust-wide Head of Social Work Discipline**
Health Professions Council	The HPC currently regulates 15 health professions, including practitioner psychologists, which covers educational psychologist, counselling psychologists and clinical psychologists. The HPC registers the above health professions. It is a criminal offence for anyone to use a professional title if they are not registered with the HPC http://www.hpc-uk.org/	All professionals covered by the HPC must be registered with the HPC to practice in the UK	Annual check is made by the HPC through Human Resources	**Bernadette Wren, Trust-wide Head of Psychology Discipline**

Party[1]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with statutory enforcement powers over NHS foundation trusts				
Health Protection Agency	The Health Protection Agency is a statutory body set up to: identify and respond to hazards and emergencies; anticipate and prepare for emerging and future threats; alert and advise the public and Government on health protection; provide specialist health protection services; and support others in their health protection roles http://www.hpa.org.uk/	A nominated member of staff and a Director must be available for alerts. Up to date contact details must be kept with the HPA Security alerts and other reports must share information with staff	Nominated staff to react and cascade alerts Health and Safety Manager and Director of Corporate Governance & Facilities receive security alerts and other reports (e.g. extreme weather)	**Pat Key, Director of Corporate Governance and Facilities** Lisa Tucker, Health & Safety Manager
Health and Safety Executive	The Health and Safety Executive is responsible for the regulation of almost all the risks to health and safety arising from work activity http://www.hse.gov.uk/	Ensure Building Regulations and training for staff is delivered Ensure Institute of Health & Safety qualified staff on site	Annual Estates Risk Assessments Lone Worker Risk Assessments Mandatory Health & Safety training for specific staff groups; Manual Handling training; Conflict resolution training Incident reporting Clinical Staff training; Supervision Risk and method statements and health and safety statements are supplied by contractors prior to projects starting HSE is given notification of	**Pat Key, Director of Corporate Governance & Facilities** Lisa Tucker, Health & Safety Manager (IOSH)

Party[1]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with statutory enforcement powers over NHS foundation trusts				
			projects where construction work is expected to: a) last more than 30 working dates; and/or b) involve more than 500 person days All contractors are given a site and orientation induction from the Support Services Manager. All contractors who attended site must be signed in. A permit to work system operates with in the Trust	
Information Commissioner	The Information Commissioner's Office (ICO) oversees and enforces compliance with the Data Protection Act 1998 and the Freedom of Information Act 2000. The ICO has the power to place restrictions on practice and fine in the event that organisations do not comply with the aforementioned Acts. http://www.ico.gov.uk/	The Trust must register annually with the ICO. The Trust must have policies and procedures to ensure compliance. The Trust must respond promptly and appropriately to any enquiries, investigations or requests for information from the ICO.	We register annually. Information Governance assessment is submitted to NHS Connecting for Health online in March every year. Embraces all aspects of Confidentiality, Freedom of Information, Data Protection Act, Human Rights Act (privacy clause), health records, data security, Information Governance Management. Such enquiries are infrequent, but are dealt with appropriately.	**<u>Simon Young, Director of Finance</u>** Richard Davies, Caldicott Guardian Lotte Higginson, FOI Officer and Access to Records Officer Pat Key, Director of Corporate Governance & Facilities Allan Archibald, Head of Informatics

Party[1]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with statutory enforcement powers over NHS foundation trusts				
Monitor	Monitor is the independent regulator of NHS foundation trusts. There are three main strands to Monitor's work: determining whether NHS trusts are ready to become foundation trusts; ensuring that FTs comply with the conditions they signed up to; and supporting FT development Monitor's role as a regulator is to ensure that FTs are well led, that their leaders are focused on the quality of care patients get, and that they are financially strong Monitor look at whether FTs are meeting the required quality standards, as judged by the CQC, and at the Trust's financial strength Monitor regulates FTs to ensure they comply with their Terms of Authorisation. These are a set of detailed requirements covering how FTs must operate. They include the general requirement to operate effectively, efficiently, and economically; requirements to meet healthcare targets and national standards; and the requirement to co-	The Trust must submit an Annual Plan and regular reports to the Trust. The frequency of reports is related to the Trust's risk ratings. Where Monitor feels the Trust is failing in an area, it requires the Trust to develop an action plan and monitors progress against that plan. The Trust must submit Annual Reports and Annual Accounts to Monitor (and Parliament) each year	The Trust has an annual planning process, which is led by the Chief Executive and the Director of Finance. The development of the Plan involves senior Trust staff, Non-Executive Directors, and the Board of Governors The Trust submits regular declarations on finance, governance, & quality. These submissions inform Monitor's risk ratings The Directorate of Finance is responsible for the production of the Annual Accounts. The Trust Secretary's office is responsible for the production of the Annual Report, in consultation with senior Trust staff.	**Matthew Patrick, Chief Executive** Angela Greatley, Trust Chair Simon Young, Director of Finance Louise Carney, Trust Secretary

Party[1]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
	operate with other NHS organisations Monitor has the powers to intervene in an FT in the event of failings in its healthcare standards or other aspects of its leadership, which result in a significant breach of its Terms of Authorisation http://www.monitor-nhsft.gov.uk/			
Nursing and Midwifery Council	The NMC registers all nurses and midwives and ensure that they are properly qualified and competent to work in the UK, and sets the standards of education, training, and conduct for nurses and midwives http://www.nmc-uk.org/	All nurses must be registered with the NMC to practice as nurses in the UK Nurses are required to maintain their registration through payment of fees set by the NMC, and by self-declaration of having completed required CPD The Trust is required to respond to any requests for information made by the NMC under their investigation of complaints and/or disciplinary procedures	HR maintains a system of checking registrations at employment and annually thereafter	**Marcus Evans, Head of Nursing Discipline** Lis Jones, Nurse Director

Party[1]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with statutory enforcement powers over NHS foundation trusts				
Police	The Police have powers to investigate any crime in the United Kingdom and to arrest any persons suspected of illegal activities.	The Police have legitimate powers of entry and investigation of anyone suspected of criminal activity. Should the Police carry out an investigation, the Trust is required to share information as agreed under Memorandums of Understanding and to co-operate with enquiries.	There are Memorandums of Understanding between the Police and the National Health Service.	**Dr Matthew Patrick, Chief Executive**
Public Accounts Committee	The Public Accounts Committee is a Parliamentary Committee with the power to call any Accounting Officer of a public body (including NHS Foundation Trusts) before it. http://www.parliament.uk/	Accounting Officer required to provide information to Public Accounts Committee if called upon.	No direct contact to date.	**Matthew Patrick, Chief Executive Officer** Simon Young, Director of Finance
Secretary of State	The Secretary of State issues directions with respect to safety and security in connection with the provision of high security psychiatric services. The Secretary of State can make an order on the Trust to act in a certain way and/or take certain actions.	The Trust is required to respond to legitimate requests for information in relation to Parliamentary questions relating to the services we offer.	Communication would come via the Chief Executive, or the Communications Team. Trust would respond as required. The Chief Executive would sign off on all communication. No direct contact to date.	**Matthew Patrick, Chief Executive**

Party[2]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with a statutory role but no enforcement powers over NHS foundation trusts				
Department of Health	The DoH is a Government department, headed by the Secretary of State for Health which sets NHS policy and guidance for the delivery of health and social care. It directors trusts via their Chief Executive to ensure that requirements for care delivery and financial management, as prescribed in policy and guidance, are met at trust level. The DoH sets national frameworks for care delivery that must be reflected in trust plans and products (e.g. mental health agendas). http://www.dh.gov.uk/	To ensure the Trust is up-to-date with any new DoH requirements. To ensure that the Trust maintains evidence of compliance with key requirements. To operate within the statutory framework (via Monitor) as an authorised NHS organisation. To report compliance with information governance standards.	The Directorate of Corporate Governance and Facilities keep up-to-date with requirements and guidance, and direct these to relevant directors throughout the Trust. Information Governance Toolkit used to report compliance with IG standards.	**Pat Key, Director of Corporate Governance & Facilities**(for emergency planning) Jane Chapman, Governance & Risk Advisor Jonathan McKee, Information Governance Lead Lisa Tucker, Emergency Planning Liaison Officer
Commissioners	Commissioners specify in detail the delivery and performance requirements of NHS Foundation Trusts, and the responsibilities of each party through legally binding contracts. NHS Foundation Trusts are	The provision of clinical services in line with contractual agreements. The provision of patient level activity data and Trust performance-related data as required by the contract and	Quarterly / six-monthly Commissioner meetings which review activity against contract. Monthly patient-level data reports to all Commissioners with whom the Trust has a contract.	**Julia Smith, Director of Service Development & Strategy**

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[2] This list is partially informed by Appendix A to Monitor's Compliance Framework 2011/12 (published March 2011)
* Lead contact appears in bold and underlined

Party[2]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with a statutory role but no enforcement powers over NHS foundation trusts				
	required to meet their obligations to commissioners under their contracts. Any disputes about contract performance should be resolved in discussion between commissioners and NHS Foundation Trusts, or through their dispute resolution procedures. Commissioners should raise with Monitor serious and persistent concerns regarding an NHS Foundation Trust's willingness to attempt to agree contracts or ability to remain compliant with its Authorisation. NHS Foundation Trusts should similarly keep Monitor informed where disputes or potential disputes with commissioners may have an impact on an NHS Foundation Trust's ability to remain compliant with its Authorisation. Monitor does not expect to be involved in specific contractual disputes.	CQUIN agreements.	A systemised linking of informal contacts between the Trust Clinical Leads / Associate Director of Business Development / Director of Service Development & Strategy and Commissioners.	
Cooperation and Competition Panel	The CCP investigates potential breaches of the Principles and Rules of Cooperation and Competition, and makes independent recommendations to Strategic Health Authorities,	The Trust is required to cooperate with the CCP in relation to proposed transactions. The Trust is subject to scrutiny	Trust will send relevant documentation as required.	**Matthew Patrick, Chief Executive**

Party[2]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with a statutory role but no enforcement powers over NHS foundation trusts				
	the Department of Health and, in relation to NHS Foundation Trusts, Monitor, on how such breaches may be resolved. On receipt of advice from the CCP, Monitor will decide what, if any, action is required on the part of the NHS Foundation Trust(s) concerned. http://www.ccpanel.org.uk/	on any mergers or acquisitions.		
HM Coroner	Investigates all "unnatural" deaths that occur in his geographical jurisdiction. Has the power order people to attend his court. http://www.coronersociety.org.uk/	To report any patient who dies whilst in therapy and to co-operate fully with any inquiry that HM Coroner chooses to undertake.	Direct reporting and/or response to requests from Coroners' Office.	**Rob Senior, Medical Director** Jane Chapman, Governance & Risk Lead
Local Involvement Networks (LINks)	The role of LINks is to give local communities a voice in commissioning health and social care. The Local Government and Public Involvement in Health Act 2007 which established LINks sets out their role and function and also gives the Secretary of State power to make regulations, imposing duties on	Trust is required to send Quality Report to LINks for feedback to be included in final version.	Trust sends Quality Report each year.	**Sally Hodges, PPI Lead**

Party[2]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
	commissioners and certain providers of health and social care services. LINks is due to be replaced by Healthwatch in April 2012.			
NHS Information Centre for Health and Social Care	The NHS Information Centre is a special health authority which collects, analyses and presents national data and statistical information about health and social care. NHS Foundation Trusts are required to report information specified by Schedule 6 of their Authorisation to the NHS Information Centre. http://www.ic.nhs.uk/	Chief Executive required to sign annual declaration confirming compliance with fire regulations.	Annual declaration signed by CEO.	**Julia Smith, Director of Service Development & Strategy**
Ofsted	**Ofsted Education** Ofsted is the inspectorate for children and learners in England. It is Ofsted's job to contribute to the provision of better education and care through effective inspection and regulation. http://www.ofsted.gov.uk/	Gloucester House is required to meet Ofsted requirements in order to retain a DCSF number and independent school status. The requirements are mandatory compliance requirements and Gloucester House needs to be able to provide evidence in relation to these. Many of the requirements are in relation to the building,	Head Teacher and other school staff need to be aware of requirements and have available evidence to support compliance. Staff must cooperate with inspection procedures. The Unit Director, the school administrator, the Trust Chair, CAMHS Director, and the Directorates of Corporate Governance & Facilities and	**Nell Nicholson, Head Teacher, Gloucester House** Rita Harris, CAMHS Director

Party[2]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with a statutory role but no enforcement powers over NHS foundation trusts				
		safeguarding etc. and the Directorates of Corporate Governance & Facilities and Human Resources need to be aware of these. Other requirements relate to the quality of teaching and learning. The Head Teacher is responsible for ensuring standards of teaching and learning are adequate. The Trust Chair is the named person as the proprietor of Gloucester House. Inspections are carried out approximately every two years and the Head Teacher is given one or two days' notice of inspection. If the school does not meet requirements, Ofsted may visit more often and will ask for additional action plans in relation to specific issues. If they are not satisfied with the response they do have the power to de-register and close the school.	Human Resources need to be aware of requirements and ensure the Head Teacher has evidence to support compliance measures. The building has to be kept in a good state of repair in respect of this.	
	Ofsted Safeguarding Children Trust is required to co-operate	To provide information as requested.	Direct request received from inspector or inspected organisation.	**Rob Senior, Medical Director**

Party[2]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
			Bodies with a statutory role but no enforcement powers over NHS foundation trusts	
	when partner organisations providing care to children are being reviewed by Ofsted / CQC.		Would be led by Medical Director and Trust-wide Safeguarding Lead.	Sonia Applyby, Trust Safeguarding Lead
Overview and Scrutiny Committees of Local Authorities	The Overview and Scrutiny Committees of Local Authorities inquire into all "matters of local concern", including the NHS, e.g. health inequalities and access to services in the NHS. NHS Foundation Trusts must consult with the relevant Overview and Scrutiny Committees before making any material changes to service offerings that will result in a change to mandatory services, and must provide the Overview and Scrutiny Committees with any information requested. A number of Overview and Scrutiny Committees, some non-local, may take an interest in provision where NHS Foundation Trusts offer a tertiary referral service on a regional or national basis.	The Trust is required to send its Quality Report to the OSC for comment. The Trust is invited to visit the OSC to report on various matters, e.g. ethnic diversity on the Boards of Governors and Directors, or the work of the Trust.	OSC feedback is built into the Quality Report timetable. The Trust sends relevant documentation and will often send a staff member to attend a meeting of the OSC.	**Matthew Patrick, Chief Executive Officer**
Parliamentary and Health Service Ombudsman	The Parliamentary and Health Service Ombudsman investigates complaints made by	Respond to any requests from PHSO for records and/or other information in relation to	Arrangements set out in the Trust's Complaints Policy and managed by the Complaints	**Matthew Patrick, Chief Executive Officer**

Party[2]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with a statutory role but no enforcement powers over NHS foundation trusts				
	or on behalf of people who consider that the trust has failed to address their concerns via the NHS complaints procedure. the PHSO has powers to request documentation and require staff to participate in interview and other reviews. http://www.ombudsman.org.uk/	internal investigation of complaints. Respond to any formal letter of conclusion from PHSO following a complaints investigation conducted by his office.	Officer.	Lotte Higginson, Complaints Officer Pat Key, Director of Corporate Governance & Facilities
Primary Care Trusts & NHS Clusters and shadow Clinical Commissioning Groups	PCTs & NHS Clusters commission secondary services from NHS trusts & foundation trusts and independent sector treatment centres, controlling 75% of the NHS budget. Each PCT/NHS cluster is responsible for monitoring compliance of trusts with their contractual obligations. PCTs/NHS Clusters play a crucial role in the management of the quality of care delivered, as measured by national and local agreements, through contractual arrangements with providers. Under the proposed Health and Social Care Bill, PCTs will cease to exist by 2014.	Input into Quality, Innovation, Productivity and Prevention programmes. Input into Quality, Innovation, Productivity and Prevention programmes. The provision of clinical services in line with contractual agreements. The provision of patient level activity data and Trust performance-related data as required by the contract and CQUIN agreements.	Quarterly / six-monthly Commissioner meetings which review activity against contract. Monthly patient-level data reports to all Commissioners with whom the Trust has a contract. A systemised linking of informal contacts between the Trust Clinical Leads / Associate Director of Business Development / Director of Service Development & Strategy and Commissioners.	**Julia Smith, Director of Service Development & Strategy**

Party[3]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with no statutory role but a legitimate interest[4]				
Association of Child Psychotherapists	The ACP is the main professional body for psychoanalytic child and adolescent psychotherapists in the UK. It is responsible for regulating the training and practice standards of members.	ACP sets training standards and standards for service supervision and for CPD	The Head of Training attends the Training Council and the Psychotherapy Discipline has members on each of the various committees. The Trust-wide Head of Child Psychotherapy is currently the Chair of the ACP	**Biddy Youell, Trust-wide Head of Child Psychotherapy**
Association of Family Therapy	The AFT is an alliance of professionals working therapeutically with children, adults, and those important in their lives, in health, social care, education, and third sector services. The AFT formally accredits professional training courses.	AFT sets standards for supervision etc. that the Trust must comply with.	The Trust has representatives on various bodies.	**Ellie Kavner, Trust-wide Head of Systemic Psychotherapy Discipline**
British Psychological Society	The BPS is the representative body for psychology and psychologists in the UK. It is the body that registers psychologists as Chartered	All staff using the title *Chartered Psychologist* must register with the BPS. It is illegal to use the title *Chartered* without registration.	All Trust appointments are for psychologists who are Chartered or at least eligible for Chartered status at the time of application for employment.	**Bernadette Wren, Trust-wide Head of Psychology Discipline**

[3] This list is partially informed by Appendix A to Monitor's Compliance Framework 2011/12 (published March 2011)
* Lead contact appears in bold and underlined
[4]These parties have no statutory powers over NHS Foundation Trusts. However, Monitor expects that NHS Foundation Trusts will generally cooperate with such bodies, and a failure to cooperate may, under certain circumstances, constitute a breach of the Authorisation and grounds for intervention

Party[3]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with no statutory role but a legitimate interest[4]				
	Psychologists. It is responsible for the development, promotion, and application of pure and applied psychology. The BPS also accredits practice placements. Chartered status, on top of mandatory HPC registration, is regarded as involving a higher threshold of professional scrutiny, and is therefore considered good practice.			
Confidential Enquiries	Confidential enquiries research the way patients are treated, to identify ways of improving the quality of care. They publish reports summarising key findings and recommendations arising from the information they gather. They aim to identify changes in clinical practice that will improve quality of care and ultimately improve patients' outcomes. The two confidential enquiries relevant to the Trust are the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness and	Trust is required to respond to requests for identification of patients who falls into either of these enquiries and may be asked to undertake reviews of cases under the direction of the inquiry.	Trust will send information as required on receipt of letter from the Director of the Enquiry.	Rob Senior, Medical Director **Jane Chapman, Governance and Risk Advisor**

Party[3]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with no statutory role but a legitimate interest[4]				
	the Centre for Maternal and Child Health Inquiries.			
Formally-appointed committees, working groups and forums advising the Department of Health on topics across health and social care	There are about 40 groups which advise the Department of Health on a range of topics across health and social care. Of these, about half may work with NHS Foundation Trusts from time to time, and include the NHS-wide Clearing Service, the National Specialist Commissioning Advisory Group, and the Specialist Advisory Committee on Antimicrobial Resistance.	Feedback on formal consultations. Input into policy fora.	The Trust inputs via the NHS Confederation, the Foundation Trust Network, and the Mental Health Network on formal responses to consultations. Individual Trust staff, e.g. the Trust Chair or the CEO, participate in more specific for a convened on policy (e.g. Children's IAPT).	**Matthew Patrick, Chief Executive Officer**
National Patient Safety Agency	The NPSA coordinates the reporting of, and learnings from, mistakes and problems that affect patient safety. It also encorporates the National Clinical Assessment Service, which provides a support service where there are concerns over the performance of an individual doctor or dentist. http://www.npsa.nhs.uk/	The Trust is required to advise the NPSA of all incidents involving patients. The Trust is required to respond to any relevant alert issued via the NPSA.	Nominated staff report all patient incidents via NPSA external web link on a quarterly basis incident and be recognised link for NPSA. All alerts issues via the CAS system are reviewed and any relevant alerts (e.g. estates alerts) are brought to the attention of appropriate senior staff for action.	**Pat Key, Director of Corporate Governance and Facilities** Jane Chapman, Governance and Risk Adviser
National Treatment	The NTA is a special health	Monthly reports to National	Monthly deadlines agreed with	**Sally Hodges,**

Party[3]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with no statutory role but a legitimate interest[4]				
Agency for Substance Misuse	authority within the NHS, established by the Government in 2001 to improve the availability, capacity, and effectiveness of treatment for drug misuse in England. http://www.nta.nhs.uk/	Drug Treatment Monitoring Service, which is a part of NTA.	Commissioners.	**Assistant Associate Director, CAMHS**
NHS Business Services Authority	The NHS Business Services Authority is responsible for policy and operational matters relating to prevention, detection, and investigation of fraud and corruption in the NHS. http://www.nhsbsa.nhs.uk/	Compliance with counter-fraud guidance. Compliance with security management guidance.	Annual return submitted by the Trust and assessed by NHS Protect (the new name for this part of the NHS BSA, previously CFSMS), leading to a rating.	**Simon Young, Director of Finance**
		NHS Pensions Agency. Provision of information from payroll.	Monthly and annual transfers of information on pension contributions.	**Simon Young, Director of Finance**
		Prescriptions pricing authority. Procedures for security of prescriptions (few). Paying invoices.	Medicines Management Procedure, approved October 2010.	**Rob Senior, Medical Director** Pat Key, Director of Corporate Governance and Facilities Simon Young, Director of Finance
NHS Litigation	The NHSLA is responsible for	The Trust is required to register	The Trust is a member of the	**Pat Key, Director of**

Party[3]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with no statutory role but a legitimate interest[4]				
Authority	handling negligence claims made against NHS bodies in England. It helps to manage clinical risks (via the Clinical Negligence Scheme for Trusts) and non-clinical risks (via the Risk Pooling Scheme for Trusts) and manages claims and litigation for both. http://www.nhsla.com/home.htm	all claims for compensation brought as clinical negligence, employer liability, or public liability with the NHSLA, and then respond to all request during the management of each claim. The Trust is required to be assessed by the NHSLA on a fixed schedule against standards for risk management.	NHSLA schemes – CNST, PES and LTPS. The Trust's Governance and Risk Adviser ensures that claims are managed in line with NHSLA requirements. The Trust has been assessed as required at Level 1 (Feb 2009) and at Level 2 (Feb 2011). Next assessment to be completed Feb 2014.	**Corporate Governance and Facilities** Jane Chapman Governance and Risk Adviser
Royal College of Psychiatrists	Royal colleges aim to ensure high quality care for patients by improving standards and influencing policy and practice in modern healthcare. They set standards for clinical practice, conduct examinations, define and monitor education and training programmes for their members, support clinicians in their practice of medicine, and advise the Government, public and the profession on healthcare issues. The Royal College of Psychiatrists is the professional and educational body for psychiatrists in the UK. It aims to: set standards and	Respond to requests for information. Ensure good standing of psychiatrists with college for CPD. Contribute to College Committees as requested.	Appraisal system for individual psychiatrists.	**Rob Senior, Medical Director**

Party[3]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
	promote excellence in psychiatry and mental healthcare; lead, represent, and support psychiatrists; and work with service users, carers and their organisations.			
Trades' Unions	Trades' unions protect the interests of their members. The Trust's staff are members of the British Medical Association, Unison, and Unite.	Trust is required to include trade union representatives in discussions about restructuring changes that affect staff and to include them in discussions about banding and grading of new posts. All staff have a right to a union representative at any formal meetings and the Trust is required to ensure that union representatives receive copies of any formal papers in advance of any meetings.	The Trust works in close partnership with Staff Side colleagues both through the formal JSCC and regular bi-weekly meetings between the HR Director and Staff Side Chair. This approach allows many issues to be dealt with at an informal level therefore facilitating progress on management issues for the Trust.	**Susan Thomas, Director of Human Resources**
Universities, post-graduate deaneries and the Postgraduate Medical Education and Training Board	NHS foundation trusts may offer professional education or training in conjunction with universities or other professional bodies. The accreditation process for such education or training may include a requirement for inspection and monitoring of provision. For NHS Foundation Trusts with	To deliver undergraduate and postgraduate medical education, in the Trust, we must ensure that GMC/PMETB standards for teaching and training are met, the London Deanery's strategic direction is supported, and that the educational contract between the Trust and the London Deanery/NHS London is fulfilled. We are required to complete an	The Director of Medical Education (DME) is responsible for ensuring the delivery of medical teaching and training in line with these requirements. The DME reports to the Medical Director and the Trust Dean, both of whom sit on the Board of Directors. The DME is aided by the Medical Education Board, consisting of the PGME administrator, the	**Jessica Yakeley, Associate Medical Director**

Party[3]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with no statutory role but a legitimate interest[4]				
	cross-border activities in Wales, the list also includes the Welsh Assembly, local health boards, Health Commission Wales, and Healthcare Inspectorate Wales.	annual report for the London Deanery in line with the requirements of the Learning Development Agreement and Quality Management Manual. Trainers and trainees are required to complete an annual survey administered by the GMC/PMETB of the quality of training provided by the Trust. The London Deanery carries out an annual inspection of the quality of medical training provided by the Trust, taking into account the results of these reports.	Training Programme Directors, Librarian, and a Trainee representative. The Medical Education Board meets regularly throughout the year to promote the development and quality of education provision. The DME also consults regularly with the wider consultant group of clinical and educational trainers, and ensures that they are fully trained in line with the London Deanery's Faculty Development Framework.	

Party[5]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
Bodies with representation on the Trust's Board of Governors				
Local Authorities – Camden	At least one member of the board must be appointed by one or more qualifying local authorities. A qualifying local authority is a local authority for an area which includes the whole or part of an area specified in the constitution as the area for a public constituency[6].	As for all Governors, keep representatives informed of developments.	The London Borough of Camden agreed to represent Local Authorities. Cllr Patricia Callaghan (Lab) is the incumbent.	**Angela Greatley, Trust Chair** Matthew Patrick, Chief Executive Louise Carney, Trust Secretary
Non-Statutory Sector – Voluntary Action Camden	An organisation specified in the constitution as a partnership organisation may appoint a member of the board[7].	Ibid.	Voluntary Action Camden agreed to represent the non-statutory sector. Ms Simone Hensby, Director, is the incumbent.	**Angela Greatley, Trust Chair** Matthew Patrick, Chief Executive Louise Carney, Trust Secretary
Primary Care Trusts – Camden Primary Care Trust	At least one member of the board must be appointed by a Primary Care Trust for which the corporation provides goods or services[8].	Ibid.	Camden PCT previously agreed to represent PCTs. The new North Central Sector Cluster has chosen not to send a representative.	**Angela Greatley, Trust Chair** Matthew Patrick, Chief Executive

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[5] This list is partially informed by Appendix A to Monitor's Compliance Framework 2011/12 (published March 2011)
* Lead contact appears in bold and underlined
[6] National Health Service Act 2006, Schedule 7, paragraph 9(4) and (5)
[7] National Health Service Act 2006, Schedule 7, paragraph 9(7)
[8] National Health Service Act 2006, Schedule 7, paragraph 9(3)

Party[5]	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
				Louise Carney, Trust Secretary
Bodies with representation on the Trust's Board of Governors				
Specialist Commissioning	Ibid.	Ibid.	There is currently no representative in this seat.	**Angela Greatley, Trust Chair** Matthew Patrick, Chief Executive Louise Carney, Trust Secretary
University of East London	Ibid.	Ibid.	Prof. John Joughin, Deputy Vice Chancellor, is the incumbent.	**Angela Greatley, Trust Chair** Matthew Patrick, Chief Executive Louise Carney, Trust Secretary
University of Essex	Ibid.	Ibid.	Dr Aulay Mackenzie, Dean of Academic Partnerships, is the incumbent.	**Angela Greatley, Trust Chair** Matthew Patrick, Chief Executive Louise Carney, Trust Secretary

Board of Directors : [September] [2011]

Item : 13

Title : Updated Risk Strategy and Policy 2011-13

Summary:

The Risk Strategy and Policy has been reviewed and updated to ensure that is accurately describes current risk arrangements in the Trust. The changes made are shown in **blue** in the text and largely relate to ensuring the strategy and policy accurately describe the way in which risk is managed via the Clinical Quality Safety and Governance Committee. A few additional minor changes have been made following feedback received from the NHSLA Assessors earlier this year.

This report has been reviewed by the following Committees:
• Management Committee 15th September 201

The Board of Directors is asked to ratify the updated Risk Strategy and Policy and agree that it should be represented for ratification in Sept 2013 (unless external requirements lead to changes to the Trust strategy and policy).

This report focuses on the following areas:
(delete where not applicable)
• Risk

For : Approval/Ratification

From : Pat Key Director of Corporate Governance and Facilities

Risk Management Strategy and Policy 2011–2013

Version:	7 (replaces Sept 2010 version 6)
Bodies consulted:	Management Committee *(note: minor updates only)*
Approved by:	Board of Directors
Date Approved:	
Name of originator/ author:	Jane Chapman Governance and Risk Adviser
Lead Director:	Pat Key Director of Corporate Governance and Facilities
Date issued:	
Review date:	Sept 2013

Contents

Appendices

Risk Management Strategy and Policy

1	Introduction

The Tavistock and Portman Foundation NHS Trust, is committed to managing all clinical, organisational, health and safety, environmental and financial risks and is committed to working within the appropriate regulatory and legislative framework set by Care Quality Commission, the Financial Governance arrangements within the Trust , the Health and Safety at Work Act 1974 and the Environmental Protection Act 1990, and requirements of the NHS Litigation Authority

The Trust accepts its responsibility for managing safety, environmental and financial risks, ensuring the health and safety as well as the welfare of employees, patients, visitors, volunteer workers and all other people who have need to attend our premises or who may be affected by our activities.

Subject to constraints within which the Trust operates, the Trust is committed to the following:

Subject to constraints within which the Trust operates, the Trust is committed to the following:

- the Trust will take the necessary actions to ensure that its statutory duties are met at all times, and that it complies with all relevant codes of practice, policies and legal requirements

- the Trust will ensure high levels of professional competence, clinical effectiveness, quality, safety, and governance within the delivery of its services

- the Trust will take all necessary actions to achieve environmental best practice in its business activities

- the Trust will produce and deliver quality professional training programmes for our staff and external delegates

- the Trust will ensure that all work processes and systems of work are designed in a way to minimise risk to patients, staff and others and are properly supervised at all times

- the Trust will ensure that employees and their representatives are encouraged to raise risk concerns

- to appoint competent people to deliver its statutory duties including, where appropriate, specialists from outside the organisation

- to provide sufficient financial resources for the implementation of Risk Management

- where risks are identified, that they will be managed on in an integrated way

- to ensure that every employee (including agency and locum staff) co-operates with the Trust to enable all statutory requirements are met according to the standards set out in this policy. Each employee has a legal obligation to take reasonable care of his/her own health and safety and for the safety of others who may be affected by his/her acts or omissions.

- That this strategy will be promoted at Induction and INSET and will be made available to staff via the intranet.

The Trust accepts that risk management is an integral part of good management practice and must be accepted by all NHS managers as one of their key responsibilities.

2   Purpose

The purpose of the Risk Management Strategy is to:

- Ensure that the health, safety and welfare of employees, patients, visitors, volunteer workers and all other people who have need to attend Trust premises and who may be affected by Trust activities.

- Protect the assets and earnings of the Trust. Effective risk management reduces unnecessary costs and minimises losses from material damage, professional negligence, and injuries to staff and visitors, and ensures that income is not reduced through lost facilities.

- Provide a systematic and proactive approach to prioritising risks and hence aid decision-making on resource allocation.

- Promote and communicate good practice with respect to risk management.

The Trust's approach to risk management underpins the achievement of all corporate objectives

3   Scope

This strategy and associated policies applies to all staff directly or indirectly employed by the Trust (e.g agency or locum staff).

3.1   Context 'Fair Blame' Approach

The Trust wishes to create an environment in which all staff feel able to raise issues of concern with their managers and other senior staff and to report adverse incidents and near-misses. This will also include working in partnership with service users, carers and other organisations involved with the services provided in an open and transparent manner.

All managers and staff need to acknowledge that risks within the Trust will be reduced if everyone adopts an attitude of openness and honesty. The Trust is committed to make all efforts to avoid cover-ups of adverse incidents and mistakes, and the approach within the Trust will be one of help and support and commitment to understanding the reasons behind the incident, rather than recrimination and blame.

The Chief Executive has confirmed that no disciplinary action will result from reported incidents or mistakes subject to certain exceptions:

- incident warranting police investigation of individual members of staff

- incidents that reveal that actions of an individual are judged to be far removed from acceptable practice, and thereby put patients at risk

- Repeated failure by a member of staff to report incidents

- Malicious use of the reporting system

Risk reduction will result from a positive approach to risk investigation and control. It is important to turn what may appear to be overwhelming difficulties into manageable challenges, and problems into opportunities. Every incident, which is reported, presents a learning opportunity enabling improved delivery of future services.

The Trust is committed to clear feedback on action taken or planned, as a result of a reported incident, to promote the continued commitment of staff. This feedback will should include a clear indication as to how that particular risk situation has been reduced, transferred, or eliminated. Thus, all Trust staff will be encouraged to report risks, incidents and near misses in the future.

4   Definitions

Risk, is defined in the context of this strategy and associated policies as "uncertainty of actions or events which may have an impact on objectives, it is described in terms of consequence and likelihood".

Risk is present throughout any organisation e.g:

- the buildings which the Trust owns or occupies may give rise to risk

- the equipment, used in the operation of the Trust may give rise to risk

- research, used as part of the treatment of patients may give rise to risk

- the people employed by the Trust or visiting it as a patient or client, visitor or business guest may give rise to risk

- the systems or management of the Trust may give rise to risk

Risk management is defined as "the systematic and consistent identification, analysis, assessment and control of risks".

Risk management requires a proactive approach which:

- addresses the different clinical and non-clinical activities of an organisation
- identifies the associated risks of such activities
- assesses those risks for potential consequence and likelihood
- identifies solutions towards eliminating risks
- reduces or controls those risks that cannot be eliminated
- puts into place financial arrangements to absorb the financial consequences of the risks that remain

Risk management activities in the Trust are those activities that seek to harness information, and expertise of individuals within the Trust who can identify and advice on risks that it faces and using this expertise to take action to reduce to a minimum the impact of these risks.

5   Duties and Responsibilities

5.1   Chief Executive

The Chief Executive has overall responsibility for risk management. The Chief Executive and Board of Directors will be responsible for ensuring the effective implementation of this strategy and for monitoring its effectiveness.

5.2   Director of Finance

The Director of Finance is responsible for ensuring that processes are in place to identify risks to strategic objectives against the Annual Plan and that these are recorded on the strategic risk register (Assurance Framework) and monitored. The Director is also responsible reporting on the Assurance Framework to the Management Committee and the Board of Directors.

The Finance Director is responsible for ensuring a sound system of internal financial control and providing adequate financial information. He/she is the key contact for the auditors and is responsible for providing assurances to the Board. The Finance Director will have ultimate responsibility for any financial implications of plans to minimise risk and the method used to incorporate such into the business planning process.

5.3   Director of Corporate Governance and Facilities

The Director of Corporate Governance and Facilities has the following responsibilities:

- to act as lead for Risk Management, and is responsible for co-ordinating the implementation of this strategy. He/she is also responsible for Incident Reporting, Claims, Health and Safety including Manual Handling.

- to provide a central resource of information and advice with regard to both clinical and non-clinical risk management

- be responsible for the Trust's operational risk register

- **act as lead Director for preparation of   assessment against the NHS Risk Management standards**

- advising the Management Committee on resourcing issues to ensure that the Directors can improve compliance with the standards

- **act at lead Director for the trust in respect of CQC compliance ensuring that the trust maintains a portfolio of evidence of compliance for all core standards**

- provide authorisation for access to the Trust's legal advisers, and monitor use of this service with the aim of minimising costs

- ensure that the advice of clinical and non-clinical specialists will be sought as required to ensure that the Trust fulfils its duties under the Health and Safety at Work Act and all other relevant legislation. This includes access to a 'competent person' as defined by the Health and Safety at work legislation

5.4   Medical Director

The Medical Director is responsible for the management of clinical risk and for ensuring the Trust has effective systems for managing these risks. In fulfilling this duty he will:

- have overall responsibility of Clinical Governance
- ensure the development, review and publishing of appropriate Trust policies and procedures for the management of clinical risks
- oversee the provision of internal clinical advice in relation to clinical risk management
- ensure that the responsibilities for the provision of adequate arrangements for risk management are assigned, accepted and implemented at all levels within the organisation
- bring to the attention of the Chief Executive details of incident trends, levels of performance, clinical claims trends,

and matters of clinical risk concern requiring attention

- lead, serious clinical incident investigations with the Trust Director and the appropriate Clinical Director
- report to the Management Committee and Board on serious clinical risk issues.

5.5   Trust Non-Clinical and Clinical Directors

Trust Non-Clinical and Clinical Directors are responsible for managing risk across their directorates. They must ensure that the following is in place:

- that the Trust's incident reporting procedure is implemented and promoted within the Directorates
- staff in the directorate are aware of their roles and responsibilities where appropriate in relation to reducing the impact of risk for the Trust in particular in relation to health and safety and financial management
- **advise the Governance and Risk Adviser of updates to the risk register as required and undertake to review the risk for which they are the risk owner at least quarterly.**

5.6   Governance and Risk Adviser

The Governance and Risk Adviser is responsible for:

- providing expert advice on governance arrangements and risk strategies and processes

- day to day responsibility for leading preparation required to achieve NHSLA Risk Management Standard compliance

- day to day responsibility for coordinating Trust's evidence to achieve compliance with standards set by the Care Quality Commission (CQC))

- acting as a coordinator for updating the Trust's Operational Risk Register

- supporting the Associate Medical Director (Patient Safety and Clinical Risk) in ensuring that risk management is fully integrated with the Trust's approach to clinical governance

- acting as the day to day contact for with the NHSLA in relation to risk management standards and clinical claims .

5.7   Managers

Managers are responsible **for ensuring that risks in the area under their management** are identified, monitored and controlled in line with the Trust's strategy. Managers are responsible for ensuring risk assessments are conducted as appropriate for their area of responsibility and for ensuring actions are taken to mitigate any unacceptable risks

All identified risks that are not capable for satisfactory mitigation will be added to the trust risk register.

Managers should ensure that reports of adverse incidents or complaints are responded to quickly and decisively. Clear feedback on action taken or planned, as a result of a reported incident, should be given to staff. The Risk matrix gives guidance on appropriate managerial responsibility.

5.8 Health and Safety Manager

The Health and Safety Manager is responsible for advising the Trust on non clinical risk, fire and security, maintaining awareness of developments in these areas and to bring these to the attention of relevant managers/directors.

5.9 Fire Adviser

The Fire safety advisor is responsible to ensure expert advice, regular inspections and training for all staff

5.10 Risk Lead

This is the person identified on the risk register as responsible for leading on mitigation of specific risks

5.11 All Staff

Every employee must co-operate with the Trust and work to the standards set out in this strategy. Each individual has a legal obligation to take reasonable care of his/her own health and safety and for the safety of others who may be affected by his/her acts or omissions.

All staff are expected to have an understanding of risk management, to participate in the processes and to follow policies and procedures as required.

All staff are required to report incidents and near misses in line with the Trust's Incident Reporting Procedure.

6   Risk Management Process

6.1   Overview of the Process

The management of risks has a well-established approach first developed in high-risk areas such as the aviation and nuclear industries. The basic principle can be applied to almost any sort of risk, whether clinical or non clinical. The process involves the following steps:

- identifying the context
- identifying and analyse the risk(s)
- consider the controls that operate to reduce/monitor the risk
- consider the consequence of the risk and ascribe a consequence score
- consider the likelihood of the risk occurring and ascribe a likelihood score
- from these scores determine a risk score (consequence x likelihood)
- develop a treatment/mitigation plan dependent on the risk score
- monitor the risk (if low risk) or the effectiveness of the treatment plan (if a moderate, high or extreme risk).

This approach has been adopted by the Trust.

The process is illustrated below:
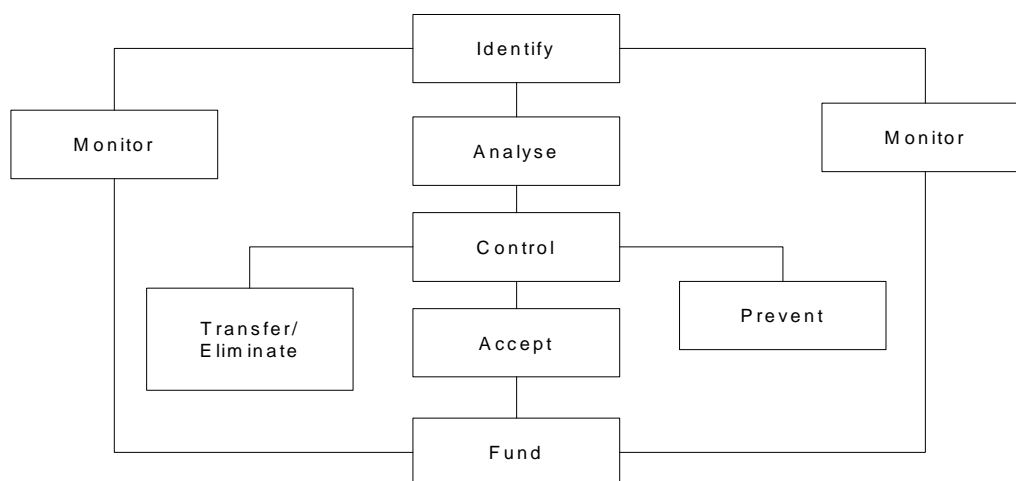
Figure 1: Risk Management Process

6.2   Prospective and Retrospective Risk

Further details on how this operates in practice is found at Appendix A "Steps in Managing Risk" The process described is to be used both for prospective risk assessment (i.e. identifying risk before it is realised) and retrospective risk analysis (i.e. the analysis of risk after an incident/event has occurred)

Staff are also referred to the Procedure for Risk Assessment which can be found on the trust intranet.

6.3   Using the Trust Risk Matrix

The Trust has developed a risk matrix to enable it to consider risks of all sorts against a common framework. The matrix enables a risk score to be ascribed to each identified risk and this score is sued to determine the level of action and escalation for review that the risk should undergo.

The Trust Risk Matrix is shown below and a guideline on how this matrix is to be used is shown at **Appendix B.**

			1	2	3	4	5
Likelihood	Almost certain to occur	5	5	10	15	20	25
	Likely to occur	4	4	8	12	16	20
	Could occur	3	3	6	9	12	15
	Unlikely to occur	2	2	4	6	8	10
	Very unlikely to occur	1	1	2	3	4	5
Risk Matrix			1	2	3	4	5
			Negli-gible	Minor	Mode rate	Severe	Catast rophic /Fatal
					Consequence		

Fig 2 Risk Matrix

6.4   The Risk Register

The key tools that the Trust uses to monitor risk are the Trust's risk registers. The Trust logs strategic and operational risks on its risk register. It holds two registers:

Assurance Framework: records risks to corporate objectives as detailed in the Annual Plan (these are strategic risks)

Operational Register: records risks to operational objectives.

The registers serve as a record of current risks and enables risks to be quantified and ranked. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated.

Both registers are a dynamic 'live' document which is populated through the Trust's risk management processes.

6.5   Escalation of Risk

Escalation levels are shown below.

Figure 3 Escalation levels

Risk level	Risk score	Escalation level
Extreme Red	15-25	Board of Directors
High Orange	9-12	Management committee (reporting to Board)
Moderate Yellow	6-8	Directorate/Team
Low Green (tolerated)	1-5	Team but monitored at Directorate level

6.6   Treating and Escalating Risks

The amount of effort/resources that are to be committed is determined by the risk score. The Trust has a scheme of escalation (shown at Figure 3).

- **Risks scored 1-5**: are considered **low risk** and therefore are tolerated by the Trust

- **Risks scoring 6-8:** are considered **moderate risks** and should be managed /treated so that they are made as 'low as reasonably practicable'. These risks will usually be managed locally unless they are Trust wide when the appropriate corporate department will lead on management.

- **Risks scoring 9-12** are considered **high risks**. These risks must be treated, i.e. an action plan should be developed and implemented that seeks to reduce the potential impact of the risk (i.e. reduces the risk score). These risks will be added to the risk register and will be reviewed by the Management Committee.

- **Risks scoring 15-25** are considered as **extreme/catastrophic risks**. These risks must be treated, i.e. an action plan should be developed and implemented that seek to reduce the potential impact of the risk (i.e. reduces the risk score). These risks will be added to the risk register and will be reviewed by the Management Committee and the Board of Director's will be informed of any new red risks . **The Board of Directors will be informed of any new red risks and will receive assurance on progress on mitigating actions from the CQSG .**

The risk register will show actions plans with dates to mitigate the risk. The Board will be asked to consider whether they have sufficient assurance that these risk are being adequately managed

Risk treatment plans are to be developed according to the level of risk and the needs of the organisation. In broad terms the Trust will seek to tolerate risks (1-5), and treat risks with a score of 6 or more, and where appropriate will seek to transfer risk to another provider, or may consider the need to terminate the risk by terminating the aspect of service affected if no other solution can be identified, and the risk is extreme (i.e. 15+).

6.7   Risk Appetite

As the Trust is actively seeking to expand and diversity it will inevitably face both challenging strategic and operational risks. Positively considering the acceptability of risks using the process described below will support the achievement of the strategic objectives that the Trust sets itself.

6.7.1 Process for reconsidering 'risk appetite'

During the process of escalating and reviewing significant risks (9+ risks) senior 'risk leads', members of the Management Committee and CQSG need to consider the 'risk appetite' for the risk under consideration.

The initial assessment will be made by the named risk lead for each risk scoring 9+, their recommendation on whether or not to accept the risk as described on the register will then be referred to the relevant committee for discussion and approval/amendment. This is a reflective process which should draw on knowledge of both the risk and the objective that is threatened.

The process in short involves the consideration of the following questions:

for the risk being considered|

- What is the likelihood and potential consequence of realising the risk?

- Are we willing to tolerate the possibility of the risk happening?

- If not do we need to do more to reduce the likelihood and/or consequence?

- Will the cost of treating the risk outweigh the potential benefit?

6.8   Reporting Arrangements for Risk Management

A flow chart summarising reporting arrangements between committees is at Appendix D

The Chief Executive and Directors will escalate risk issues of serious concern to the Management Committee and /or the Board as required throughout the year.

The Board of Directors will be advised of high operational risks via the CQSG report on a quarterly basis and will receive the full operational register to review annually.

The Director of Finance will present the updated strategic risk register (Assurance framework) in June each year, following the approval of the annual plan in May.   He will also present an updated strategic register to the Board in Set, Nov and Feb of each year.

The Governance and Risk Adviser will facilitate review of the operational register with the Directors and risk leads and risk on the register scoring 9+ the

register will be received for review on a quarterly basis by the Corporate Governance and Risk Work stream and the Patient Safety and Risk work streams on a quarterly basis. Both work stream leads will escalate issues by exception toe Clinical, Quality Safety and Governance Committee .

The Management Committee and the Board of Directors receive the full operational register for review annually. A guide to how the risk register operates is as Appendix C

Audit Committee will assure the work of the CQSG by receipt of minutes, and on an annual basis will invite the Chair of the CQSG to attend a meeting to provide a verbal account of how risk is being managed and answer questions from members of the committee

Clinical Quality, Safety and Governance Committee (CQSG)

This committee, comprising Executive Directors, Non-Executive Directors, and Governors will seek assurance that the Trust is managing risks to all non-financial aspects of our work and will provide a quarterly assurance report to the Board.

The CQSG will receive assurance reports from the following work streams to an agreed reporting schedule:
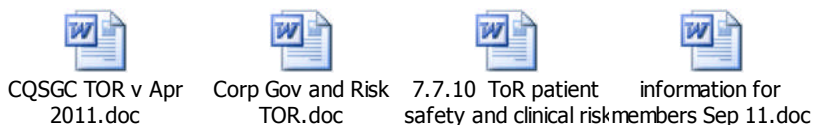
- Corporate Governance and Risk

- Patient Safety and Risk

- Outcome monitoring

- Clinical Audit

- Patient and Public Involvement

- Quality Reports

- Information Governance

Each work stream report will also be considered by the Management Committee for support/comment/action prior to being received by the CQSG

The CQSG will report directly to the Board on its level of assurance in respect of management of risk, and confirm that in the event risks are identified an effective action plan is in place which is being monitored.

The terms of reference of the CQSG and the two work streams with primary responsibility for safety and risk management, i.e. the Corporate Governance

and Facilities[1] work stream and the Patient Safety and clinical Risk Work stream are shown here, with the CQSG Members guidance document which sets out advice on how the CQSG members are to carry out their assurance role

CQSGC TOR v Apr 2011.doc

Corp Gov and Risk TOR.doc

7.7.10 ToR patient safety and clinical risk members Sep 11.doc

information for

6.9 Management of Risk Locally that reflects the Trust wide approach

Due to the small size of the Trust risk management is managed centrally on behalf of all directorates.

Risks can be identified locally via risk assessment, as a result of an incident or as a result of internal or external changes to service provision. If once identified a risk cannot be mitigated to an acceptable level it will be logged on the single trust operational risk register that records risks relevant to each Directorate for which the local director is risk lead and Trust wide risk which have a nominated risk lead.

The Governance and Risk Adviser acts as trust wide coordinator and meets with/liaises with   Directors during the year to support local risk activities and ensure that all local unmitigated risks are recorded and monitored via the risk register. The management committee and the CQSG then monitor progress of risk reduction through receipt of the register

7   Implementing the Strategy and Training Requirements

Implementing and Promoting the Strategy

The Trust will implement and promote this strategy in the following ways:

- The Governance and Risk lead will provide direct support to all risk leads as they implement the trust's approach to risk management , in particular in relation to risk assessment, grading of risks and building effective action plans

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[1] Note: The Health and Safety Committee reports to the Board via the Corporate Governance and Risk work stream and CQSG

- The strategy is published on the intranet and will be promoted at both corporate induction and INSET
- The Trust will also share this strategy with any stakeholders as required, and make it available on request to other interested parties via the Trust's external website.
- The Trust will promote strategy and policy in risk training.

7.2 Training

The Trust recognises that training of staff is an essential element of any successful risk management strategy. It has conducted a training needs analysis and full details of this are published in the Trust's Staff Training Policy.

The following table summarises the key training provided in relation to the Risk strategy

Target group	Training activity	Training aim	Frequency
Board of Directors and Senior Management Team (ie members of the Management Committee)	Overview of development of risk management systems and assurance framework , plus corporate risk assessment / review This course is tailored annually to needs of trust	Improve strategic management and understanding of risks to Trust,	Annual Delivered by: Governance and Risk Adviser with/without external advisory input
Staff who undertake investigations	RCA training	To enable staff member to undertake a RCA	One to one training by Governance and Risk Adviser, to any senior member of staff asked by CEO to undertake a serious investigation
All staff	Risk update including risk assessment and incident reporting	To maintain risk awareness and activity throughout the organisation	At two yearly INSET delivered by Governance and Risk Adviser
All new staff	Introduction to risk management and incident reporting	To raise awareness of Trust approach, trust policies and procedures and to promote incident reporting	Once at induction delivered by Governance and Risk Adviser or Health and Safety Manager

Fig 4: Summary of Risk Management Training from TNA

Managing attendance at mandatory risk training

Management of attendance and following up non-attenders of staff at induction and INSET risk training will be managed under the Staff Training Policy

In the event that a member of the Board of Directors or Management Committee is unable to attend the annual risk update the Governance and Risk Adviser will provide a repeat session and/or one to one session using the same materials

7.3   On-going Information to Staff on Risk Management Issues

The Trust will provide information on risk management and risk reduction to its staff throughout the year through a variety of different ways which will include:

- Hazard notice circulation with obligatory feedback

- Policies and Procedures on the Intranet

- Health and Safety Information available by internet/intranet

- Updating at mandatory induction and INSET days

- Provision of specific training on different aspects of risk management, published in the Trust's training prospectus

- Provision of feedback to those who report/ are involved in specific incidents.

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8   Process for monitoring compliance with this policy

The Trust will monitor compliance with the risk strategy in the following ways:

An annual report on management of risk across the trust will be presented to the CQSG and Audit Committee in June/July each year covering the previous year.

This report will review compliance with:

- **Organisational reporting arrangements for the Trust key risk committee (CQSG) and reporting from work streams reporting into the CQSG**

- **Receipt and review of the strategic and organisational risk register by CQSG and the Board**

- **Management of risk locally via incident reporting , risk assessment and additions/changes to the Risk register by all Directorates**

- **Attendance record for trust key risk committee (CQSG)**

- **Compliance with risk register review process**
- **Compliance with annual risk management training for Board of Directors and Management Committee**

This report will be prepared by the Governance and Risk Advisor and presented via the Corporate Governance and Risk Work stream to the CQSG. The Corporate Governance and Risk Work stream lead will monitor compliance with agreed actions to address deficiencies and report by exception to the CQSG

In addition the Trust will invite its Internal Auditors to review aspects of risk management and governance practice each year as part of the trust agreed schedule of audits

9	References

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10	Associated documents[2]

Staff are referred to the following related procedures for advice and support on investigating and learning from incidents, complaints and claims:

- Incident Reporting Policy and Procedure
- Policy and Procedure for the Management of Formal Complaints

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[2] For the current version of Trust policy /procedures listed above , please refer to the intranet.

- Procedure for Claims management
- Procedure for Investigation and Learning from Serious Incidents
- Procedure for Learning from Incidents Complaints and Claims to improve Patient Safety and Reduce Risk
- Health and Safety Policy and Procedures
- Staff Training Policy

11   Appendix: Equality Impact Assessment

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

Response: Yes

This is a strategic document that sets out systems and processes to be applied in all circumstances. It has no direct impact on equalities issues.

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

Response : No

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

Response: LOW NEGATIVE

Date completed   Sept 2011

Name   Jane Chapman   Governance and Risk Adviser

Steps in Managing Risk

i) Identifying and scoring the risk

This is done in three steps:

a) **Establish the context**   -   Define the activity
   - What are the goals and objectives of the activity
   - What's the relationship of the activity being assessed to achieving the Trust's objectives

b) **Identify the risk**   -What can happen;
   - How can it happen (or if this is a risk identified after an incident, what happened and how did it happen)

c) **Determine the level of risk** (risk score) by considering consequence and likelihood). This ensures consistency of grading across the trust and is used for incidents, complaints, claims and risk assessments.

ii) Managing and/or controlling the risk

Once identified, assessed and prioritised, ways of controlling the risk should be formulated. The main categories of controls that can be used are:

- **Terminate /Eliminate the risk -** wherever possible, avoid the risk altogether (replace faulty equipment, use a different method of therapy, do not accept certain types of patients)

- **Transfer** – avoid the risk by passing the risk to another organisation (eg PCT, local authority, contractor)

- **Treat** – develop an action plan to address the risk by introducing new systems, processes, training or protocols etc.

- **Tolerate** – Understand and accept that the consequence of the risk is insignificant or no practical steps can be taken to reduce it. That it may be unrealistic from a cost benefit perspective (too expensive for unlikely outcome)

It should be recognised that controls can themselves give rise to additional risks. This should be carefully considered when deciding how to rectify a particular risk

iii) Risk Funding/Risk Treatment Plans

There are numerous ways by which risk can be controlled, many of which require little or no financial outlay (for example the development of polices, improved communication, and staff training)

Each type of control will have a resource implication. These implications should be considered as an integral part of the process of treating the risk. It is possible that the most desirable control is not acceptable because of resource constraints. The relationship between the cost of controlling the risk, and the benefits gained, must be considered. It is recognised that there will always be a limited budget to address the issues and this should be included in the risk treatment plan. These plans should be created for each control option and the most realistic/feasible at the time should then be implemented. This may mean that there is a stepped implementation towards treating the overall risk but that certain measures can be taken to minimise the elements of the risk before resources are fully available to address the overall risk.

<u>*An example of a risk treatment plan*</u>

<u>*:*</u>

Risk : Petty theft has been identified as a risk to the trust resulting in frequent loss of cash, equipment and personal property.

A range of possible treatment plans to control this risk are shown below

Option	*Action to mitigate risk*	*Cost:*
1	*Accept risk*	*Losses of £10 – 15000pa*
2	*New post of additional security staff*	*£15000*
3	*Security guard plus swipe card access system for high risk areas*	*£35000*
4:	*Security guard plus trust wide swipe card access system*	*£45000*
5:	*Security guard plus trust wide swipe card systems and CCTV*	*£ 80000*

iv) Monitoring the risk

The action to be taken to control each risk should be noted, together with the person responsible for taking action forward, and a realistic review date. A vital part of the risk management process is that progress be kept under review, to ensure that it is actually taking place.

The risk must be re-assessed after a specific period of time, or if an incident occurs, to ensure its significance has not changed. This should be noted on the risk register.

It is essential that those involved in the risk management process take responsibility for ensuring that monitoring is carried out rigorously to make sure the systems to avoid risks continue to work and the lessons continue to be learnt.

Risk Score Definitions and Matrix

Descriptor /Grade	CONSEQUENCE/IMPACT DESCRIPTION
Negligible (1)	**Negligible impact** on strategic objectives **Nil/negligible:** Injury; loss; service interruption; environmental/estate impact; impact on reputation; impact on quality; litigation or complaint
Low (2)	**Small variance** from overall strategic objective First aid treatment with full recovery Complaint possible ; Local low key external interest **Minor:** financial loss (up to 5K); service interruption; environmental/estate impact; impact on reputation; impact on quality
Moderate (3)	**Notable variance** from overall strategic objective Medical treatment required up to 3 months to recover; Reportable under RIDDOR Complaint probable **Moderate :** financial loss (5K – 200K); service interruption for more than one week; environmental/estate impact; Impact on reputation. Local press, stakeholders express concern; impact on quality; moderate loss of information (recoverable) ; moderate risk of low value claim
Major (4)	**Significant variance** from overall strategic objective Long term illness or injury (up to one year); Reportable under RIDDOR Complaint expected/received **Major :** financial loss (200K – 3M); service interruption of more than one month; environmental/estate impact leading to loss of service; significant impact on reputation, significant medial interest more than one week, significant concerns raised by stake holders ;significant impact on quality including risk of failing to meet CQC standards ; major loss of information (recoverable) ; high value claim or action by HSE anticipated, moderate risk of high value claim
Extreme/ Catastrophic (5)	**Failure to meet strategic objective threatens independent functioning** or stability of the Trust. Death and/or Financial loss3M+ **Certain :** risk to reputation, national press 3+ days, risk of questions in the House of Commons **Serious/long term and/or permanent** loss of information that impacts directly on service delivery; Quality- External controls exerted ; Threat of Judicial review, expected litigation valued at 1M+; High profile breach of confidential information (eg patient identity) Buildings/property condemned leading to major loss of service

Score	Descriptor	LIKELIHOOD OF REPEAT EVENT DESCRIPTION
1	Very unlikely to occur	Will only occur in exceptional circumstances.
2	Unlikely to occur	Unlikely to occur but the potential exists
3	Could occur	Reasonable chance of occurring; has happened before on occasions
4	Likely to occur	Likely to occur – strong possibility.
5	Almost certain to occur	The event is expected to occur in most circumstances.

RISK = CONSEQUENCE SCORE X LIKELIHOOD SCORE

RISK SCORE MATRIX

Likelihood			1	2	3	4	5
	Almost certain to occur	5	5	10	15	20	25
	Likely to occur	4	4	8	12`	16	20
	Could occur	3	3	6	9	12	15
	Unlikely to occur	2	2	4	6	8	10
	Very unlikely to occur	1	1	2	3	4	5
Risk Matrix			1	2	3	4	5
			Negligible	Minor	Moderate	Major	Catastrophic/Fatal
			Consequence				

Escalation of Risk is determined by risk score

Risk level	Risk score	Escalation level
Extreme Red	15- 25	Board of Directors
High Orange	9-12	Management committee (reporting to Board)
Moderate Yellow	6-8	Directorate/Department
Low Green (tolerated risks)	1-5	Department but monitored at Directorate level

Response to Risk   the 4 T's

Tolerate	Accept the risk. I.e. do nothing.
Treat	Continue the activity but actively work on mitigating the risk
Transfer	Move the risk for example, outsource to another organization.
Terminate	Stop the activity, as it is too risky to do anything else.

Closing risks: When the risk has been treated, transferred or terminated and is no longer considered to be a risk to the Trust the risk is 'closed'.

Tolerated risks remain on the risk register and should be reviewed periodically at Committee level and escalated as appropriate

Guidance for Staff: How does a Risk Register Work?

1.0   Purpose of the risk register

*The register p*rovides the Trust with a 'live' log of risks of all kinds that threatens the Trust's ability to achieve its aims and objectives.

The register enables risk of all kinds to be evaluated and graded using a common grading system. It provides a structure for collating risks that helps both in the analysis of risks and decisions about whether or how those risks should be treated. As a 'live' (i.e. regularly updated) documents it provides an up to date record of how identified risk are being managed/treated.

2.0   What risks are to be included:

Risks are identified from a number of sources including

- incidents, complaints and claims

- internal and external risk assessments

- internal and external performance assessments (Standard Better Health, Assurance Framework, audit, ……etc)

The Risk Management System utilises this information for the analysis and treatment of risk and the subsequent production of the risk register. Items on the risk register are given a risk score according to their impact, or potential impact, and their likelihood of occurrence or recurrence. The grading system is to be found in the Trust's Risk Matrix (see appendix 1). This score guides the trust as to what level the risk should be managed and monitored.

It is not expected that every single identified risk will be quantified and ranked, and entered onto the register. Risks that have a high probability and high impact should be included. Low impact, low probability risks should be grouped together and quantified and ranked as groups.

3.0   What information is recorded on the register?

- The following information is recorded for each risk on the register: .A **description** of the risk which is profiled according to **risk type** as shown below:

Type of risk	Risk Group	Description
Strategic	**Excellence** **Efficiency and surplus** **Improve knowledge and practice** **Equality** **Expansion** **Influence**	Threats to trust strategic objectives and the Trust Business Plan.
Operational	**Financial**	Planning, income and savings targets, projections, VFM, fraud
Operational	**People(HR)**	Skills ability, health and safety, occupational health, workload
Operational	**Education and Training**	Trust staff training, commercial training, demand changes, skills to deliver
Operational	**Building, Fabric and Environment**	Building, fire, H and S, environment
Operational	**IM and T**	Technology, information exchange, confidentiality
Operational	**Security**	Risks (verbal and physical) to staff and others, theft
Operational	**Clinical**	Risks related to delivery of clinical care and treatment (subdivided by directorate)
Operational	**Other**	Risks that don't fit into above categories

- **Current control measures** to manage the risks, which identify the controls on place to minimize, risk impact.

- **Current assurances of controls** being effective, i.e. summary of arrangement in place to monitor and review risk
- **Current gaps** in controls this identifies the weaknesses

- **Current action plan** using the 4 T's treat, terminate, tolerate or transfer risk.
- **Risk references** which cross reference with Business Plan.
- **Risk owner** - person responsible for managing the risks
- **Risk review date**

4.0   Corporate and Directorate Risk Registers

It is proposed that in time the Trust will develop one integrated risk register, covering all risk from the most serious to the lower impact risks. This register will be developed from a combination of a corporate risk register and registers developed at directorate/care group level,

As a starting point it is recommended that a corporate register be developed and populated, covering all the higher level risks (i.e. risk score 9+) and at the same time each directorate will be supported to develop their own register of risks with a risk score of up to 9 that can be managed, or tolerated at directorate/department level

Any risk calculated at corporate or directorate level as having a risk score of 10 or more by the Directorate must be fed up to the corporate risk register.

With the introduction of a trust wide computer data base for the risk register escalation notification can happen automatically at the outset this may need manual notification

5.0   Adding to the Risk Register

Entries to the risk register will be made on completion of a risk notification form. Full details of how to complete this can be found in **Guideline for staff on adding to the Risk Register**

6.0   Using and Reviewing the Risk Register

Once developed the risk register will record risks with a risk score. This score provides the Trust with a basis on which to determine the level in the organisation that management of risk should be planned, and monitored.

The escalation scheme is shown below:

Risk level	Risk score	Escalation level
Extreme	15- 25	Board of Directors
High	9-12	Management committee (reporting to Board)
Moderate	6-8	Directorate/Department
Low (tolerated risks)	1-5	Department but monitored at Directorate level

7.0   How are the entries on the register reviewed?

Risk Leads will be asked to review entries on the register at least quarterly. The Trust will review the register via the Management Committee and the Clinical Quality Safety and Governance Committee as set out in the Terms of Reference.

Discussions and changes to risk ratings/risk treatment plans should be noted in the minutes and the registered updated accordingly.

When reviewing risks at the appropriate level the following should be considered:

- Reviewing and approving action plan
- Reviewing progress towards plan
- Confirming the risk rating and or changing the risk rating
- Approving (if required) relevant resources to meet the agreed treatment plan
- For extreme risks to approve as appropriate to terminate and/or transfer arrangements proposed to manage the risk

The Board of Directors will receive the full operational register for review and comment annually.

Error! No topic specified.

Board of Directors : September 2011

Item : 14

Title : Health & Social Care Bill

Summary :

Currently the Health & Social Care Bill is at the second reading stage in the House of Lords. This reading is due to take place on 11th October, when the official debate will take place. This paper addresses the proposed revisions to Foundation Trusts in light of the Bill

This report focuses on the following areas:

- Quality
- Patient / User Experience

For : Discussion

From : Trust Secretary

Health & Social Care Bill

1. Introduction

1.1 Following the recent listening exercise undertaken by the Government, and recommendations from the NHS Future Forum, the Health & Social Care Bill is due to go to the House of Lords for its second reading in October. This means that we are now able to give a better idea of the provisions that will affect the Trust. Some of the major changes are simply a move away from implicit instructions or guidelines, and instead they are enacted in legislation.

2. Listening Exercise

2.1 Following the consultation carried out by the Government, the NHS Future Forum was set up to oversee the listening exercise that took place, and also to encourage and ensure engagement with the process. The Forum was split into four groups, each with a different area of focus. These were; Choice & Competition, Clinical advice & Leadership, Education & Training and Patient Involvement & Public Accountability.

2.2 Engagement was carried out face-to-face at meetings, and also online, via web chats and social networking sites.

2.3 There was concern expressed over the focus that had been placed on improving competition, and the Forum recommended that it be made clear that the primary focus of Monitor is ensuring high standards of patient care. Following this recommendation, the Bill was amended to be clear that Monitor and the Secretary of State are prohibited from exercising their functions with the purpose of influencing market share of providers. The Government noted that the focus should always be on quality of patient care.

2.4 Fears over privatisation of the NHS were also alleviated with a statement from the Government that the NHS would not be sold off to private companies.

2.5 The Forum expressed the need for clarity in the involvement of patients. It was thought to be too vague. In response to this the Bill was amended to include express duties on Monitor to involve service users in decision making. Duties were also placed on Monitor, the Secretary of State and the CQC to strengthen the collective voice of patients and carers.

2.6 Another major issue raised by the listening exercise was the pace of change. Some were concerned it was going to be too quick, whilst others were pushing for changes to happen more quickly. The Future Forum's recommendation regarding the pace of change was that the current plan was the most appropriate, and the safest with regards to patient care. This was that those commissioning bodies that are ready to take over in April 2013 will do so, while those that are not will have more time to prepare to take control. The Government reacted by removing the blanket deadline of 2014 that was previously in place, but stressed that this would not mean that those trusts unable to meet this deadline would not have the same stringent tests set by Monitor.

3. Express Statutory Duties

3.1 Governors will continue to carry out many of the same duties as at present, such as appointing/removing the Chair and Non-Executive Directors, approving the appointment of auditors and so on.

3.2 A major proposal is that Governors will now have an express statutory duty placed upon them to hold Non-Executive Directors (NEDs) to account. This will be both individually and collectively for the performance of the Board. Governors will be able to do this by requiring NEDs to attend meetings, to provide relevant information. The Trust already does many of these things in an informal manner. NEDs are invited to every Governors meeting and at least one NED usually attends. Governors are also invited to attend Board of Directors meetings, both part one and two. Through the Vice Chair, Governors have significant input into their own agendas, often requesting ad hoc papers on topics they are interested in. Governors will also have the power to vote on the performance of a NED individually or the Board of Directors as a whole.

3.3 It is already an express requirement for Governors to represent members of the Foundation Trust. The Bill extends the scope of this representation to include members of the public as a whole. There is no indication however, as to how this should be done, and the assumption is that it will be up to individual Foundation Trusts to develop their own systems for this.

3.4 The Board of Governors will be known as the "Council of Governors". This does not change their position and is simply a change of title.

4. Mergers & Acquisitions

4.1 In respect of both major mergers and acquisitions, a vote in favour from over half of the Board of Governors will be required in order for the Trust to make an application to the regulator. This provision gives Governors greater powers in terms of approving or preventing major changes within the Trust.

5. Private Patients

5.1 The Bill removes the previously imposed private patient income cap placed on Foundation Trusts. This allows Foundation Trusts to increase the proportion of private revenue streams, provided that the primary purpose of the Foundation Trust remains free of charge. However, this is qualified in that it requires a vote in favour of any significant transactions, from over half of the Board of Governors.

6. Advisory Bodies and Regulators

6.1 The Bill allows for the establishment of an advisory panel by Monitor, to which Governors may refer questions of whether the Trust is acting in accordance with its constitution and the Bill itself. A submission to this panel would require a vote of over half of the Board of Governors.

6.2 However this continuing role as Foundation Trust regulator will only be in the interim. In future Monitor will no longer provide the same safety nets as they have done previously. They will become an economic regulator as opposed to clinical.

6.3 In their place as Foundation Trust Regulators will be Healthwatch organisations, and local councils will be able to create health and wellbeing boards.

7. Training

7.1 In respect of the changes proposed, Governors are likely to require training and there is a requirement placed upon Foundation Trusts to ensure that Governors are equipped with the skills and knowledge to carry out these duties. The Trust is giving consideration to this, as are organisations such as the FTN.

8.   Conclusion

8.1   The Bill is due to be debated at its second reading in the House of Lords. If it is not upheld by the House of Lords it could go back to the House of Commons for further revision. The Trust will keep abreast of further developments. If the House of Lords approve the Bill, it will gain royal assent in the near future

Terri Burns
Assistant to the Trust Secretary
16th September 2011

Board of Directors : September 2011

Item : 15

Title : Quality Report Quarter One Review

Summary:

Attached is the Quarter One progress report on quality priorities.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance that sufficient progress is being made with quality priorities, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place.

This report focuses on the following areas:
(delete where not applicable)

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

For : Noting

From : Trust Director

Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2011/12 25%	50%	75%	100%	RAG Status	Actions for Next Quarter
Outcome Monitoring	CAMHS (Child and Adolescent Mental Health Service): 1. To achieve a return rate of 60% for the Goal-based Measure for Time 1 and Time 2 (for those patients who completed the GBM at Time 1).	Caroline McKenna	• OM tracking system • Monitoring of progress by the OM Lead • Quarterly progress report • Quarterly review by the CQSG Committee and Board of Directors	• OM analysis of the % return rate for Time 1 and Time 2 per quarter	1st July 2011	31st January 2012	Currently, none of the patients who meet the criteria (i.e. have attended 4 treatment appointments) have completed the GBM at Time 1.					Amber	Since the last CQSGC meeting in June 2011 the focus of the Clinical Outcomes lead has been on the development of the integrated OM system as per phase 1 of the project plan (presented to CQSGC June 2011). The work has focussed in particular on the development of a web based OM tracking system. All other aspects of the development of an integrated outcome monitoring system are dependent on a robust tracking system being in place. A number of targets have been achieved. Testing had been planned for end of July through August 2011 but has been delayed by 4-6 weeks primarily because of demands on the one member of the informatics team who is building the system and also because of the emergence of new issues that were not anticipated. The launch of the tracking system is an exciting development and testing is scheduled to begin in early September 2011.
	Adult Department: 2. To achieve a return rate of 60% for the CORE for Time 1 and Time 2 (for those patients who completed the CORE at Time 1).				1st April 2011	31st January 2012	A return rate of 55% was achieved for Time 1 and 2, for the CORE OM, by the end of August 2011, for patients attending the Adult Department who have completed their assessment between April 2011 and January 2012	■	■			Amber	
Access to Clinical Services and Health Care Information for Patients and Public	1. To increase the number of leaflets about specific treatment modalities from 0 to at least 5 leaflets	Sally Hodges	• PPI Lead to initiate and oversee the process for developing these leaflets • Monitoring of progress by PPI Lead • Feedback from patients and members on the accessibility of this information • Quarterly progress report • Quarterly review by the CQSG Committee and Board of Directors	• Copies of the leaflets	1st April 2011	31st January 2012	The PPI Lead presented this proposal to the Management Committee in July 2011. The Management Committee agreed to provide the clinical content of the modality leaflets.	■				Amber	All reporting topics are proceeding on time and are expected to meet their respective deadlines.
	2. To ensure that links to this information are clearly accessible through the website			• Evidence of feedback received from patients and members • Evidence of how feedback was obtained and when	1st April 2011	31st January 2012						Amber	
Patient and Public Involvement	1. To have held at least 3 stakeholder quality meeting	Sally Hodges	• Maintain minutes from the stakeholder quality meetings • Maintain monthly records of the number of members • Patient and Member feedback • Monitoring of progress by PPI Lead • Quarterly progress report • Quarterly review by the CQSG Committee and Board of Directors	• Minutes from the stakeholder meetings	1st April 2011	31st January 2012	Two stakeholder meetings have been arranged for September 2011 and January 2012. A third meeting involving the Clinical Director, Quality Lead and some of the Governors has been schedule to discuss quality.	■	■			Amber	All reporting topics are proceeding on time and are expected to meet their respective deadlines.
	2. To increase the membership numbers by 10%			• Number of members per month	1st April 2011	31st January 2012	Membership as of April 2011 was 6234, equating to a 14.68% rise in membership since April 2010 when the membership was 5436.	■	■	■	■	Green	Achieved
	3. To develop a clear strategy around BME engagement			• Documentation of the BME engagement strategy	1st April 2011	31st January 2012	Members of the PPI team are attending the Somali and Bangladeshi community mental health forums in September 2011, and will become more involved with local organisations to promote awareness of our services to BME communities.	■				Amber	
	4. To trial a patient forum and to hold at least 3 patient information / discussion groups			• Minutes from the patient information / discussion groups	1st April 2011	31st January 2012	A series of discussions open to patients, Trust members and the general public have been organised. The first of these forums was held in July 2011, with three more planned for November 2011, February 2012 and May 2012.	■	■			Amber	All reporting topics are proceeding on time and are expected to meet their respective deadlines.
	5. To increase our presence on at least one of the social media websites			• Links to our presence on the social media websites	1st April 2011	31st January 2012	The Trust's current social media presence includes YouTube, Twitter and Wikipedia. The Communications Committee decided in June 2011 that it was important for a policy on social media uses to be developed for the Trust.	■				Amber	

Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2011/12				RAG Status	Actions for Next Quarter
								25%	50%	75%	100%		
Maintaining a High Quality Effective Workforce	1. For 75% or more of Trust staff to have attended the mandatory training/INSET day once every 2 years, as required	Susan Thomas	• Staff database in order to keep track of new starters and leavers • Attendance records for the mandatory training, INSET day and trust-wide induction • Completion records for the local inductions • Monitoring of progress by HR Director • Quarterly progress report • Quarterly review by the CQSG Committee and Board of Directors	• Number of staff in the Trust • Number and % of staff who attended mandatory training/ INSET day per quarter	1st April 2011	31st March 2012	Action plan approved at the Corporate Governance and Risk Work Stream meeting held on 18.7.11 for implementation by November 2011: 1. Appoint administrator with dedicated responsibility for monitoring and ensuring compliance (record keeping, chasing non responders etc). 2. Dates of INSET days for the year to be publicised in the Annual Staff Training Programme and all staff will be notified via e-mail of the dates and informed that they should book into an event to ensure their attendance does not lapse. 3. Staff that are required to attend to be notified via e-mail at least 8 weeks before event, list of staff due to attend will be sent to directors, Heads of discipline and managers. 4. Non-responders and their managers will be contacted regularly before event. All correspondence will state that sanctions will apply if staff fail to attend. 5. After the event, staff that fail to attend to be notified of sanctions. Directors, managers and heads of discipline to be notified of staff that sanctions will apply to.					Red	
	2. For 75% or more staff joining the Trust to have attended Trust-wide Induction			• Number of staff in the Trust • Number and % of staff who attended Trust-wide Induction	1st April 2011	31st March 2012	Action plan approved at the Corporate Governance and Risk Work Stream meeting held on 18.7.11 for implementation by November 2011: 1. Appoint administrator with dedicated responsibility for monitoring and ensuring compliance (record keeping, chasing non responders etc). 2. Invitations to event, reminders and escalation of non responders to Directors and CEO, to take place at regular intervals. 3. Reminders and invitations will include details of sanctions that apply if staff fail to attend. 4. Regular quarterly reports to be provided to managers, Directors and CEO, highlighting poor performing directorates and naming individuals that fail to attend. 5. Where staff fail to attend, staff will be given a date to attend the next induction. Failure to attend on the second occasion will result in sanctions being applied.					Red	Action plan to continue as planned and the Corporate Governance and Risk group will continue to monitor progress.
	3. For 75% or more staff joining the Trust to have completed their Local Induction			• Number of staff in the Trust • Number and % of staff who have returned local induction completion forms	1st April 2011	31st March 2012	Action plan approved at the Corporate Governance and Risk Work Stream meeting held on 18.7.11 for implementation by November 2011: 1. Appoint administrator with dedicated responsibility for monitoring and ensuring compliance (record keeping, chasing non responders etc). 2. Checklists to be provided by HR Recruitment team on sign-on, reminders to be sent to staff and managers within one week. Reminder to notify staff and managers that sanctions will apply if checklists are not returned. 3. HR Recruitment Checklist for new starters to include local induction return section. This will ensure additional monitoring of returned Checklist by HR general office. 4. Escalation of non responders to Directors and CEO to take place at regular intervals. 5. Sanctions will be applied where checklists are not returned with two months of staff commencing work. 6. Regular quarterly reports to be provided to managers, Directors and CEO, highlighting poor performing directorates and naming individuals and managers that fail to return checklists.					Red	