

# Board of Directors

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

2.30pm – 4.30pm  
Tuesday 28<sup>th</sup> June 2011

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

**Board of Directors**  
2.30pm – 4.30pm, Tuesday 28<sup>th</sup> June 2011

**Agenda**

***Preliminaries***

**1. Chair's Opening Remarks**

*Ms Angela Greatley, Trust Chair*

**2. Apologies for Absence**

**3. Minutes of the Previous Meeting**

*(Minutes attached)  
For approval*

*p.1*

**4. Matters Arising**

***Reports & Finance***

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

*Non-Executive Directors as appropriate*

*For noting*

**6. Chief Executive's Report**

*Dr Matthew Patrick, Chief Executive*

*(Report attached)  
For discussion*

*p.12*

**7. Finance & Performance Report**

*Mr Simon Young, Director of Finance*

*(Report attached)  
For discussion*

*p.19*

**8. Gloucester House Steering Group Annual Report**

*Dr Rita Harris, CAMHS Director*

*(Report attached)  
For discussion*

*p.28*

***Corporate Governance***

**9. Board of Directors' Aims and Objectives**

*Ms Angela Greatley, Trust Chair*

*(Objectives attached)  
For approval*

*p.37*

**10. CQSG Quarter Four and Annual Review Report**

*Dr Rob Senior, Medical Director*

*(Report attached)  
For discussion*

*p.45*

**11. Business Development & Investment Committee  
Terms of Reference Review**

*Mr Richard Strang, Committee Chair*

*(ToR attached)  
For approval*

*p.49*

**12. Committee Reports & Minutes**

*Committee Chairs, as appropriate*

*For noting*

## Quality & Development

<b>13. Munro Report</b> <i>Dr Rob Senior, Trust Director</i> <i>Prof. Andrew Cooper, Social Work</i>	(Report attached) For discussion	p.55
<b>14. Service Line Report – Adolescent Directorate</b> <i>Dr Richard Graham, Clinical Director, Adolescent Department</i>	(Report attached) For discussion	p.60
<b>15. Service Line Report – Portman Clinic</b> <i>Mr Stan Ruszczyński, Clinical Director, Portman Clinic</i>	(Report attached) For discussion	p.75
<b>16. Staff Survey Report</b> <i>Ms Susan Thomas, Director of Human Resources</i>	(Report attached) For discussion / approval	p.93
<b>17. Workforce Statistics</b> <i>Ms Susan Thomas, Director of Human Resources</i>	(Report attached) For discussion	p.118

## Conclusion

### 18. Any other business

### 19. Notice of future meetings

Tuesday 26<sup>th</sup> July 2011: Board of Directors  
 Monday 12<sup>th</sup> September 2011: Directors' Conference (*Topic TBC*)  
 Thursday 15<sup>th</sup> September 2011: Board of Governors  
 Tuesday 27<sup>th</sup> September 2011: Board of Directors  
 Tuesday 25<sup>th</sup> October 2011: Board of Directors  
 Tuesday 8<sup>th</sup> November 2011: Directors' Conference (*Plan Review*)  
 Tuesday 29<sup>th</sup> November 2011: Board of Directors  
 Thursday 1<sup>st</sup> December 2011: Board of Governors  
 Tuesday 31<sup>st</sup> January 2012 : Board of Directors  
 Thursday 2<sup>nd</sup> February 2012 : Board of Governors  
 Tuesday 28<sup>th</sup> February 2012 : Board of Directors  
 Tuesday 27<sup>th</sup> March 2012 : Board of Directors  
 Tuesday 24<sup>th</sup> April 2012 : Board of Directors  
 Thursday 3<sup>rd</sup> May 2012 : Board of Governors  
 Tuesday 29<sup>th</sup> May 2012 : Board of Directors  
 Tuesday 26<sup>th</sup> June 2012 : Board of Directors  
 Tuesday 31<sup>st</sup> July 2012 : Board of Directors  
 Thursday 13<sup>th</sup> September 2012 : Board of Governors  
 Tuesday 25<sup>th</sup> September 2012 : Board of Directors  
 Tuesday 30<sup>th</sup> October 2012 : Board of Directors  
 Tuesday 27<sup>th</sup> November 2012 : Board of Directors  
 Thursday 6<sup>th</sup> 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, 2.30pm – 4.30pm, Tuesday 24<sup>th</sup> May 2011

Present:			
Ms Angela Greatley Trust Chair	Mr Martin Bostock Snr Independent Director	Ms Lis Jones Nurse Director	Mr Altaf Kara Non-Executive Director
Ms Trudy Klauber Dean	Ms Louise Lyon Trust Director	Ms Joyce Moseley Non-Executive Director	Dr Matthew Patrick Chief Executive
Dr Ian McPherson Non-Executive Director	Dr Rob Senior Medical Director	Mr Richard Strang Deputy Trust Chair	Mr Simon Young Director of Finance
In Attendance:			
Miss Louise Carney Trust Secretary (minutes)	Dr Sally Hodges PPI & Comms Lead (Items 8, 15, & 16)	Dr Rita Harris CAMHS Director (Items 12, 13, & 14)	Dr Richard Graham Adolescent Director (Item 14)
Ms Julia Smith Dir. Service Dev. & Strategy (Item 17)			

## Actions

AP	Item	Action to be taken	Resp	By
1	3	Miss Carney to amend minutes	LC	Immed
2	5	Miss Carney to circulate literature on King's Fund NHS Leadership and Management Programme	LC	Immed
3	8	Dr Hodges to develop a PPI mission statement	SH	Sep 11
4	10	Ms Thomas to give consideration to how responsibilities outside of departments are covered in appraisals	ST	Sep 11
5	12	Ms Greatley, Dr Patrick, & Ms Lyon to be invited to attend Audit Committee on Thursday 26 <sup>th</sup> May	RSt	Immed
6	12	Audit Committee to make recommendation on Board statement for Annual Plan following meeting on Thursday 26 <sup>th</sup> May	RSt	May 11
7	12	Mr Young to give consideration to suggested amendments	SY	Immed
8	12	Mr Young to amend date for unsecured income	SY	Immed
9	12	Mr Young to send final draft of Annual Plan commentary by Thursday 26 <sup>th</sup> May	SY	May 11
10	12	Board members to send comments on final draft of Annual Plan commentary by Monday 30 <sup>th</sup> May	Board	May 11
11	14	Adolescent Directorate Service Line Report to be presented to June meeting	RG	Jun 11
12	16	Board members to provide feedback on AGM plan to Dr Hodges	Board	Jun 11
13	17	Management to address bullying and harassment in Staff Survey action plan	Mgmt	Jun 11

## Actions Agenda item

## Future Agendas

### 1. Trust Chair's Opening Remarks

Ms Greatley welcomed everyone to the meeting.

### 2. Apologies for Absence

None. Dr Senior noted that he would be leaving the meeting at 4pm.

### 3. Minutes of the Previous Meeting

**AP1** The minutes were approved subject to two minor typographical amendments.

#### **4. Matters Arising**

None.

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

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

Ms Greatley had attended a meeting of University College London Partners on 23<sup>rd</sup> May, where they had received Peter Fonagy's report on mental health.

Ms Greatley noted that two Governors, Ms Chrissie Kimmons and Ms Jan McHugh, both from the Rest of England and Wales class of the Public Constituency, had resigned, and a by-election would be held. Prof. Steve Trevillion, Stakeholder Governor representing the University of East London, would be retiring in July, and the Trust would be seeking another representative.

Ms Greatley had attended a Future Forum meeting, and a King's Fund meeting on the mental health strategy.

##### ***Ian McPherson, Non-Executive Director***

Dr McPherson had attended the King's Fund NHS Leadership and Management programme. Miss Carney to send link to literature.

**AP2**

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

Dr McPherson noted that anxiety surrounding potential restructuring was to be expected. Ms Lyon noted that despite this anxiety, she had received many helpful and constructive comments from staff.

The Board noted the death of Barbara Dale. Dr Patrick noted that she had made significant contributions to the work of the Trust.

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

Mr Young reminded the Board that the draft accounts had been summarised in his April Finance & Performance Report. Since then, the External Auditors had required some changes, and the Trust's surplus was subsequently revised to £90k. Mr Young noted that the Financial Risk Rating would remain at 3.

Mr Young noted that risks in the first two Quarters were related to securing income, but in the second two Quarters were related to the Trust meeting its productivity savings. The Trust would need to carefully monitor all

income, including small amounts.

Mr Young explained that the error referred to in 2.1.2 was a human error and not a computing error, where two individuals had both entered the same thing into the system.

Mr Strang raised his concerns about Tavistock Consulting (TC) income falling short so early on in the year, and queried the budgeting process. Ms Lyon explained that the Trust was looking carefully at the monthly reporting process, but was confident they were on track to meet their annual budget. Mr Young noted his dissatisfaction with TC's phased forecasts, and would be discussing this issue further with Ms Bell. Mr Strang noted that TC was a high margin business, so any shortfalls in income were significant. Dr Patrick noted that he and Ms Lyon were meeting monthly to discuss TC.

The Board discussed the training contract. Ms Klauber noted that it was slightly better than the Trust had been anticipating, but only marginally so, and did not include any inflationary uplift. Mr Young noted that the training contract had fared worse than clinical contracts.

## **8. Board Committee Annual Review: Patient & Public Involvement Committee**

Dr Hodges noted that information contained in the Report was drawn from a variety of sources. The Review provided the PPI Committee with a clear work plan.

Mr Strang suggested it would be helpful to have comparative statistics in future years.

Mr Young queried whether Dr Hodges felt that increasing the number of participants in the Patient Survey would improve the response rate. Dr Hodges felt it would. Dr Senior noted that an increased return rate may capture a wider range of opinions, and satisfaction rates could be lower.

Ms Moseley queried whether the PPI Committee was digging down in the responses. Dr Hodges explained that this was difficult as the names of respondents were not recorded so the Trust could not get in touch to discuss further. However, the Survey did provide the opportunity to include more information.

Dr Patrick queried whether the PPI Committee was able to include any benchmark data. Dr Hodges explained that there was a pan-London PPI Forum, which shared information, but many organisations have in-patient facilities, which makes comparisons difficult.

Ms Klauber noted that there was a retrospective aspect to the Patient Survey, and queried whether it would be possible to survey people whilst in treatment. Dr Hodges noted that the Trust was producing smaller scale surveys to elicit feedback, using the kiosk in the ground floor waiting room

and a token-based question of the week (each person is given a token and asked to place this token in the relevant answer box for a particular question).

Mr Strang suggested that the Trust ought to be thinking about what it offers to Members, rather than what it wants *from* Members. Ms Greatley noted that a meeting between the Board of Directors and the Board of Governors was being arranged to think about Member engagement and this could be further developed then.

**AP3** Dr Patrick suggested the PPI Committee develop a mission statement. Dr Hodges to produce.

## **9. Corporate Governance Report**

The recommendation to hold discussions on code of conduct compliance to the annual review of the Board of Directors was approved, subject to an annual minuted confirmation that this had taken place.

## **10. Trust Policies: Data Quality Policy**

Dr Senior highlighted changes to the Policy since it was last presented to the Board. The Policy was approved.

**AP4** The Board queried whether individual discharge of responsibilities for matters not necessarily 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.

## **11. Committee Reports & Minutes**

Nothing to report.

## **12. Annual Plan**

### ***Statement from the Board (pp. 1-8)***

Mr Young explained that the Board must confirm either statement 1a or 1b. However, the report from the External Auditor on the Quality Report, which would inform this decision, was not yet available, due to the tight reporting deadlines. The declaration within the Plan had to be made by Tuesday 31<sup>st</sup> May, which was a week before the Annual Report, including the Quality Report, would be approved.

**AP5** Mr Strang noted that the Audit Committee were meeting on Thursday 26<sup>th</sup> May and would be questioning the External Auditors on the Quality Report. It was agreed that Ms Greatley, Dr Patrick, and Ms Lyon would be invited for the discussion on the Quality Report. It was agreed to confirm statement 1a, with the proviso that should the External Auditors issue any qualifications or concerns about the Quality Report, the Trust would

**AP6** confirm statement 1b. A recommendation from the Audit Committee would follow immediately after the meeting.

Dr McPherson noted that the Board devoted a significant amount of time to quality and could be reasonably assured of the Trust's position.

***Strategy (pp. 11-13)***

Mr Young highlighted that the priorities were listed on Page 13, and asked Board members to confirm these. These were confirmed.

**AP7** The following recommendations were made for consideration:

- Include reference to nationally-commissioned services
- Include reference to "sustainability" under buildings-related priorities
- Include reference to "patient experience" under outcome monitoring
- Refer to "commissioning environment"
- Include responding to external environment
- Include reference to marketing experience
- Include reference to influencing local / national policy (not a priority)

***Trust Plans (pp.17-31)***

**AP8** The date for unsecured income was to be revised.

Mr Strang noted that the Plan did not include financial activity targets for 2013/14. Mr Young explained that it was difficult to plan for these within a turbulent economic environment and did not anticipate any problems with this omission.

Page 27 – Mr Bostock suggested there was an over-reliance in the use of leaflets under "provision of information to promote informed choice of treatment". Ms Lyon explained that the contents of the Plan must be measurable. Mr Kara suggesting including website hits.

Mr Young confirmed that the Framework flowed down from the Plan and would be revised following approval of the Plan.

***Final Version of Annual Plan***

**AP9** Mr Young to send final draft of commentary by Thursday 26<sup>th</sup> May via e-mail.  
**AP10** Comments to be received no later than Monday 30<sup>th</sup> May.



### **13. Quality Report**

Ms Lyon highlighted that the Report would be presented for approval at the Extraordinary meeting of the Board of Directors on 2<sup>nd</sup> June.

Ms Moseley queried why, if recording marital status was no longer a requirement, it was being report on. Ms Lyon explained that the Report covered 2010/11, and the requirement had been dropped for 2011/12.

Ms Lyon highlighted that the priorities had been made into SMART objectives. There were also more discursive descriptions of the Trust's services. Board members to send feedback to Ms Lyon.

Mr Young explained that Monitor required the Quality Report to be finalised and submitted with the Annual Report (deadline Tuesday 7<sup>th</sup> June) but there was a provision to subsequently amend the Quality Report and re-submit that by Tuesday 30<sup>th</sup> June.

### **14. Service Line Report: Adolescent Directorate**

**AP11** This item was deferred due to time constraints.

### **15. Communications Report**

Ms Klauber suggested that the increase in the number of communications suggested that the Trust was experiencing success in raising its profile. Mr Bostock noted that the Trust now needed to move from being reactive with inbound media requests to be proactive and seeking these out.

### **16. Annual General Meeting Plan**

**AP12** Ms Greatley suggested that the Trust may wish to move the focus to its work, rather than getting asking an external speaker to discuss their own work. Dr Patrick highlighted, however, that past experience had demonstrated that people were not particularly interested in hearing about the work of the Trust in this forum. Board members to provide feedback to Dr Hodges.

### **17. Equalities Report**

Ms Smith noted that the Equalities Committee was a lively and well-functioning one. However, the Committee needed to ensure that it was making an impact in the Trust, and identified the use of data as an area for improvement.

Ms Greatley noted that a significant amount of time had been dedicated to equalities at the Trust's recent INSET day, which indicated that it was an area many staff were interested in. Ms Jones suggested that Ms Smith give consideration to how to share information on equalities in a digestible format.

It was noted that the Trust still had some way to go with improving the public perception of the Trust with regards to sexual orientation.

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.

**18. Any Other Business**

None.

**19. Notice of Future Meetings**

Noted.

# Board of Directors Meeting Minutes

10am – 11.30am, Thursday 2<sup>nd</sup> June 2011

Present:			
Ms Angela Greatley Trust Chair	Mr Martin Bostock Snr Independent Director	Ms Lis Jones Nurse Director	Mr Altaf Kara Non-Executive Director
Ms Trudy Klauber Dean	Ms Louise Lyon Trust Director	Ms Joyce Moseley Non-Executive Director	Dr Matthew Patrick Chief Executive
Dr Ian McPherson Non-Executive Director	Mr Richard Strang Deputy Trust Chair	Mr Simon Young Director of Finance	
In Attendance:			
Miss Louise Carney Trust Secretary (minutes)	Mr Jonathan McKee Governance Manager		
Apologies:			
Dr Rob Senior Medical Director			

## Actions

AP	Item	Action to be taken	Resp	By
1	3a	Ms Moseley's biography to be updated	JMc	Immed
2	3b	Quality Report to be amended as suggested	LL	Immed
3	5	Board papers to be discussed at Board of Directors' Annual Review away day	BD	Jun 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. Annual Report

#### 3a. Annual Report

Mr Young and Mr McKee highlighted some minor amendments to the Report:

- Page 13 to 17, Directors' Report: This section had been updated in line with revised figures as reported to Board of Directors in May 2011
- Page 17, Statement as to disclosure to auditors: This was a new section, which had been e-mailed to all Directors. All Board members confirmed (those not able to attend had already confirmed prior to the meeting via e-mail)

- Page 35, Audit Committee work in 2010/11, Paragraph 4: This had been updated to include more information about the Local Counter Fraud Specialists work, as recommended by Richard Strang (Chair of Audit Committee)

**AP1** Ms Moseley noted that her biography needed to be updated. Mr McKee to liaise and update.

The Report was approved, subject to the above amendment.

### ***3b. Quality Report***

Ms Lyon noted that the Board of Directors had discussed the Quality Report on two previous occasions. The Report now included feedback from the Camden Local Involvement Network (LINKs). Ms Lyon noted that feedback had been constructive, and a meeting had been arranged with LINKs to discuss this feedback further. Mr Strang noted that the feedback suggested that members of the public were interested in the Trust's work, and this was encouraging when considering Member engagement.

Ms Jones queried whether the absence of feedback from the Camden Overview and Scrutiny Committee was a problem. Ms Lyon explained that the Trust was required to send the Report to the OSC, but that the OSC were not required to provide feedback.

Mr Strang noted that the Audit Committee had given careful consideration to the Quality Report. The Trust's External Auditors, KPMG, had made several significant recommendations, and the Audit Committee had agreed to hold a review of progress against the Report in September. Based on this, KPMG had given the Report "limited assurance", which was the best rating possible.

Mr Kara noted that there were some areas of the Quality Report that he did not understand, and that, to some extent, he was relying upon the Executive for confirmation that the Report was correct. Mr Strang noted that Non-Executive Directors do not always understand the minutiae of Trust issues, but their interrogation of Executive Directors was sufficient to ensure that they were aware of all relevant matters. Ms Lyon agreed to hold an away day on the Quality Report, in order to improve Non-Executive Directors' understanding. Dr Patrick noted that it was sometimes difficult to follow the Report due to the structure and format, which was set by Monitor.

Ms Jones suggested that future Reports contain fewer abbreviations and a glossary.

**AP2** The Quality Report was approved, subject to minor amendments for clarity.

### ***3c. Statement on Internal Control***

Mr Young noted that a minor amendment had been made at the request of the Audit Committee.

The SIC was approved.

### **3d. Letter of Management Representation**

Mr Strang noted that the Audit Committee had seen the letter and had asked Mr Young to confirm that all the statements were true. Mr Young did so.

The letter was approved.

## **4. Annual Accounts**

Mr Young noted that the statement of comprehensive income showed the surplus for 2010/11 as £90k. This was lower than the 2009/10 surplus, but Mr Young explained that last year had been exceptional and none of the Trust's surplus had been needed.

Mr Strang queried whether planning for a £150k surplus at year-end was sufficient. Mr Kara highlighted that budgetary control needed to be very sharp. Dr Patrick noted that the Trust had budgeted for a significant contingency on top of the planned surplus, and that it was the combined figure that was critical for planning. It was agreed that further discussion should be held on this matter.

The accounts were approved.

## **5. Any other business**

The Board noted that papers had been circulated late, and expressed their dissatisfaction with this. It was noted that this was due to several late changes to the Report, combined with several other small problems, including printing and photocopying problems. Mr Kara noted that there were often papers circulated late to the Board, and that this impaired Directors' abilities to carry out their functions effectively. This to be discussed at away day for the Board's annual review (scheduled for 14<sup>th</sup> June).

AP3

## **6. Notice of future meetings.**

Noted.

## Outstanding Action Part 1

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date
2	Apr-11	4. Matters Arising	Dr Patrick to update Board of Directors on Big White Wall contract	Matthew Patrick	Jun-11
3	Apr-11	5. Trust Chair's and Non-Executive Directors' Reports	Ms Greatley to update Board of Directors on developments with London mental health chairs and CEO's groups	Angela Greatley	Jun-11
8	Mar-11	5. Trust Chair's and Non-Executive Directors' Reports	Ms Klauber to prepare report on workforce development, education and training	Trudy Klauber	Jun-11
13	Jan-11	4. Matters Arising	Dr Senior and Ms Lyon to give further consideration to cavassing GP's knowledge of mental health	Rob Senior / Louise Lyon	Jun-11
10	Apr-11	4. Matters Arising	Dr Senior to liaise with auditors to align terminology	Rob Senior	Jul-11
12	Apr-11	12a. Quality Report	Ms Lyon to liaise with Dr Hodges on communicating Quality Report to patients and public	Louise Lyon	Jul-11
15	Mar-11	8. Health & Social Care Bill Update: Governance in NHS Foundation Trusts	Miss Carney to investigate insurance policies for Directors	Louise Carney	Jul-11
16	Mar-11	8. Health & Social Care Bill Update: Governance in NHS Foundation Trusts	Miss Carney to update Board of Directors on Governors' and Directors' responsibilities as appropriate	Louise Carney	Jul-11
17	Apr-11	12a. Quality Report	Ms Lyon to provide quarterly updates on the Quality Report	Louise Lyon	Jul-11
18	Jan-11	7a. Finance & Performance Report	Ms Lyon to report back on structure of consultancy work	Louise Lyon	Jul-11
11	Apr-11	7c. Operational Risk Register	Mr Young to give consideration to preparing Board paper on performance management	Simon Young	Sep-11
21	Jan-11	10. Estates & Facilities Report	Ms Key to investigate whether the Public Services Bill affects the NHS and FTs in particular	Pat Key	As appropriate
22	Feb-11	5. Trust Chair's and Non-Executive Directors' Reports	Ms Greatley to forward any briefings on the changing role of Non-Executive Directors and Governors	Angela Greatley	As appropriate

## Board of Directors : June 2011

**Item :** 6

**Title :** Chief Executive Report

**Summary :**

The report covers the following items:

1. Introduction
2. NHS Health and Social Care Bill
3. Payment by Results update
4. University of East London
5. UCL Partners
6. Children's IAPT
7. London Programme for IT
8. And Finally...

**For :** Discussion

**From :** Chief Executive

## Chief Executive Report

### 1. Introduction

- 1.1 Within the Trust, work has continued to focus over the past month on productivity projects, with a particular emphasis on service redesign. As you know, the work is partly driven by our need to manage costs in the short, medium and longer term, while protecting and developing the quality of our work and our capacity for innovation; but also by the need to ensure that we shape our services such that they are best placed and supported to respond to opportunities for growth. Plans are taking on a much more concrete form with the outcomes of the Trust's Voluntary Redundancy Scheme. These outcomes are reported on in the Finance and Performance Report.
- 1.2 Three further staff meetings are being held to discuss the work, each one focusing on a separate domain: the first on specialist and adult services, the second on CAMHS, the third on central services.
- 1.3 At the same time, however, you will all be aware of the focus that the NHS has held in the public domain. I intend to devote the majority of this Report to these external developments, and to others that you may be less aware of but that are significant for us as an organisation.

### 2. NHS Health and Social Care Bill

- 2.1 On 13<sup>th</sup> June, the NHS Future Forum, chaired by Professor Steve Field, reported to the Government on the NHS Health and Social Care Bill.
- 2.2 The Government responded quickly, accepting the core proposals for change. Many of you will have seen or heard the details of proposed changes, and many summaries have already been published. I will highlight here what I consider to be amongst the key changes.
  - 2.2.1 Anxieties around competition and threats to the development of integrated care are addressed by making regulators, commissioning consortia and the NHS Board responsible for integration and coordination of services around patient need.



- 2.2.2 Monitor, instead of promoting competition, will be required to “support choice, collaboration and integration”. Monitor’s core duty will be to protect and promote patients’ interests.
- 2.2.3 In addition, Monitor will retain oversight over foundation trusts until 2016, ‘to enable governors to build capacity in holding their boards to account’.
- 2.2.4 The ‘drop dead’ deadline for foundation trust authorisation has been lifted, but remaining an NHS trust ‘is not an option’ and the majority of trusts are still expected to be authorised by 2014.
- 2.2.5 GP commissioning consortia will be renamed clinical commissioning groups to emphasise a broader membership (including a nurse and a secondary care doctor).
- 2.2.6 Primary Care Trusts will cease to exist in April 2013. However, clinical commissioning groups will not be authorised to take on any part of the commissioning budget in their local area until they are ready and willing to do so.
- 2.2.7 Commissioning groups should not cross Local Authority boundaries, unless clearly justified in patients’ interests.
- 2.2.8 Clinical networks will be strengthened, and clinical senates created to give expert advice, which clinical commissioning groups are expected to follow. Clinical senates will have a formal role in the authorisation of clinical commissioning groups. In addition they will have a key role in advising the NHS Commissioning Board on whether commissioning plans are clinically robust and on major service changes.
- 2.2.9 Both clinical networks and clinical senates will be hosted by the NHS Commissioning Board.
- 2.2.10 Local Authorities will also have a formal role in authorising clinical commissioning groups through Health and Wellbeing Boards.
- 2.2.11 Further details on training and education will be provided in the autumn, although a specific commitment is given to ensure ‘a safe and robust transition’. During the transition, deaneries will continue to oversee the training of junior doctors and dentists.

- 2.2.12 The Secretary of State will have an explicit duty to maintain a system for professional education and training as part of the comprehensive health service.
- 2.2.13 Lastly, there will be a requirement for foundation trusts to produce separate accounts for NHS and 'private-funded services'. The position of the private patients cap remains unclear
- 2.3 There is little doubt that the proposed changes are significant and, I believe, in a positive direction in relation to patient care. The current timetable for revision of the Bill, however, remains unclear, and many commentators have expressed continuing concerns. The NHS is still facing its hardest financial challenge at the same time as its largest structural reorganisation; the proposed changes will not help in making hard decisions about hospital or trust rationalisation; the timetable remains very unclear with continued uncertainty in a number of areas; and the removal of PCTs, coupled with the inevitable lag before PCT clusters become properly effective, could mean that commissioning is poorly held at a local level – of particular concern in relation to the commissioning of mental health services.

### **3. Payment by Results Update**

- 3.1 Bob Alexander (Director, NHS Finance) and Bruce Calderwood (Director, mental health policy) at the Department of health last week wrote to all mental health service leads with an update on Payment by Results (PbR) for mental health services for working age adults and older people. The letter's main points are as follows:
  - 3.1.1 The DH is now in the 'implementation phase' of mental health PbR
  - 3.1.2 They have decided that for 2010/11 only, they will collect reference costs for mental health in two ways. The first will be the usual reference cost collection exercise in July 2011. The second will be a specific cluster reference cost collection exercise. This will take place in September 2011.
  - 3.1.3 All service users accessing mental health care that have traditionally been labelled working age adults and older people's services, must be allocated to a cluster by 31<sup>st</sup> December 2011.

- 3.1.4 The earliest possible date for a national tariff for mental health (if evidence from the use of a national currency presents a compelling case for a national price) is 2013/14.
- 3.2 A more detailed report on the development of payment by results in mental health will be provided by the Director of Finance at the next Board.

#### **4. University of East London**

- 4.1 As reported in earlier CEO reports, UEL has recently undertaken a significant restructuring exercise. One result of relevance to the Trust is that the social sciences will now be divided between two schools: Social Work will be located in the School of Education, while Sociology and Psychosocial Studies will be located in the School of Law.
- 4.2 Our own links with UEL will, therefore, now span these two separate schools. In view of the potential risks associated with this we have been engaged in a detailed dialogue with the university involving both of our professors of social work; Trudy Klauber, our Dean; and myself.
- 4.3 I recently met with the UEL Vice Chancellor, Professor Patrick McGhee. At that meeting we agreed a number of actions to ensure that the potential of the partnership was properly supported:
  - 4.3.1 We agreed to re-constitute a high level partnership board and which both VC and CEO would be present.
  - 4.3.2 The primary linkage for the partnership would be held at the level above individual school, on our side by the Dean.
  - 4.3.3 Two UEL Associate Deans, one in social care and the other in social sciences are being appointed, one in each of the relevant schools. Each would sit on the partnership board.
  - 4.3.4 The School of Education will be renamed, probably as the School of Education and Social Care.
- 4.4 It was agreed that the partnership held tremendous potential, but that this would not be delivered if we were not able to recreate a shared narrative relating to its value.

## **5. UCL Partners**

- 5.1 The Board of UCLP has invited the four member mental health trusts (TPFT; CIFT; BEH and NELFT) to nominate a representative to sit on the Board. This invitation represents the value that UCLP attaches to mental health and the work of the mental health theme, and recognises the important interdependencies between physical and mental health.
- 5.2 I believe that taking up this opportunity is a very important step for the mental health community in north central London, and am strongly supporting it. The cost of Board membership is £50k per year, which would be shared amongst participating trusts.
- 5.3 I have arranged to meet my CEO colleagues in July to discuss the opportunity, with the hope that all will agree.

## **6. Children's IAPT (Improving Access to Psychological Therapies)**

- 6.1 The Government has provided a limited amount of funding to support the development of CAMHS services, and in particular access to evidence based psychological therapies within these services.
- 6.2 Rita Harris, our CAMHS and Children's IAPT lead, has been closely involved with these developments and is a member of one of the expert reference groups.
- 6.3 Bids to deliver training are now being invited from collaboratives encompassing Higher Education Institutes, NHS CAMHS providers and a PCT to hold funding.
- 6.4 We are in active discussion with a number of partner organisations around the contribution that we might make to such a bid.

## **7. London Programme for IT**

- 7.1 For information, I have, on a temporary basis, taken over as chair for the LPfIT mental health and community services programme board. The board oversees the implementation of the London RiO project, and will also be considering arrangements around the end of the RiO contract in 2015.

## **8. And Finally...**

- 8.1 On Thursday 26<sup>th</sup> May, I attended an exceptional evening here at the Trust, organised by the Department of Education and Training. The evening comprised a conversation between film-maker Stephen Poliakoff and Professor Michael Rustin, chaired by Trudy Klauber. Clips of Stephen's films were shown during the evening and the discussion was excellent. The Trust awarded an honorary doctorate to Stephen Poliakoff at our last graduation ceremony.

Dr Matthew Patrick  
Chief Executive Officer  
June 2011

## Board of Directors : June 2011

**Item : 7**

**Title : Finance & Performance Report**

**Summary :**

After two months a surplus of £23k is reported, £2k below the planned surplus of £25k. Income shortfalls on Directorate Consultancy and Productivity schemes have been offset by under spends in Training and Central Functions. These variances are being investigated, but no major variances for the year are forecast at this early stage.

An update on Service Line Reporting is to be provided separately.

The cash balance at 31 May was £3,537k, £418k below the revised Plan. It is expected that this shortfall should be recovered over the course of the year.

**For : Discussion**

**From : Director of Finance**

## Chief Executive Report

### 1. External Assessments

#### 1.1 Monitor

- 1.1.1 Monitor has confirmed that our Financial Risk Rating at Quarter 4 remains at 3; and the ratings for governance and for mandatory services remain green.
- 1.1.2 The Annual Plan, as approved by the Board, was submitted to Monitor in May. Following their review, a response is expected in July. The Plan should lead to a Financial Risk Rating of 3. It is currently expected that the actual rating for the year will also be a 3 in all four quarters.

### 2. Finance

#### 2.1 2010/11

- 2.1.1 The Annual Report and Accounts were approved at the extraordinary meeting of the Board of Directors on 2<sup>nd</sup> June. They have been submitted to Monitor, and will be laid before Parliament early in July. The surplus was £90k, as reported in April.

#### 2.2 Income and Expenditure 2011/12

- 2.2.1 After two months the trust is reporting a surplus of £23k, £2k below Plan. Income is £186k below budget, and expenditure £184k below budget. Some of these variances are due to timing, and the forecast for the year remains in line with Plan.
- 2.2.2 Consultancy income is £73k under budget; TCS under target by £10k and departmental consultancy under by £63k. Other Income is £54k below target mainly due to under achieved productivity schemes in Adult £30k and Adolescent £15k. There is also a shortfall in clinical income due to a credit note relating to 2010/11. These main income sources and their variances are discussed in sections 3, 4 and 5 below, though income over the first two months will have been affected by the unusual number of holidays in April and by the current work on service redesign.
- 2.2.3 The cumulative expenditure under spend of £184k is due to £120k on non-pay and £61k on pay across the organisation. The majority of the non-pay under spend is £60k within DET apportioned across the courses and departments; this under spend is expected to reduce over the year.
- 2.2.4 Although the total pay budget is £61k under spent, CAMHS is currently £99k over spent. This is partially due to the rephrasing of the vacancy control factor which had an adverse effect of £60k. The vacancy control factor was rephrased to reflect the likely profile of vacancies across the year, with fewer vacancies in the latter part of

the year due to the planned restructure and Voluntary Redundancy Scheme.

2.2.5 The forecast outturn for expenditure is likely to be around £500k favourable; a more robust forecast will be possible in future months.

2.2.6 Without effective action and controls, forecast income for the year would be £215k below budget as in Appendices A and B. Larger shortfalls than this should be covered firstly by the underspending 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.

## 2.3 **Cash Flow (Appendix C)**

2.3.1 The actual cash balance at 31 May was £3,516k, compared to the revised Plan of £3,934k. Receipts from NHS are above Plan due to late payments for the final quarters of contracts with LB Barnet and Haringey Council as well as receipts in advance for the City & Hackney Contract. This has been offset by receipts from General Debtors, SHA and Students all below plan. The SHA shortfall has been received in June. Expenditure to Suppliers was above Plan due to higher than anticipated expenditure in March; this is expected to be partially recovered in June, and does not represent a significant risk to the Trust's income or liquidity. Debt recovery is currently being reviewed both internally for student debt and with SBS for other sources of income.

	Cash Flow year-to-date		
	Actual £000	Plan £000	Variance £000
Opening cash balance	4,712	4,712	0
Operational income received			
NHS (excl SHA)	1,416	1,129	287
General debtors (incl LAs)	856	1,116	(260)
SHA for Training	1,707	1,848	(141)
Students and sponsors	290	450	(160)
Other	26	36	(10)
	4,295	4,579	(284)
Operational expenditure payments			
Salaries (net)	(2,453)	(2,466)	13
Tax, NI and Pension	(1,817)	(1,812)	(5)
Suppliers	(1,202)	(1,081)	(121)
	(5,472)	(5,359)	(113)
Capital Expenditure	(21)	0	(21)
Interest Income	2	2	0
Payments from provisions	0	0	0
PDC Dividend Payments	0	0	0
Closing cash balance	3,516	3,934	(418)

## 2.4 **Training**

2.5 Training income is £13k below budget in total after 2 months, with the main shortfalls being Child Psychotherapy Trainees (offset by lower costs).



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

2.7 Income shortfall was offset by under spends as above.

### **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 two months, there is a small favourable variance on cost and volume activity of £2.5k. However, this has been offset by a credit note of £33k relating to a transaction from 2010/11. Part of the budgeted income for the year is dependent on meeting our CQUIN<sup>1</sup> targets agreed with commissioners and achievement is reviewed on a quarterly basis.

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

3.1.3 The income budget for named patient agreements (NPAs) was reduced this year from £239k to £230k. £110k of the total budget is for the Portman, with smaller amounts for other Directorates. After two months, actual income is £8k below budget, with £4k of this shortfall in the Portman. However, the forecast for the year without action would be a shortfall of £147k.

3.1.4 Court report income (which is budgeted at £285k for the year, of which £210k is for the Portman) was £5k below budget after two months.

3.1.5 Monroe income is slightly above budget after 2 months. The annual budget was reduced from £780k to £504k this year.

3.1.6 Day Unit was £20k above target as they had 14 pupils against a budgeted target of 12.5. However, student numbers are likely to decrease over the year.

3.1.7 Project income is forecast to be balanced for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.

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<sup>1</sup> Commissioning for Quality and Innovation

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	1,583	1,547	-2.3%		-33	Small underachievement due to CQUIN element plus old year credit note.
Cost and vol variances	2	3			7	
NPAs	38	30	-20.5%	-47	-147	
Projects and other	322	345		-	0	Income matched to costs, so variance is largely offset.
Day Unit	176	196	11.6%	122	0	
Monroe	70	72	3.4%	17	0	
FDAC 2nd phase	65	34	-46.8%	-182	-31	Income matched to costs, so variance is largely offset.
Court report	47	43	-8.6%	-25	0	
Total	2,302	2,271		-115	-204	

#### 4. **Consultancy**

- 4.1 TCS income was £94k up to May, compared to the budget of £104k. Current forecasts for June expect the in-month budget of £48k to be achieved. Our forecast for the year assumes at present that budget is achieved for the remaining ten months.
- 4.2 Departmental consultancy is £62k below budget after two months. The majority of the shortfall is within CAMHS which is currently £30k below target. Actions to recover the shortfall will be required to deliver against plan.

#### 5. **Voluntary Redundancy Scheme**

- 5.1 There have been 34 expressions of interest in the scheme; 2 are still awaiting information. 21 applications have so far been approved and 7 requests have not been approved. The current 21 applications, if all proceeded, would have a one off cost of £867k and would release £629k of productivity savings, just over half of which would benefit the Trust in 2011/12.

Mr Carl Doherty  
Deputy Director of Finance

17<sup>th</sup> June 2011

**THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST**

**APPENDIX A**

**INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2011-12**

		CUMULATIVE			FULL YEAR 2011-12		
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST OUTTURN £000	BUDGET VARIANCE £000
<b>INCOME</b>							
1	CLINICAL	2,302	2,271	(31)	13,899	13,695	(204)
2	TRAINING	2,602	2,589	(13)	16,544	16,543	(1)
3	CONSULTANCY	224	151	(73)	1,351	1,278	(73)
4	RESEARCH	28	13	(15)	167	167	0
5	OTHER	136	82	(54)	818	764	(54)
<b>TOTAL INCOME</b>		<b>5,292</b>	<b>5,106</b>	<b>(186)</b>	<b>32,778</b>	<b>32,447</b>	<b>(332)</b>
<b>OPERATING EXPENDITURE (EXCL. DEPRECIATION)</b>							
6	CLINICAL DIRECTORATES	2,865	2,893	(28)	17,323	17,373	(49)
7	OTHER TRAINING COSTS	1,074	940	133	7,098	6,999	99
8	OTHER CONSULTANCY COSTS	104	92	13	589	576	13
9	CENTRAL FUNCTIONS	1,077	1,011	66	6,334	6,278	56
10	TOTAL RESERVES	0	0	0	399	186	213
<b>TOTAL EXPENDITURE</b>		<b>5,120</b>	<b>4,936</b>	<b>184</b>	<b>31,743</b>	<b>31,412</b>	<b>332</b>
<b>EBITDA</b>		<b>172</b>	<b>170</b>	<b>(2)</b>	<b>1,035</b>	<b>1,035</b>	<b>0</b>
<b>ADD:-</b>							
12	BANK INTEREST RECEIVED	2	2	0	11	11	(0)
<b>LESS:-</b>							
11	DEPRECIATION	85	85	0	509	509	0
13	FINANCE COSTS	0	0	0	0	0	0
14	DIVIDEND	64	64	0	386	386	0
<b>RETAINED SURPLUS</b>		<b>25</b>	<b>23</b>	<b>(2)</b>	<b>151</b>	<b>150</b>	<b>(0)</b>
<b>EBITDA AS % OF INCOME</b>		<b>3.3%</b>	<b>3.3%</b>		<b>3.2%</b>	<b>3.2%</b>	

**THE TAVISTOCK AND PORTMAN NHS TRUST**  
**INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2011-12**

**APPENDIX B**

	CUMULATIVE			FULL YEAR 2011-12		
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST £000'S	REVISED BUDGET VARIANCE £000
<b>INCOME</b>						
NHS LONDON TRAINING CONTRACT	1,209	1,209	0	7,254	7,254	0
TRAINING FEES & OTHER ACA INC	877	876	(1)	6,028	6,027	(1)
POSTGRADUATE MED & DENT'L EDUC	12	12	0	70	70	0
JUNIOR MEDICAL STAFF	173	179	6	1,037	1,037	0
CHILD PSYCHOTHERAPY TRAINEES	332	313	(18)	2,155	2,155	0
R&D	28	13	(15)	167	167	0
CLINICAL INCOME	1,936	1,918	(18)	11,616	11,443	(173)
DAY UNIT	176	196	20	1,055	1,055	0
MONROE	70	72	2	504	504	0
FDAC	73	42	(31)	439	408	(31)
TCS INCOME	104	94	(10)	613	603	(10)
DEPT CONSULTANCY INCOME	120	57	(62)	737	675	(62)
COURT REPORT INCOME	47	43	(5)	285	285	0
EXCELLENCE AWARDS	19	19	0	116	116	0
OTHER INCOME	117	63	(54)	702	648	(54)
<b>TOTAL INCOME</b>	<b>5,292</b>	<b>5,106</b>	<b>(186)</b>	<b>32,778</b>	<b>32,447</b>	<b>(332)</b>
<b>EXPENDITURE</b>						
EDUCATION & TRAINING	698	604	94	4,679	4,586	94
PORTMAN CLINIC	220	216	3	1,316	1,316	0
ADULT DEPT	520	520	(1)	3,109	3,109	0
MEDNET	41	25	16	246	230	16
ADOLESCENT DEPT	263	264	(1)	1,723	1,723	0
C & F CENTRAL	1,349	1,448	(99)	8,095	8,194	(99)
MONROE & FDAC	182	149	33	905	872	33
DAY UNIT	128	127	0	751	750	0
SPECIALIST SERVICES	146	140	6	1,083	1,083	0
COURT REPORT EXPENDITURE	16	2	14	95	95	0
TRUST BOARD & GOVERNORS	18	18	(1)	106	106	(1)
CHIEF EXECUTIVE OFFICE	52	51	0	311	310	0
PERFORMANCE & INFORMATICS	128	122	7	708	701	7
FINANCE & ICT	203	210	(7)	1,200	1,200	0
CENTRAL SERVICES DEPT	364	356	8	2,165	2,165	0
HUMAN RESOURCES	114	129	(14)	646	646	0
CLINICAL GOVERNANCE	67	38	29	410	381	29
TRUST DIRECTOR	64	48	15	381	366	15
PPI	38	33	5	231	226	5
SWP & R+D & PERU	44	24	20	264	264	0
R+D PROJECTS	0	0	0	0	0	0
PGMDE	10	5	6	63	58	6
NHS LONDON FUNDED CP TRAINEES	332	307	25	2,155	2,155	0
TAVISTOCK SESSIONAL CP TRAINEES	15	13	1	88	88	0
FLEXIBLE TRAINEE DOCTORS	19	11	8	113	113	0
TCS	97	86	11	542	531	11
DEPARTMENTAL CONSULTANCY	7	5	2	47	45	2
DEPRECIATION	85	85	0	509	509	0
PROJECTS CONTRIBUTION	(15)	(19)	4	(87)	(87)	0
CENTRAL RESERVES	0	0	0	399	186	213
<b>TOTAL EXPENDITURE</b>	<b>5,205</b>	<b>5,021</b>	<b>184</b>	<b>32,252</b>	<b>31,921</b>	<b>332</b>
<b>OPERATING SURPLUS/(DEFICIT)</b>	<b>87</b>	<b>85</b>	<b>(2)</b>	<b>526</b>	<b>526</b>	<b>(0)</b>
INTEREST RECEIVABLE	2	2	(0)	11	11	(0)
UNWINDING OF DISCOUNT ON PROVISION	0	0	0	0	0	0
DIVIDEND ON PDC	64	64	0	386	386	0
<b>SURPLUS/(DEFICIT)</b>	<b>25</b>	<b>23</b>	<b>(2)</b>	<b>151</b>	<b>150</b>	<b>0</b>

# 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	4,733	3,934	3,531	3,085	2,560	1,771	1,623	1,421	1,091	1,516	1,483	4,712
Operational income received													
NHS (excl SHA)	525	604	640	958	988	870	858	989	869	857	990	870	10,018
General debtors (incl LAs)	742	374	871	534	425	400	594	500	450	839	626	487	6,843
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
	2,499	2,080	2,593	2,524	2,364	2,402	3,034	2,691	2,351	3,128	2,668	2,389	30,724
Operational expenditure payments													
Salaries (net)	(1,233)	(1,233)	(1,233)	(1,233)	(1,233)	(1,492)	(1,478)	(1,190)	(1,190)	(1,190)	(1,190)	(1,190)	(15,085)
Tax, NI and Pension	(900)	(912)	(912)	(911)	(912)	(912)	(1,103)	(1,092)	(879)	(880)	(880)	(880)	(11,173)
Suppliers	(346)	(735)	(807)	(720)	(645)	(535)	(542)	(553)	(563)	(573)	(572)	(572)	(7,163)
	(2,479)	(2,880)	(2,952)	(2,864)	(2,790)	(2,939)	(3,123)	(2,835)	(2,632)	(2,643)	(2,642)	(2,642)	(33,421)
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	4,733	3,934	3,531	3,085	2,560	1,771	1,623	1,421	1,091	1,516	1,483	929	929

## 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	3,113	2,667	2,142	1,353	1,205	1,003	673	1,098	1,065	4,712
Operational income received													
NHS (excl SHA)	691	725	640	958	988	870	858	989	869	857	990	870	10,305
General debtors (incl LAs)	618	238	871	534	425	400	594	500	450	839	626	487	6,583
SHA for Training	0	1,707	914	914	933	914	914	934	914	914	934	914	10,906
Students and sponsors	198	92	150	100	0	200	650	250	100	500	100	100	2,440
Other	4	22	18	18	18	18	18	18	18	18	18	18	206
	1,511	2,784	2,593	2,524	2,364	2,402	3,034	2,691	2,351	3,128	2,668	2,389	30,440
Operational expenditure payments													
Salaries (net)	(1,243)	(1,210)	(1,233)	(1,233)	(1,233)	(1,492)	(1,478)	(1,190)	(1,190)	(1,190)	(1,190)	(1,190)	(15,072)
Tax, NI and Pension	(900)	(917)	(912)	(911)	(912)	(912)	(1,103)	(1,092)	(879)	(880)	(880)	(880)	(11,178)
Suppliers	(705)	(497)	(807)	(720)	(645)	(535)	(542)	(553)	(563)	(573)	(572)	(572)	(7,284)
	(2,848)	(2,624)	(2,952)	(2,864)	(2,790)	(2,939)	(3,123)	(2,835)	(2,632)	(2,643)	(2,642)	(2,642)	(33,534)
Capital Expenditure	0	(21)	0	(100)	(100)	(60)	(60)	(60)	(50)	(60)	(60)	(109)	(680)
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	3,376	3,516	3,113	2,667	2,142	1,353	1,205	1,003	673	1,098	1,065	511	511

## Board of Directors : June 2011

**Item :** 8

**Title :** Gloucester House Steering Group Report

**Summary:**

This report outlines the main developments in the Day Unit over the past 10 months.

The move to more locally based provision in Local Authorities presents a challenge in terms of sustaining good practice and income levels whilst developing new models of work.

**For :** Discussion

**From :** CAMHS Director

## Gloucester House Steering Group Report September 2010 – June 2011

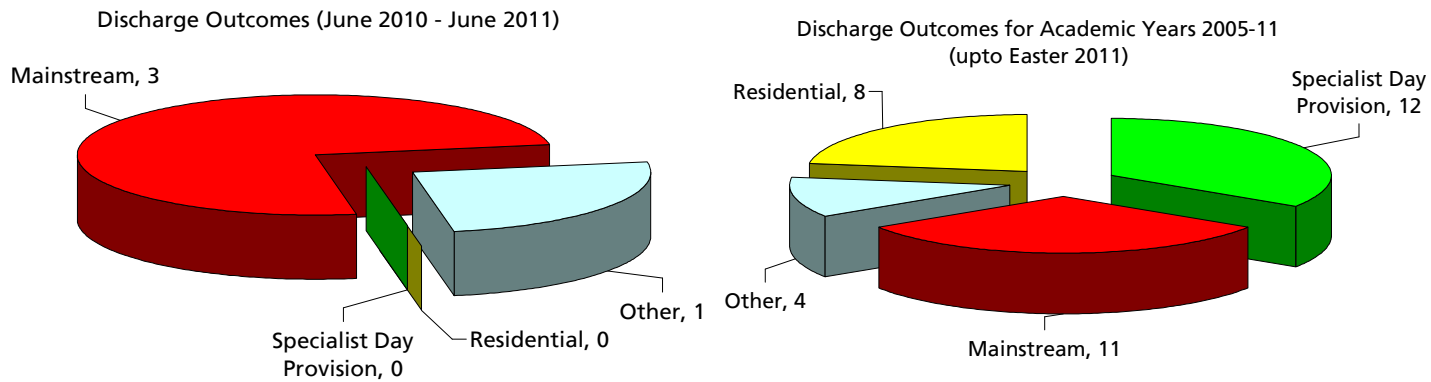
### 1. Introduction

- 1.1 The Day Unit Steering Group meets quarterly and reports to the Board of Directors annually. It was established to focus on strategic planning for the service in relation to the Trust objectives and the Annual Plan; to agree a developmental plan and objectives for the Unit; to receive reports from the Unit Director and Head Teacher; and to support the Unit Director and Head Teacher in carrying out the plan and to ensure compliance with education regulations and NHS requirements such as clinical governance. The Steering Group also reviews strategic and operational risks. The membership includes a Non-Executive Director, Richard Strang. We have not yet been successful in replacing the Public Governor, representing parents and carers.
- 1.2 Until recently this group was chaired by the Associate Clinical Director for the "Vulnerable Children" Service Line. He has stepped down from this role and whilst we are reviewing how we organise and deliver our services the Steering Group is chaired by the CAMHS Director.
- 1.3 This report outlines the main developments within the Day Unit over past ten months, the period since the last report to the Board was submitted. It considers the effects on the Unit of a range of external factors, and suggests ways that the Unit can continue to move forward and build on the achievements of recent years, while at the same time taking into account developments in the political and economic climate.

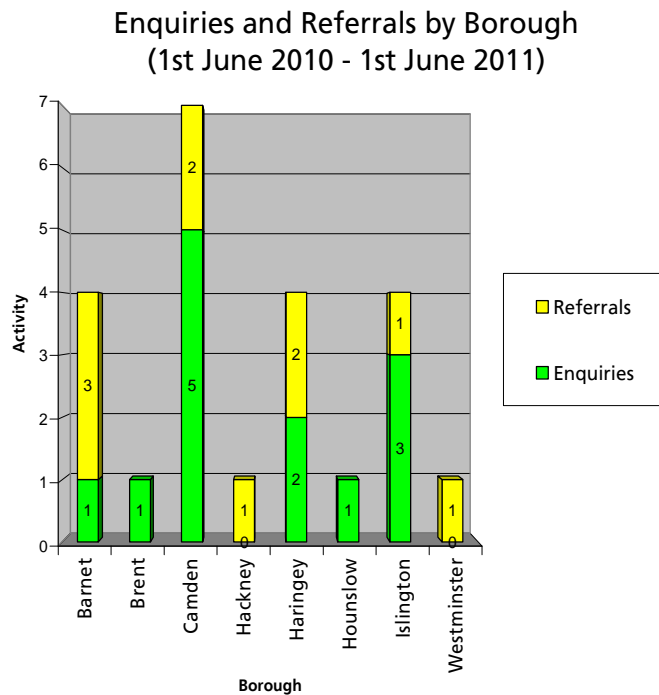
### 2. Activity

- 2.1 The Day Unit has had an average occupancy of 13.2 (breakeven = 12.5) between June 2010 and June 2011. There were three admissions and four discharges. Of the four discharges, three were successfully reintegrated into mainstream education, and one is currently being home schooled.

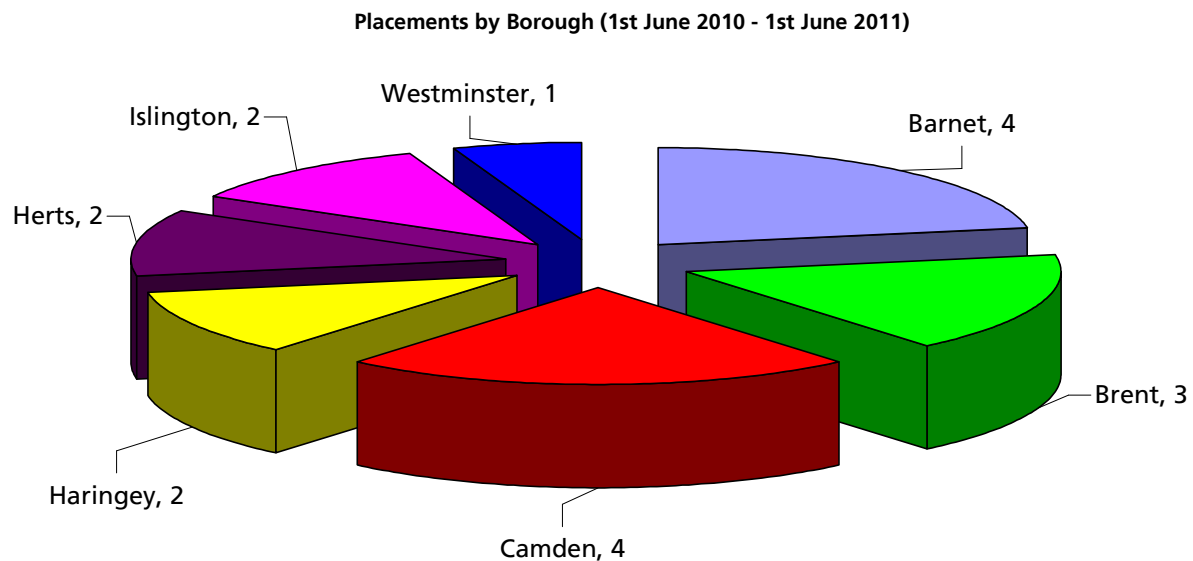




2.2 We have had ten referrals and 13 formal enquiries over the past year. These have come from a range of agencies and localities.



- 2.3 Actual placements over the past year show a similar wide ranging distribution.



- 2.4 We currently have Service Level Agreements with Camden (four places) and Barnet (three places). These have been used at 100% and 94% respectively.
- 2.5 It is important to note that eight children (a larger number than usual) are expected to leave over the summer. Unfortunately, even at this late stage, in four cases there is still uncertainty about where they will be moving on to. It is therefore possible that some of them might still be with us in September.
- 2.6 It is therefore encouraging that there are currently three referrals being processed, with admissions planned for the start of next term. There are also a further four enquiries and another referral in the pipeline.
- 2.7 Outcomes: The results of our regular survey of users suggests that our parents and carers agree or strongly agree that their children benefit from the Day Unit, make progress and enjoy being here, and that parental views are taken into consideration. The children's feedback forms reflect a more mixed picture. Whilst the majority of children enjoy lessons, school trips, playtimes, and feel they have enough homework, 50% feel that their complaints are not listened to. This will be the focus of further work. We have added Goal Based Outcomes to our standard range of outcome measures. Though thus far there are insufficient numbers for these to be of significance, early results suggest that we are meeting most of the targets that have been set jointly.

### **3. Ofsted**

- 3.1 In October 2010, the Unit was inspected by Ofsted. We were graded as a good school during this process. However, a number of issues were raised in terms of serious concerns about the building – particularly in relation to the state of repair and cleanliness. We were required to supply an Action Plan to Ofsted in relation to these issues raised and it was made clear that there would need to be significant improvement before the next visit, in order to pass our next inspection. Ofsted also recommended some changes to our educational assessment processes. We have been evaluating and developing these accordingly in line with their recommendations.

### **4. Relationship with outside stakeholders**

- 4.1 We have been given notice by Camden that they will not be renewing their Service Level Agreement from September 2012. Despite having had, on average, 5.2 children placed in the Unit each year over the past five years, they are planning to meet this need locally in a reconfigured local service.
- 4.2 We continue to prioritise our relationships with commissioners and referrers. A key issue we need to address with our commissioners is the tension between their agenda being increasingly focused on providing all services “in-house” for each Borough, and our remit of providing a service that (through the nature of our client population) needs to be across both Boroughs and agencies.
- 4.3 We continue to be proactive in terms of publicity for the Unit. The new brochure is now ready for distribution, four months ahead of schedule. The website has been in place for six months and is generating an increasing number of hits.
- 4.4 We continue to receive requests for consultancy and teaching, and our regular open days continue to be well attended. One school organised a visit to the Unit as its INSET Day.
- 4.5 We have been proactive in trialling innovative ways of working with other agencies, organisations and departments, delivering packages that are tailored to needs of particular cases. For example, we have worked collaboratively with the Portman Clinic on two such cases. We are also in negotiations with a specialist fostering agency (ISP) and a residential home provider (CHT) about the possibility of offering combined packages.

- 4.6 We continue to foster good links with the local community. These have included a recent visit to the Unit by a nationally known children's author.

## **5. Staffing**

- 5.1 Overall the staff group has been stable over the past twelve months. There will be two planned leavings over the summer. These positions will probably remain vacant in September, and not be filled until the capacity of the Day Unit returns to normal levels after Christmas.
- 5.2 There have been three incidents of stress-related absence over the past year, all of which have involved junior staff at the Unit.
- 5.3 There is a proposal to pilot a Learning Support Team in the Unit. Many, if not all, of the children at the Unit display challenging behaviours which mean they are at times out of control, and effectively "unteachable".
- 5.4 By introducing a part of the team tasked specifically with attending to these behaviours, we hope not only to deal with them more effectively, but also allow other staff to concentrate on their designated tasks. By moving resources away from a reactive to a preventative function, we also hope to make savings in overall staff costs (e.g. on bank Teaching Assistants) in the longer term.
- 5.5 When at full complement, the Learning Support Team will consist of one senior part-time nurse, one junior full-time nurse, and one full-time nursing assistant. This project is seen as a pilot and will be subject to audit and review.
- 5.6 The Unit continues to have a varied and successful INSET programme for both clinical and educational staff. This academic year we have had 5.5 INSET days.
- 5.7 All staff have been trained in child protection to the appropriate level and we send staff to the mandatory Trust INSET days. We now have a system in place whereby we close the Unit once in two years so that all staff can attend these days together.
- 5.8 Staff are encouraged to train in ways that can both further their career and support the work of the Unit.
- 5.9 The Unit continues to provide an opportunity for a placement for psychiatric, social work, psychotherapy and psychology trainees. Once the Learning Support Team is in place we will also be able to include trainees from psychiatric nursing.

## **6. Health & Safety**

- 6.1 Given the type of children and families we work with at the Day Unit, it is not surprising that the Unit will always account for a large proportion of Trust incidents. Over the last year there have been three major incidents, two involving children and one involving a staff member being injured. There have been no formal complaints received since the last Board Report.
- 6.2 We continue to offer annual Team Teach training about ways of dealing with challenging behaviours for all staff (above the recommended bi-annual level), as well as offering regular refresher courses throughout the year.

## **7. Accommodation**

- 7.1 The current building is not purpose built and is difficult and costly to maintain. The very nature of the building has contributed to several recorded incidents, and the recent Ofsted report noted that either there needed to be a significant improvement in the fabric of the building, or that the service should be moved to better accommodation prior to the next visit. A paper outlining the various accommodation options was considered by the Day Unit Steering Group and the short listed options were separately evaluated against both financial and non-financial criteria and reconciled in a cost-benefits analysis to determine the best option overall. The preferred option was to build a new building on land to be acquired and the second preferred option was to refurbish an existing building. It was recommended that the Trust pursue more than one option due to the lack of certainty over which site would be available at acceptable terms, various planning scenarios and the need for design solutions to deliver service requirements.
- 7.2 Accommodation schedules have been developed to suit either the Day Unit as a stand alone service or a site which could house both the Day Unit and additional CAMHS. The latter would be a necessity if a possible Day Unit site was not co-located with a suitable partner organisation and would ease accommodation pressures at the Tavistock Centre as well as address access issues.
- 7.3 The Trust appointed an agent to undertake a weekly appraisal of suitable sites within the boroughs of Camden, Barnet and Haringey. This has subsequently been extended to include Brent and Islington. A few possible sites have come via this route and have been the subject of further exploration. None have been able to adequately

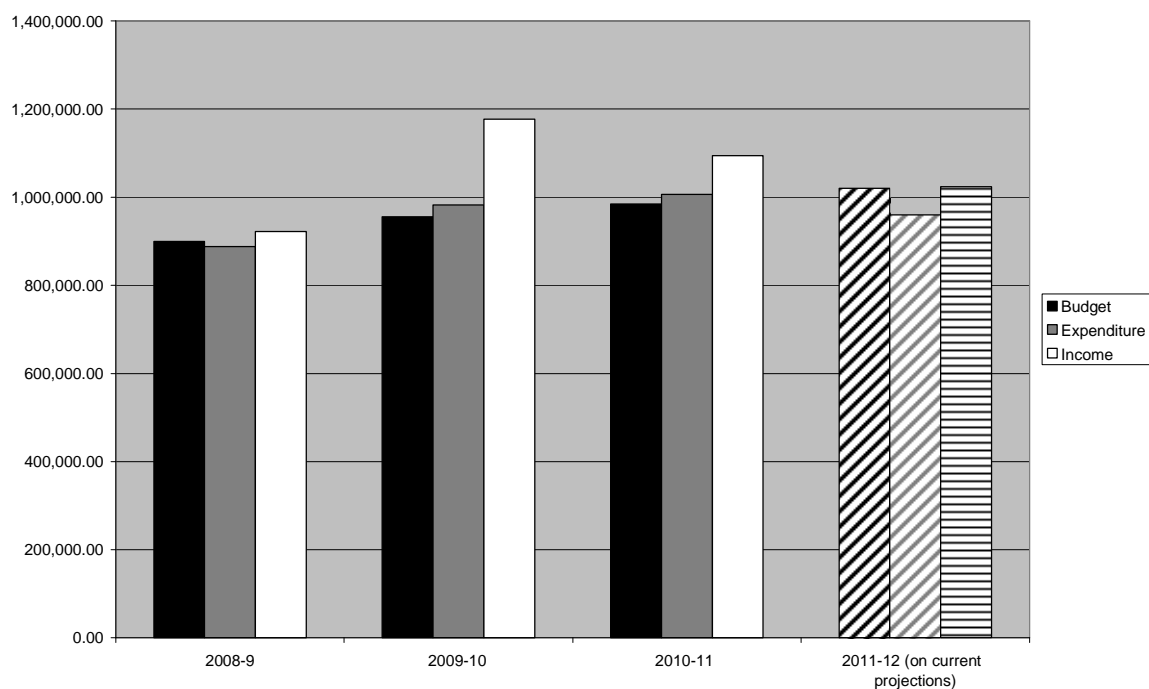
address the Trust criteria to date although this avenue is still open. Public sector contacts in Camden, Barnet and BEH (Barnet, Enfield, & Haringey) have been consulted and there are possibilities available which are currently being considered. It is envisaged that this is likely to be the most fruitful option.

## 8. RiO

8.1 The Day Unit has been using RiO for six months now, and, after the initial challenge of categorising the varied work carried out by the unit staff so that the full extent of the team's productivity is captured, it is proceeding smoothly.

## 9. Financial Situation

9.1 Figures for the last financial year (2010/11) show a surplus of £89k.



9.2 In the light of the possible changes in the market, the major challenge for us this financial year is how to sustain current good practice and activity whilst developing possible new markets. Although some of this work is underway currently, the process will need to be accelerated.

## 10. Conclusion

- 10.1 The Day Unit caters for a group of children and families at the extremely disturbed end of the spectrum, who present with complex, challenging, and seemingly intractable difficulties. This client group does not fall clearly within the remit of any individual agency or service, nor does it respond quickly or easily to most interventions.
- 10.2 There are two main concerns around the future of the Day Unit. The first is around how to survive the likely / possible dip in demand as commissioning agencies adjust to political and financial pressures to which they are subject. The second, related, issue is how to facilitate the development of new models of working whilst protecting existing good practice and income.

Dr Rita Harris  
CAMHS Director  
17<sup>th</sup> June 2011

## Board of Directors : June 2011

**Item :** 9

**Title :** Board of Directors' Aims and Objectives

**Summary :**

Attached are the 2011 / 12 aims and objectives for the Board of Directors.

**For :** Approval

**From :** Trust Chair



## Board of Directors' Aims and Objectives 2011/12

### Overarching Aims

#### *Strategy*

- Create an inspiring strategy that takes into account the Trust's accountability for meeting patient, student and public need; and the Trust's mission, focused as it is on making a significant contribution to mental health and wellbeing.
- Focus on improving our understanding of outcomes in order to drive up quality; locating outcomes, safety and patient experience at the heart of our clinical work. Our aim is to measure, communicate and develop the quality of the Trust's services.
- Focus on successful productivity and performance in order to remain financially sustainable while delivering affordable excellence in all areas of service.
- Develop our understanding of emerging local and national education and training markets in order to maximise our contribution, also looking to the potential for international development.
- Develop our understanding of the potential impact on the Trust of changes in local, regional and national health, social care and education markets.

#### *Developing People and the Organisation*

- Build on the annual Board review to ensure maximum performance as a unitary board.
- Ensure that Trust staff are trained and equipped to meet the demands of reconfigured and evolving services.
- Actively seek and engage with the views of staff and ensure these views contribute to the shaping and future development of the organisation and its services retain this.
- Develop the trust's succession planning models.
- Ensure that 'equalities' retains a high priority in the Trust's clinical, education, consultancy and research programmes.

### **Governance**

- Develop the relationship between the Board of Governors and Board of Directors, to ensure that they work well together in order to ensure effective governance of the Trust.
- Support the Governors in developing their relationship with Members and the public.

### **Performance: Quality and Finance**

- Ensure that productivity gains are realised whilst maintaining the high quality and safety of Trust services.
- Ensure that the Trust retains unqualified registration with the Care Quality Commission (CQC).
- Ensure that the Trust retains a Monitor Financial Risk Rating of 3 or above.
- Ensure that the Trust retains a green rating for governance.
- Ensure that the Trust meets the requirements of education regulatory bodies and meets the requirements of the commissioners of education and training.
- Promote close working with the Trust's customers, purchasers, commissioners, and university partners to respond to emerging need and associated business opportunities.

## Special Emphasis for the Year

Special Emphasis for the year	Aim	Objective	Review Date
External environment and place in the market	Ensure that the Trust is optimally positioned in relation to the developments in emerging health, social care and education markets, managing risks and maximising opportunities	Review Annual Plan and annual objectives in order to develop a strategic response to market developments	October 2011
		Develop and agree a marketing and a communications strategy in order to position the Trust optimally in relation to commissioners, public and patients	November 2011
		Engage actively with local and national markets in order to deliver new products and reconfigured clinical and education services	In 2011/12
		Explore national opportunities for clinical services and international developments in education and training	In 2011/12

Special Emphasis for the year	Aim	Objective	Review Date
<b>Performance</b>	Ensure that the Trust delivers on the objectives contained within the Annual Plan according to the timetable set out	Retain CQC Registration without condition	Quarterly
		Monitor Finance Risk Rating of 3 or better across all four quarters	Quarterly
		Monitor Governance Rating of Green across all four quarters	Quarter 4
		Ensure that the Annual Plan 2011/12 – 2013/14 encompasses effective longer-term strategy to achieve performance objectives	Annual Plan cycle, starting Summer 2011
		Implement reconfigured service lines	September 2011
		Use service line data to drive performance monitoring and planning	Monthly

Special Emphasis for the year	Aim	Objective	Review Date
Productivity	Ensure that the Trust delivers on national and local productivity challenges, including the QIPP programme	Monitor action plans for delivery of productivity targets for 2011/12 up to 2014	Annual Plan cycle; July 2011
		Ensure Trust is prepared to react to reductions in demand for its services	Quarterly
	Ensure that these action plans do not impact negatively on quality and safety of services	Review issues of quality and safety in relation to all Service Line Reports to the Board	Monthly
		Ensure that the CQSG provides continuously improved assurance of quality to the Board	Quarterly
Customer Relations	Maintain an awareness of the impact on the Trust of changes in the NHS, social care, education and training markets both nationally and locally, and in the Trust's markets more specifically	Ensure that political and local intelligence forms an integral part of Annual Plan development	Annual Plan cycle
		Ensure that education and training intelligence forms and integral part of Trust plans	Annual Plan cycle
	Ensure that staff work responsively with sector-wide development and with emerging commissioner arrangements	All members of Board to take up opportunities for local engagement	Ongoing

Special Emphasis for the year	Aim	Objective	Review Date
Quality and Safety	Ensure that the Trust continues to focus on the quality and safety of all its services, locating patient, student, and customer experience at the centre of all of our work and developments	Ensure that patient experience and public expectation are reviewed regularly by CQSG and form part of its report to the Board	Quarterly
		Develop an improved understanding of outcomes as measured and monitored in order to continuously improve quality	Quarterly
		Use patient experience and outcome data routinely as a component of Service Line Reports	Monthly as each Service Line reports

Special Emphasis for the year	Aim	Objective	Review Date
<b>Members and Governors</b>	Develop the relationship between the Board of Governors and Board of Directors, to enhance joint working and improve governance	Ensure that delivers on objectives around capacity and capability in this area	November 2011 and April 2012
		All members of the Board of Directors to take up opportunities to engage with individual Governors and the Board of Governors including joint work on specific issues e.g. working with the public and the membership	Ongoing

## Board of Directors June 2011

**Item :** 10

**Title :** CQSG Committee Q4 and Annual Review Report

### **Summary:**

Q4 outcomes indicate that the Trust has been able to achieve its objectives; issues addressed included: mandatory training; plans for clinical audit; plans for clinical outcomes; clinical incident reporting.

This report has been reviewed by the following Committees:

- Management Committee, 16<sup>th</sup> June

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, 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:**

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

**For :** Discussion

**From :** Rob Senior, Chair CQSG



## CQSG Committee Q4 Report and Annual Review Report

### 1. Quarter Four Key Issues

- 1.1 The Committee explored the assurance from each lead and accepted all reports and action plans; issues highlighted included:

#### 1.1.1 *Corporate Governance and Risk*

- 1.1.1.1 Plans to enforce mandatory training through sanctions had been implemented; the Committee looks forward to seeing the results for Q1
- 1.1.1.2 Information Governance will be a major work area from 2011/12, having doubled in size and will become the subject a separate work stream led by Simon Young in his SIRO role

#### 1.1.2 *Clinical Audit*

- 1.1.2.1 Plans to improve the process are being developed; implementation will need to be effectively project managed and sustained – resources to do so will be required
- 1.1.2.2 Clinical audit is likely to be an area the CQC examines in their forthcoming review of the Trust (there are relatively few areas upon which to assess the Trust)

#### 1.1.3 *Clinical Outcomes*

- 1.1.3.1 The first phase of a project to develop this work has been implemented (in CAHMS)
- 1.1.3.2 Lack of RiO functionality was hampering delivery; this needs to be addressed at national level
- 1.1.3.3 A shift in culture and practice is being facilitated

#### 1.1.4 *Patient safety and clinical risk*

- 1.1.4.1 Numbers of incidents and complaints remain low; nevertheless; both individual incidents, clusters and trends had been explored

1.1.4.2 Improvements to safeguarding systems had been introduced

1.1.4.3 Reversing the declining trend in incidents reported will be a project for 2011/12

#### **1.1.5 Quality reports**

1.1.5.1 This had been a challenging year; a more formal project plan will be implemented in 2011/12

1.1.5.2 The report itself was fit for purpose and had been approved by the Board of Directors

#### **1.1.6 PPI**

1.1.6.1 Work to support Governors engaging Members had been enhanced through investment with additional staff

1.1.6.2 Response rates in the patient survey remain low; additional and/or alternative means of getting feedback need to be explored and tested

### **2. Internal Audit Review of Governance**

2.1 This had found that the Committee was working well and was delivering the assurance that the Board of Directors needed; though some recommendations had been made, these had previously been identified and were being addressed.

### **3. Audit Committee review of process**

3.1 The Audit Committee had found that the Committee was functioning effectively.

### **4. Annual review of effectiveness**

4.1 The Committee had undertaken this after one year; issues had been identified effectively and the feeling of members was that the previous system had clearly no longer been fit for purpose. Work stream reports will be updated to ensure that they include:

4.1.1 mandatory external reporting requirements

4.1.2 related annual plan objectives

4.1.3 exceptional issues that affect a or b.

4.2 It is envisaged that this will help the BD focus on business critical issues.

Jonathan McKee  
Governance Manager  
8<sup>th</sup> June 2011

## Board of Directors : June 2011

**Item : 11**

**Title : Terms of Reference Review**

**Summary:**

The Terms of Reference for the Business Development & Investment Committee are attached. These have been reviewed and amended by the BDIC, and are presented to the Board of Directors for approval.

**For : Approval**

**From : Business Development & Investment Committee Chair**

# Business Development and Investment Committee Terms of Reference

Ratified by:	Board of Directors
Date ratified:	28 <sup>th</sup> June 2011
Name of originator/author:	Richard Strang
Name of responsible committee/individual:	Business Development & Investment Committee / Richard Strang, Committee Chair
Date issued:	October 2007; June 2009; November 2009; June 2011
Review date:	April 2012

## Business Development and Investment Committee Terms of Reference

### 1. Constitution

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

### 2. Membership

- 2.1 The Committee will be appointed from amongst the Executive and Non-Executive Directors of the Trust. The following will be members of the Committee:

2.1.1 Trust Chair

2.1.2 Up to three Non-Executive Directors

2.1.3 Chief Executive

2.1.4 Trust Clinical Director

2.1.5 Director of Finance

- 2.2 A Non-Executive Director shall be the Committee Chair.

- 2.3 At the discretion of the Committee Chair, other persons (Trust managers and staff, and other interested persons) may be invited to attend and participate in Committee meetings. The Director of Service Development & Strategy and the Associate Director of Business Development shall be invited to attend all meetings. However, only members of the Board of Directors have the authority to vote and determine decisions on behalf of the Committee.

### 3. Quorum

- 3.1 This shall be a minimum of one Executive Director and one Non-Executive Director.

#### **4. Frequency of meetings**

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

#### **5. Agenda & Papers**

- 5.1 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.
- 5.2 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.

#### **6. Minutes of the Meeting**

- 6.1 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.
- 6.2 Approved minutes will be forwarded to the Board of Directors for noting.

#### **7. Authority**

- 7.1 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.

#### **8. Duties**

- 8.1 The Committee's primary duty is to evaluate proposals for new business developments, and to make considered judgement as to whether they should proceed or not to implementation. The Committee will make recommendations on proposals to the Board of Directors. However, if tenders are to be submitted prior to the next meeting of the Board of Directors, the Committee can give the authority to submit providing that two Non-Executive Directors and the Chief Executive are present.

8.2 This will relate to all business ventures that require financial investment by the Trust or from outside, if either:

8.2.1 the proposed annual turnover is in excess of £400k within the first two years; and/or

8.2.2 the commitment in terms of staff costs and time is expected to exceed income for the first twelve months of the business; and/or

8.2.3 the nature of the business development is of strategic importance and/or requires a new business, organisational or legal structure (e.g. joint ventures).

8.3 It is expected that all other ventures should be considered at a Directorate level or by the Business Development Council.

8.4 All such ventures will be evaluated based on their Business Case.

8.5 The Committee will take account of the guidance published by Monitor, "Risk Evaluation for Investment Decisions by NHS Foundation Trusts."

8.6 The Committee will be responsible for drafting clear guidance as to the expected structure and content of the Business Case, and individual members may be called upon to assist in the development of such cases prior to the case coming to the Committee.

8.7 The Committee will expect to receive a well-developed Business Case for each venture that it evaluates. It will be the responsibility of the Business Development Council to agree that a project should go forward to the Committee. The Committee will make a decision on whether to proceed together with any conditions and will and give advice.

## **9. Other Matters**

9.1 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.

## **10. Sources of Information**

10.1 The Committee will receive and consider sources of information from any individual or department relevant to the case under consideration.



## **11. Reporting**

- 11.1 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 Board of Directors to any issues in the minutes that require disclosure or executive action.
- 11.2 The Committee shall prepare and submit a summary Annual Report of its activities to the Board of Directors.

## **12. Support**

- 12.1 The Committee will be supported by a Secretary from the Business Development team.

## Board of Directors : June 2011

**Item :** 13

**Title :** Munro Review of Child Protection

**Summary:**

The paper offers a commentary on the recently published Munro Review of Child Protection, the political and policy environment into which it is launched, and an indication of opportunities for the Trust and its responses to date.

This report has been reviewed by the following Committees:

- Management Committee, 16<sup>th</sup> June 2011

**This report focuses on the following areas:**

*(delete where not applicable)*

- Patient / User Safety
- Risk

**For :** Discussion

**From :** Professor of Social Work  
Medical Director

## Munro Review of Child Protection

### 1. Discussion

- 1.1 Professor Munro's review of the child protection system was published on 3<sup>rd</sup> May 2011. As she remarked at the launch event, the report is the first review of this area of work for some decades not to be driven by an immediate sense of crisis in the system. However, this may prove to be a double-edged advantage. The report has also attracted little media attention or public debate since its publication, although this may change once the parliamentary process is set in train.
- 1.2 Consistent with the 'whole systems' analysis underpinning her review, Prof. Munro argued at the launch that her findings and recommendations should be adopted wholesale, and not 'cherry picked'. However, the Minister (Tim Loughton MP) made it clear that the Government would take its time in considering the report, and would not necessarily implement every recommendation in the 'knee jerk' fashion that previous reviews have been received.
- 1.3 Arguably, the report and its implementation process is caught in a network of political tensions.
  - 1.3.1 The central argument is for a 'de-bureaucratised' system that supports a return to 'judgement based' practice, local determination of assessment and intervention timescales, and an inspection process that focuses on quality of decision-making in the interests of children rather than compliance with targets and protocols. These ambitions have attracted widespread support within the professions involved. On the other hand it is possible that the present Government's generalised opposition to centralised bureaucratic control of public sector service delivery might have delivered this 'release' from bureaucracy anyway.
  - 1.3.2 The report's commitment to 'localism' allied to uncertainty about whether Government will agree to even those rather minimal policy prescriptions the review recommends, is causing some anxiety within the statutory sector. The complex, uncertain and high-risk nature of the work probably requires a strong, basic national framework of procedures and protocols.
  - 1.3.3 The review process did engage Government around issues of 'instant mediatisation' of selected child abuse cases, but it is unclear whether or how media responses can in future be

better contained or managed. The concern is that a single case, or new revelations of systematic institutional abuse (cf. recent disclosures in the social care domain) could rapidly destabilise the reviews ambition for cultural change in the system.

- 1.3.4 The review is sophisticated in its analysis of the problems afflicting child protection work in recent decades, and also advocates the development of a sophisticated model of practice for the future. But there are concerns about whether the current workforce is sufficiently skilled and well trained – at both practice and management levels – to safely, confidently and consistently realise the reviews (laudable) ambitions. Reasonably stable and thoughtful organisational conditions, and adequate resourcing are preconditions for the successful implementation of the Munro vision, and both are in doubt.
- 1.3.5 The Review and its aims are tied in to other key Government initiatives such as the Allen Review of Early Intervention, which is still to be completed and which may also have an uncertain political fate.

## **2. The Trust's response**

- 2.1 Trust staff (Dr Lawlor, Dr Bell and Prof. Cooper) made various direct contributions to the review process at Prof. Munro's invitation. Since its publication the Trust is engaged in the following ways:
  - 2.1.1 A conference to explore the implications of the report with workshops on a range of relevant specialised models of practice is planned for June 24<sup>th</sup>
  - 2.1.2 Staff have developed a concise programme of organisational training and development to be offered nationally at a competitive price.
  - 2.1.3 The *Care Matters Partnership* has written to the Minister requesting a meeting to discuss positive proposals about how best to secure the Review's aims – proposing models of strong professional and local policy leadership that steer a course between central Government prescription and uncoordinated localism.

### 3. Comment

- 3.1 The Trust is well placed to make a strong contribution to the implementation phase of this review. A number of models of practice pioneered at the Trust (FDAC, Complexity Forums etc.) are absolutely consistent with the Munro vision, and were indeed cited. Equally, current cost pressures in the Trust directly reflect the difficulties of the current public sector environment, and the challenge of continuing to innovate and 'transform' in a context of survival anxiety. Munro's bold proposals for a return to practices rooted in professional and managerial trust, the exercise of professional discretion and more realism about the impossibility of predictive risk or 'no failure' organisational cultures, sit uneasily in this climate. There is evidence that some authorities and children's services are responding to this tension with increased, not diminished managerial control of front-line practice, and the Trust itself is negotiating a period of heightened strain in this respect.

### 4. Brief Summary of Munro Review

- 4.1 Overall, she argues that the current system has become 'over-bureaucratised' with too much emphasis on nationally set targets, a 'standardised' service and with too much of social workers' time being spent recording, completing forms and complying with procedures.
- 4.2 The Report therefore proposes creating a system where there is much more emphasis on engaging with children, young people & their families and carrying out relationship-based social work.
- 4.3 In addition, the existing national system with requirements to meet time-scales for particular assessments, and use national recording and IT systems should be replaced by more *localised* services and procedures which can meet a range of needs and should be developed by each Local Authority.
- 4.4 This includes revision of current statutory guidance – notably the Working Together and Framework for Assessment of Children in Need – to distinguish only the *essential* rules for children protection work which must be applied nationally.
- 4.5 Local Authority child protection services should work in partnership with early intervention, preventative initiatives where there is clear evidence that they are effective. These services must have good understanding of child abuse and neglect and be able to refer on to children's social care services when this is identified.

- 4.6 Ofsted inspections of children's social care services should be unannounced and should focus on the child's experiences and journey from needing / receiving help through to how this shaped the provision of services and their effectiveness.
- 4.7 Social workers should be encouraged to rely less on 'compliance' with procedures and to use their 'professional judgement' to make decisions – including taking necessary, reasoned risks.
- 4.8 This will require the development and promotion of 'social work expertise' from improving initial training and the quality of student placements through to on-going professional development.
- 4.9 There has been too much emphasis on a 'rational-technical' approach to social work with a 'managerial' focus on process. This should be replaced with the development of social workers' analytic and intuitive skills. This will require time and space to reflect on experiences and decision making, and needs good supervision.
- 4.10 As a result, each local system should make arrangements for practitioners to have frequent *case consultations* to explore and reflect on their direct work – *separate* from on-going case supervision arrangements.
- 4.11 Each local system should also make arrangements for practitioners to have frequent *case supervision* to reflect on service effectiveness and decision-making – *separate* from arrangements for individual pastoral care and professional development.
- 4.12 In addition, to promote the development of good practice and 'professional expertise' each local authority must designate a Principal Child & Family social worker – a senior manager who is still involved in front-line practice – who can also report on the views and experiences of those in front-line work to other senior managers in the organisation.
- 4.13 Government should also create a Chief Social Worker whose duties should include advising government on practice and informing the Secretary of State's annual report to Parliament on the working of the Children Act, 1989.

Andrew Cooper  
Professor of Social Work  
12<sup>th</sup> June 2011

## Board of Directors : June 2011

**Item : 14**

**Title:** Service Line Report – Adolescent Directorate

### **Summary:**

The Adolescent Directorate, since the last Service Line Report to the Board 18 months ago, has maintained a financially viable and quality service whilst embracing new developments which it is hoped will support the historical, core activities. The current report is a snapshot of the Directorate in transition, recognising both risks to certain core activities, such as clinical income and embracing developing services some of which have considerable potential. Perhaps the greatest challenge has been the shift to a greater diversity of activities and roles for the staff and a larger and more complex Directorate structure. A continued enthusiasm to offer a service to adolescents and young adults has helped support the staff group and manage the current anxieties of work in the public sector.

This report has been reviewed by the following Committees:

- Management Committee, 12<sup>th</sup> May 2011.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, 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 :** Discussion

**From :** Clinical Director, Adolescent Directorate



## Adolescent Directorate Service Line Report

### 1. Introduction

1.1 Since the last Service Line Report in 2009, the Directorate has grown modestly in a number of ways and now is structured into 5 units. These are:

- Core Adolescent Services
- Gender Identity Development Unit
- Psychological Therapies Development Unit
- Big White Wall and Digital Services
- Centre for Social Work Research

1.2 Growth in areas of social care, developing psychological therapies and engaging with online developments has undoubtedly had a marked impact on the culture and identity of the Directorate. They are also seen as necessary in order to enable us to offer clinical services to Adolescents and their families given the many restrictions on access to services, largely as a result of single points of entry systems, as well as offering a broader range of services. Clarification of both core activities and the specific qualities of the Directorate has become one of the central issues strategically for the Directorate and the core aspect to the Directorate's Lean project. A key premise to current thinking is that it is easier for staff to free up time if there is a meaningful and productive task to take on. Consequently the redesign or restructuring of the Directorate is progressing with simultaneous attention to opportunities for development and growth.

1.3 One dimension to the core expertise of the Directorate which informed its working culture was the continuing attempt to understand adolescence and transition into adult life. It is fortunate that this continues to be a part of the future mental health strategy. However, it was also recognised that developmentally sensitive psychological therapies had become an area of expertise, particularly in relation to brief and very brief psychological therapies, such as YPCS, which were effective in the context of adolescence. Whilst the Directorate is committed to a multi-modal and multi-disciplinary approach to assisting young people in their development, the associated interest in working for those that care for them does lend further meaning to the Directorate's involvement in social care training and innovative ways of offering high quality psychological therapy to adolescents and young adults. Developments in these areas have brought a great deal of strain upon the staff group, and in addition, we have seen many considerable changes in the staff group. In addition the

Directorate's contribution to the Rio project and my own involvement in the Big White Wall project has undoubtedly created gaps that have been difficult to cover. It is hoped that the combination of the Lean project and the developments in the Psychological Therapies Unit and the Big White Wall project will allow future investment to ensure that the core clinical activities and contracts are not strained any further. This will also require a much higher level of organisation and communication between different units within the Directorate. One of the earlier advantages of the Adolescent Department was its relatively small size, but this has been greatly affected by the different areas of growth. An interesting 'side effect' of the Lean project is that the Department is working more closely together in many areas and the hope is efficiencies will also arise out of these greater opportunities for collaboration.

## **2. Adolescent Department – core services**

- 2.1 346 referrals were received in the year 1<sup>st</sup> April 2010 – 31<sup>st</sup> March 2011, although according to current reports less than half of these referrals were accepted and attended for treatment. This information needs to be interrogated further as a parallel report on first attendances for the first three-quarters of 2010 suggested that first attendances were 175. However, the Department does now have to contend with single point of entry systems within both CAMHS and adult age ranges and in many areas there has been a very significant restriction on what can be accepted. Curiously, this does not appear to be reducing referrals though perhaps of some concern is the necessity to liaise with the very great number of clinicians managing the local single points of entry. In some areas, such as Camden there has been a very fruitful and promising development with Jeff Halperin interfacing the local IAPTService with what the Department can offer and helping their services understand the needs of young people. However, it remains the case that this is a highly labour-intensive process and one area to consider in relation to efficiency is how better this might be achieved.
- 2.2 Previously the peak age for point of entry into the service was 17.4 years, followed by a second peak at 19 years, which we understood as those struggling with transition or having difficulties soon after becoming independent (for example problems at university or at work). The Department has seen considerable growth in the post-18 age range since that time, which again reflects some restructuring of the Camden work which is now delivered to the under-18 age range by the North and South Camden Teams and also some reductions in previously high-referring areas such as Haringey and Barnet. However, preliminary data does suggest a shift to 77% of the

Department's referrals are now for the over-18yrs. This clearly identifies a gap in service delivery elsewhere that the Department is able to meet. As stated above, more local work with SPEs does appear to be helping clarify care pathways but also involves sharing experience and skills to ensure that young adults are achieving an improved service, whether we are seeing them directly or not. This echoes our engagement with the Camden and Islington Mental Health Trust Early Intervention Service in Psychosis Service which has proved to be an excellent example of integrated care across the transition, where both CAMHS and adult mental health professionals are able to benefit from the expertise of the other service. It is worth adding that the single point of entry processes have been specially damaging to the self-referral services such as YPCS. Unfortunately, whilst those managing the single points of entry can both understand and appreciate the value of easy access into such a service, which itself is a cornerstone of the IAPT programme, there may be differences in view with Commissioners such that even if locally supported by clinicians we are not able to offer the YPCS service.

- 2.3 As stated above the single points of entry have led to some reduction in clinical income which at year end was £496,000 (against a budget target of £521,000) for core contract activity, though we believe some of this is recoverable in key areas such as Barnet CAMHS and Haringey CAMHS, especially the latter where improved relations at the single point of entry have led to the recent upsurge in referrals. We recognise that demand management though will be a key issue if referral numbers continue to increase and bring fresh challenges in the forthcoming year.
- 2.4 DNA rates of 8.9% for the first and 17.9% for subsequent appointments is undoubtedly higher than average though somewhat lower than the figure quoted in 2009, which was probably over-calculated at 30%. This remains a challenging area in terms of engaging ambivalent or challenging adolescents who are hard to reach, but also in supporting trainees who are often trying to keep in treatment for their training needs individuals who are difficult to offer help to.
- 2.5 This is an area to consider further in terms of the Lean project but it is almost certainly the case that there is very little real change in DNA rates, which have been accommodated by the Department in working with this group.

### 3. Financial Status

- 3.1 The Department grew modestly in the past year, with an income of £4,299,000 (£3,995,000 in 2010) against a budget of £4,141,000 (£3,781,000 in 2010). This was possible through growth in GIDU, Training and the Psychological Therapies Development Unit. With a significant reduction in Service Level Agreements particularly in the adult age range to the value of £90K. However, reduced staff costs also contributed so although there was no surplus at year end compared with the previous year 8% of income, the contribution to the Trust of 18% of income was above that budgeted at 16%.
- 3.2 Undoubtedly the further challenges in the year ahead will be met with development in many areas of training, improved care pathways with single point of entry systems and further growth in psychological therapies development unit. Income from Big White Wall will hopefully address any further losses on clinical income as will the Lean project.

### 4. Clinical Outcomes

- 4.1 As with other parts of the Trust, return rates beyond the first session for outcome measures has been a considerable challenge for the Adolescent Department. Part of the difficulty related to ongoing concerns that the lengthy questionnaire used to obtain outcome data (ASEBA) was off-putting and time-consuming for both clinicians and users alike. In the autumn of 2010 a new system was put in place using brief measures that would be delivered to users by administrators at the necessary intervals which would improve returns of outcome forms. It was hoped that a single measure could be used to simplify the process for administrators but due to requests from Commissioners those under the age of 17 years are given the "Strengths and Difficulties" questionnaire whereas those over the age of 17 years complete the CORE questionnaire. Some work was conducted in focus groups asking young people what measures they found appropriate to their needs and it was of considerable interest that they disliked brief measures used in IAPT, such as PHQ9 and GAD7 because of their very brief nature. They experienced this as lack of interest and preferred the longer CORE measure, which was just right! The introduction of Rio in the autumn of 2010 undoubtedly complicated the systems coming into place, in addition to multiple changes in administrators. Questions remain as to whether outcome monitoring would be better delivered if outsourced to a company who are experienced in the field, or delivered electronically. There have been many challenges and obstacles but work continues to try and deliver both improved outcome data and a system that users find easy to use.

4.2 The work of the Department in this field has also been complicated by the necessity to complete the Mental health Clustering Tool (MHCT) on all 18+ year olds, starting assessment from April 2011. Consideration will be given to whether this additional measure might afford us, at the intervals specified by Commissioners, sufficient outcome data for current users.

4.3 The system for obtaining experience of service information that was established almost two years ago by telephoning all users between their second and third assessment appointments continues to obtain good feedback (see section 9).

## **5. Complaints**

5.1 There has been one complaint to the Gender Identity Development Unit within the past month that is currently being investigated. No other complaints received.

## **6. Clinical Governance and Audit**

6.1 Much of the focus in recent months has been on improving data quality and implementation of the Rio project, obtaining better outcome data and implementing the MHCT project. There have been a number of small individual audit projects, such as establishing ICD10 diagnoses in the current user group which proved illuminating in terms of the challenges of describing and understanding the current users. It is expected that as MCHT data accumulates it will be possible to audit further the profiles of those attending the service and correlate this with outcomes in terms of attendance and clinical outcome.

## **7. Serious Incidents/Patient Safety Incidents**

7.1 There has been one clinical incident in January 2011 of a patient who was also involved with a community mental health team in the Brent area. At the time of referral it was recognised that this individual patient had very high needs and the referrer had wanted to admit them to a Tier 4 Adolescent Service but this had been refused by the patient and her family. An episode of self-harm was reported in a session which led to appropriate rapid transfer to the Royal Free Hospital, though lessons were learnt in relation to a junior doctor who felt compelled to both take the patient and wait with them in the Accident and Emergency Department. The patient

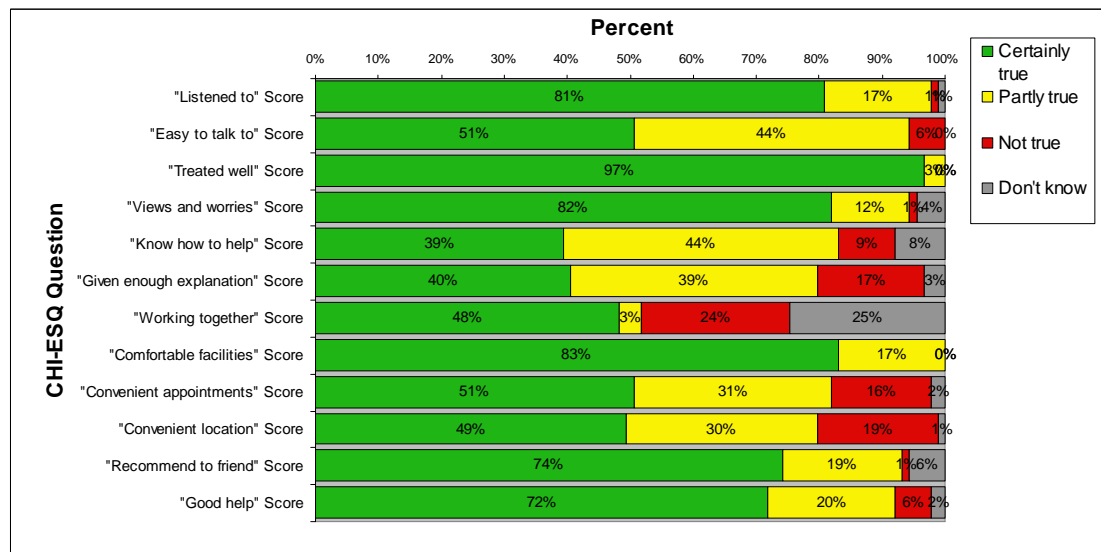
responded well to future care and remains in treatment and is making satisfactory progress.

## **8. Patient and Public Involvement**

- 8.1 Commitment to other projects has limited progress that was hoped for in this area, so as rather than reconvene focus groups when user involvement is sought, a provisional plan was established to set up a youth council in relation to the Department Executive. If this proved to be too difficult to establish, links would be sought with Camden Youth Council so that the Department could be usefully informed of young people's concerns of today.
- 8.2 We have undertaken two very interesting focus groups in relation to communication with patients and in relation to 'views' on the name of the Department. The recognition that electronic communication is a rapidly changing and progressing area was confirmed by focus groups in that some young people reported that they did not even open letters if sent. This has informed the development of a protocol for electronic communication.
- 8.3 Of further interest as the result of focus groups on the name of the Department which might appear to be a pressing concern given that the majority of users attending the Adolescent Department are now over 18 years. Curiously, those interviewed felt terms like "Young People or Youth" were more negative than the term "Adolescent" as they felt "Young People" suggested a child more than a young adult. There was no clear recommendation as a result of this process and it is hoped that further involvement of current users in thinking about the way in which the Department is 'named' essential.

## 9. Patient Satisfaction

9.1 The following chart captures the latest ESQ data.



9.2 It is recognised that young people do attend now with greater expectations for partnership in the process of making decisions about their treatment, and that this needs to influence delivery of services and clinical training. Enabling users to make an informed decision would undoubtedly raise the quality of what is delivered, even if the great majority of users feel treated very well.

## 10. Training

10.1 Since the last report there have been changes within the Directorate with respect to training. Firstly, Professor Steve Briggs has taken on the post of Associate Dean to the Specialist and Adult Mental Health Services within the Trust and has been leading on a strategy in relation to that. Locally, the Training Lead position was taken on by Agnes Bryan who has continued to support both the discipline trainings within the Directorate in Psychiatry, Psychology, Child Psychotherapy and Social Work, as well as the major courses in Social Care (M23& D60) and the courses in Management and Black Leadership (M26 & D66) as well as the Department's core course in Adolescence (M33).

10.2 In addition there has been a successful CPD programme including a 3 day conference for Kids Company employees and the expectation is that further training groups and study days will be commissioned by Kids Company in the forthcoming year. The current Lean project has identified many other areas for development through e-learning and supervision, specific areas of expertise in relation to clinical

problems of adolescence, new developments such as dynamic interpersonal therapy (DIT) and possible areas of development in relation to the digital environment.

10.3 As part of the Lean project training activities are also under review with consideration to be given to how courses are delivered and in relation to the SAMHS productivity plan, how pooling resources across the Directorates might improve efficiencies.

10.4 It is important to conclude that the training activities of the Department remain very successful and productive and they very much support the Department at a time when clinical income has diminished.

## **11. Research**

11.1 Research has been rather limited, partly related to changes in staffing such as Professor Steve Briggs moving to the Associate Dean role and partly related to commitments to other areas. However, the Department has been committed to certain areas of research and these include:

11.1.1 Commitment to the Adolescent Depression Research (IMPACT Study) – offering the treatment as usual service to adolescents.

11.1.2 A joint research project with the Anna Freud Centre for a randomised control trial on the effectiveness of dynamic interpersonal therapy.

11.2 The student population continues to undertake a range of small research projects including a study of the incidence of body dysmorphic disorder in the current patient group and an imminent study on the use of technology in adolescence, in both a community and clinic population.

## **12. Consultation**

12.1 It was recognised that there is little development in this area at present but discussions with TCS and Jeannie Milligan taking on the Consultancy Lead role for the Directorate will hopefully lead to the development of new projects.



### **13. Equalities**

13.1 The Department has been committed to finding further ways to improve access to minority populations who find it difficult to access our services. Previous data has demonstrated that on the whole those accessing the service in each minority group are similar to those in the population with the noticeable gap being in the Bengali population of Camden. Our plan at present is to develop a model for "Thinking Space" which incorporates a community building for users and professionals, using social media, with public lecture events such as the previously successful "Bullet Boy" film showing and CPD events and courses. The aim is to use the technology available through LinkedIn and Facebook to create online thinking spaces for the groups who already are interested in the "Thinking Space" activities which we would then hope through online linkages raise awareness of what can be offered from the Department, discreetly. It is highly likely that those in minority groups, as shown through the experience of Big White Wall, may access services initially through technology and find appropriate help.

13.2 This project will inform how all other minority groups may be reached and informed, to improve accessibility.

### **14. HR and Staffing**

14.1 As stated earlier there remains a sense within the Directorate of considerable turbulence at the level of staffing. Two members of staff are currently on long-term sick leave due to very serious illnesses and a number of others have been seconded or have taken up additional Trust wide activities:

- Professor Steve Briggs – Associate Dean
- Professor Alessandra Lemma – Director, DTPU
- Matthew Doocey - Seconded to position of Assistant Director of Education and Training
- Justine McCarthy-Woods – Trust Wide Quality Lead

14.2 This within the staff group of 14 WTE has been considerable, without taking into consideration the at times all-consuming impact of the Rio project and Big White Wall.

14.3 One of the regretful aspects of this situation is that staff availability for Trust wide liaison and projects has felt much more limited particularly with respect to the Child and Family Department although on a more positive level there has been greater liaison with the Adult Directorate in particular which given the nature of

the current population accessing the Adolescent Department this may well be more appropriate.

## **15. The Lean Project**

15.1 The Adolescent Department took the opportunity to engage in the Lean project involving consultations from Mental Health Strategies and Andrew Keefe. One of the great challenges of this project has been finding the mental space and time to undertake the detailed work necessary to support a process of transformation and effectively restructuring of all job plans. Despite the challenges Andrew Keefe's input was well received by the staff group and has led to some transformations already, such as the Department's Executive Meeting largely becoming that of a Project Board. We are in the process of refining and adding costs to activities within each job plan and within each Departmental activity, both training and clinical, in the hope of establishing a clear picture of what is either less-efficient or too costly to continue. What has also been extremely helpful about the process is recognising that if staff are to free up time it is very helpful for them to know how they would then use the time which then lends the focus to the process of change.

## **16. Other Directorate Units**

16.1 I will give a brief summary of the work undertaken by the Units within the Adolescent Directorate in addition to the core clinical and training activities.

### **16.2 Gender Identity Development Unit**

16.2.1 The Gender Identity Development Unit continues to expand and develop at a rapid pace and is faced with a particularly challenging year. Funding by the National Commissioning Group remains stable and supportive, which is very helpful in light of the developments necessary this year. A comprehensive report is available regarding this service but for the purpose of this report it is important to recognise the following developments:

16.2.1.1 The service will develop a second centre, most likely to be established in Leeds GIDU will develop a part-time staff team there, that will be part of the Tavistock service and have strong governance and clinical links to the London team.

- 16.2.1.2 The steady and substantial growth in referrals each year and the clinical activity (approximately 20% increase per year) is likely to increase further given ease of access to a Northern centre.
- 16.2.1.3 Ethics approval has now been achieved for a clinical research project to investigate the benefits and risks of the early use of hormone blocking treatments which would delay puberty in those suffering from severe gender dysphoria.
- 16.2.1.4 The demand for hormonal treatments, for more patients at earlier ages, has placed enormous demands on the joint clinics run at University College Hospital which has necessitated further recognition of this important part of the work by the National Commissioning Group.
- 16.2.1.5 The above has placed a great strain on the GIDU budget, most of which will be absorbed by the developments above.
- 16.2.1.6 The Service continues to maintain a lively PPI engagement with users and it is of some note that in the summer of 2010 they offered expert comment to a Hollyoaks storyline.

### 16.3 Big White Wall

- 16.3.1 This intensely absorbing area of work continues to progress and now has an established budget line and identified resources within the Trust. In addition to opportunities related to the engagement with the digital revolution, Jenny Hyatt has recently announced the following developments:
  - 16.3.1.1 *Mental Health and Wellbeing:* PCTs, GP Consortia and Mental Health Foundation Trusts across England are now commissioning Big White Wall. We are working with champions of innovative approaches to mental wellbeing in areas including Barking and Dagenham, Brighton and Hove, Cambridgeshire, Croydon, East Sussex, Greenwich, Hastings, Havering, Hertfordshire, Kent and Medway, Lincolnshire, Newham, Rochdale/Heywood/Middleton, Sutton and Merton, Wandsworth and West Sussex.

16.3.1.2 *Denise Abel, Head of Access and Community Development at Newham Psychological Services* commented 'Newham has been in the forefront of improving the IAPT agenda, especially to groups that are traditionally under-represented. Big White Wall offers us a way to reach out to these groups'.

16.3.1.3 *Government Work Programme:* Big White Wall has been selected as a specialist intervention partner of a4e to deliver the new Government Work Programme.

16.3.1.4 *Educational Support:* Following successful participation of colleges in referring to BWB, Sheffield has become the first University to commission Big White Wall to help deliver support to its students.

16.3.1.5 *Veterans, Serving Personnel and their Families:* The Department of Health pilot of Big White Wall amongst veterans, serving personnel and veterans is now underway with a growing network of NHS and third sector partner organizations helping to make it a resounding success.

16.3.1.6 *Pilot in Australia:* BWB is going to be piloted in Australia with the Australian Institute for Suicide Research and Prevention, a WHO Collaborating Centre for Research and Training in Suicide Prevention, Griffith University.

16.3.2 It is hoped, within the year, income from the project will at least cover this year's costs with hope that as pilots are established and opportunities to promote digital intervention within IAPT, future income streams will be much more substantial.

## 16.4 Psychological Therapies Development Unit

16.4.1 There has been significant growth in this area due to Alessandra Lemma's development of dynamic interpersonal therapy in collaboration with the Anna Freud Centre which has now been accepted as part of adult IAPT programmes. There has been considerable demand upon Professor Lemma's time for this work and there are developments within the Trust to develop clinicians who will be able to assist her in both training and supervision tasks as DIT is rolled out further across the country. An online group based

version of DIT has also been piloted within Big White Wall with research support from the Anna Freud Centre.

- 16.4.2 The opportunities of establishing an effective online intervention for those with mild levels of difficulty would create very significant opportunities for the Trust especially if some aspects of the intervention are of a self-guided nature.

## 16.5 The Centre for Social Work Research

- 16.5.1 Having had a very successful year achieving an income above the budgeted £46k at £66k, the current financial year has proved to be much more difficult given the impact of the spending review on local authority budgets. The centre has been well supported by the social work discipline within the entire Trust and the Business Development Lead, Andrew Whittaker, is working extremely hard to establish further opportunities for research and consultation. Previous projects have created opportunities for further work which are currently being pursued.

Dr. Richard Graham,  
Consultant Child & Adolescent Psychiatrist,  
Clinical Director, Adolescent Directorate.  
10<sup>th</sup> May 2011

## Board of Directors : June 2011

**Item : 15**

**Title : Service Line Report – Portman Clinic**

### **Summary:**

This report gives an overall view of the Portman Clinic and goes on to provide some details of its current work, setting out recent changes and the threats and opportunities the Clinic faces.

It might be of value to address in particular:

- The financial position of the Clinic
- The difficulty of sustaining an expert staff team, with appropriate quality controls, to manage the Clinic's particular patient population and the colleagues and institutions it works with
- The developmental projects currently being discussed

This report has been reviewed by the following Committees:

- Management Committee, 16<sup>th</sup> June 2011
- Trust Clinics' Committee, 17<sup>th</sup> June 2011

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, 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)*

- Patient / User Experience
- Equality

**For :** Discussion

**From :** Director of Human Resources

## Service Line Report – Portman Clinic

### 1 History

- 1.1 The Portman Clinic was set up as the clinical arm of the Institute for the Scientific Treatment of Delinquency, established in 1931, and later called the Institute for the Study and Treatment of Delinquency (ISTD), and became operational when its first patient was seen in 1933. In 1948, with the coming into being of the National Health Service, the Clinic separated from the ISTD and became part of the NHS. In 1970 the Clinic moved to its current location in Fitzjohns Avenue, London, adjacent to the Tavistock Centre which housed the Tavistock Clinic.
- 1.2 During the 1980's the two clinics were both organised under a special sub-committee of the Hampstead Health Authority and whilst maintaining their separate identities, increasingly joined forces and as part of the structural changes in the NHS jointly became an NHS Trust in 1994 and then a Foundation Trust in 2006.

### 2 The Work of the Portman Clinic

- 2.1 The range of work of the Portman Clinic, whilst continuing to be substantially rooted in its clinical work, has developed as outlined below:
  - An assessment and clinical service
  - Family and criminal court reports
  - Risk assessments
  - Teaching, training, and CPD programmes
  - Institutional and clinical consultancy
  - Research and publications
- 2.2 The core activity of the Clinic continues to be the assessment and psychoanalytic treatment of patients who are disturbed and distressed by their delinquent, criminal and violent behaviours or as a result of their sexual activities causing hurt and damage to others and/or to themselves. By definition, these patients and offenders act out their disturbance and in doing so have an



emotional impact on those around them including the clinicians and services charged with their care. This impact has to be taken into account very seriously in the delivery of services to these patients and in the understanding offered in the teaching and consultancy to colleagues working with similar patients/offenders.

- 2.3 The Portman's clinical service is offered to children and adolescents, and their families and to adults. The treatment is individual or group treatment, with some couple work. Frequency of sessions is mostly once weekly, with a very few patients being seen twice weekly and a very few patients being seen intermittently. Treatment tends to be medium- to long-term.
- 2.4 In addition, the Clinic undertakes the writing of 'expert witness' reports for both the family and criminal courts and also risk assessment reports. Based on the accumulated experience of trying to understand the relationship between patients' emotional states and the use of the body, the Clinic also provides a clinical service to those members of the transgender community, transvestites, and pre- and post-operative transsexuals who approach the clinic for help and advice.
- 2.5 Rooted in this in-depth clinical experience with patients, the Clinic provides a range of teaching, training and CPD activities and organisational and clinical consultancy to colleagues in community or institutional settings working with similar patients and offenders. This includes front line practitioners of all disciplines, their supervisors, service leads and managers, working in community mental health teams, in hostels and day care provision, in low-, medium- and high-security hospitals, and in prisons.
- 2.6 The Clinic's third substantial area of activity is audit, research and publication. This has been a growing activity, essential to the development of the Clinic but is now threatened by the need to focus staff on income generating activities.

### **3 Clinical staff group**

- 3.1 The clinical staff group has fallen in number dramatically in the last twelve months as a result of significant cost reductions made for the 2011/12 budget. Table 1 provides figures for June 2010 and July 2011 for comparison, showing a reduction of over 18.4%.

**Table 1: Portman Clinical Staff Group**

Clinical Staff	WTE	
	2010	2011
Consultant Adult Psychotherapists	6.20	4.90
Consultant Child & Adolescent	2.60	2.40
Consultant Psychiatrists in Psychotherapy	3.45	2.70
<b>Total Clinical Staff</b>	<b>12.25</b>	<b>10.00</b>

- 3.2 The Clinic has two full-time medical Forensic Psychotherapist SpRs (currently one in post and one just appointed as a replacement for a recent graduate), funded directly by the Deanery, who are training in a national scheme jointly run with the West London Mental Health Trust. The Clinic also has a number of one-day-a-week Honorary staff (currently five with another in the process of being appointed).
- 3.3 The Clinic employs one full time Assistant Psychologist (two were in post a year ago, and this loss was another contribution to the required savings). The Assistant's primary responsibilities are to support the audit and research functions of the Clinic and to provide other support to clinical staff, i.e. literature searches. The Assistant does not have clinical responsibilities but meets patients to administer research / audit instruments as appropriate.
- 3.4 Among the clinical staff group three, in addition to their Portman work, have Trust-wide roles, these being:
- the Lead for Personality Disorder
  - the Caldicott Guardian
  - the Assistant Medical Director
  - the Director of Medical Education<sup>1</sup>
- 3.5 At the time of writing, within the clinical staff group referred to above, the Clinic has one long-term medical locum, providing a specific clinical service, and another short-term medical locum covering two sessions from a medical colleague who is staging her return back to work following maternity leave. Also at the time of writing, one colleague is on long term sick leave (absent since mid-December 2010 due to return in January 2012).

<sup>1</sup> The latter two roles are held by one person

- 3.6 The 10.00 WTE clinical staff group is made up of 16 people (including the short term locum). Of these, one is on three sessions (reducing his sessions as he makes a planned departure at the end of 2011) and three are on two sessions each (including the two locum staff), two of whom have project specific responsibilities in the Clinic. All other staff are on a minimum of five sessions. The number of staff on three or less sessions was reduced significantly in the staff reduction referred to above.
- 3.7 The Administrative and secretarial staff of the Portman Clinic is made up of:
- a full-time Clinic Manager (who shares the work of PA to the Clinical Director with the full-time Administrative Manager<sup>2</sup>
  - a full time Administrative Manager
  - a full-time court report secretary who also acts as PA to the court reports service leads within the Clinic and
  - 3.40 secretarial staff (a reduction of 14% on June 2010)
- 3.8 The overall reduction in the Admin staff group, between June 2010 and April 2012 will be 22.3%.
- 3.9 The pay and non-pay budget for the Portman Clinic for 2011/12 is £1,486,183 a reduction on the 2010/11 budget (£1,724,697) of 13.8%.
- 3.10 The Clinic's organisational structure and line of authority is very simple. There is a shallow hierarchy with the Director of the Clinic being (internally) supported in his role by an Executive Committee and externally by the Trust Director. Medical staff are answerable to the Trust's Medical Director, and members of the nursing and psychology disciplines have professional contact with these disciplines across the Trust, but the line of authority for all Portman staff is to the Portman Clinic Director.

## **4 Maintaining quality of practice**

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<sup>2</sup>This arrangement is in place to facilitate succession planning and one of these posts will go in April 2012

- 4.1 Given the toxicity and disturbing nature of most of patients dealt with in the Clinic, robust professional structures are in place to support and develop the staff and maintain high quality practice.
- 4.2 All the clinical staff are trained and experienced in one of the core disciplines, nursing, social / probation work, psychology or psychiatry, and all have further specialist training as child and adolescent psychotherapists, adult psychoanalytic psychotherapists or psychoanalysts (with a number having trained both as both child and adult psychotherapists).
- 4.3 The clinical work is supported by two obligatory weekly clinical meetings, one supporting on-going individual treatment and the other supporting group treatment; and by a fortnightly meeting where assessments and appropriate disposal of patients following assessment is discussed. There is an obligatory termly extended clinical staff meeting where specific clinical issues are discussed, with staff bringing clinical vignettes for consideration, audit details if they exist of the matters being discussed are made available and there is encouragement to read agreed relevant literature. There is also a voluntary monthly reading seminar.
- 4.4 These systems which support and develop the standard of practice in the clinic are always well attended but, when necessary, staff absent themselves from these meetings to carry out work that cannot be done otherwise. This is perhaps inevitable but it is of major concern that with fewer staff and increased workloads pressure will be put on staff to absent themselves more often and threaten these 'quality controls'.
- 4.5 The whole staff group meets at least once a term to discuss and decide on policy matters and has an annual whole day Away Day to more fully consider and debate policy issues and the establishment of new projects. The Administrative staff have regular meetings to discuss details of their own structure and work and to process the nature of the Clinic's work and the sometimes very disturbing material they are reading and typing.

## **5 Clinical Activity**

- 5.1 As stated earlier, the core activity of the Clinic is the assessment and psychoanalytic treatment of patients. The vast majority of patients have actually enacted their criminality, violence or sexual perversion and hence have that emotional and material fact to contend with in addition to the often profound deficits and conflicts of their original developmental history. Such patients and offenders

are broadly referred to as 'forensic' or as 'anti-social personality disordered' and are known to acute and forensic psychiatry services, to social care services and to the criminal justice system.

- 5.2 The Clinic receives approximately 200 referrals per year, approximately 160 adults and 40 children / adolescents (mostly adolescents (see below)). Though the financial value of the clinical London Specialist Commissioned Contract, which facilitates referrals from within London (see below) is now more or less static, referrals are actually increasing.
- 5.3 The following figures, giving some details of adult referrals, are taken from the last audit carried out of adult referrals.
  - 5.3.1 Adult referrals come mostly from secondary care (50%) and primary care (25%). Only 5% of referrals are self-referrals. The vast majority of those referred have had a number of previous interventions from mental health services and the criminal justice system
  - 5.3.2 The Portman Clinic has three broad 'tickets of entry' for treatment: criminality, violence and sexual perversions. 48% of all referrals come with two or three 'tickets of entry'. 21% of all referrals have all three tickets (examples of these are rape, paedophilia, incest, sexual assault, i.e. criminal, and violent and sexual)
  - 5.3.3 85% of Portman patients are men: men tend to act out their conflict and disturbance in anti-social ways, and so gain a 'ticket of entry' for Portman Clinic services, whilst women tend to express their distress by harming themselves and/or those closest to them such as their children or partners.
  - 5.3.4 Paedophilia, compulsive use of internet pornography (usually paedophilic), sexual and non-sexual violence, and transvestism / transsexualism are the most frequent factors, in that order, in referrals. The largest increase by far in the last few years in reasons for referral is compulsive use of internet pornography.
  - 5.3.5 Recent audits show that 76% of patients stay in treatment for at least two years, 51 % stay in treatment for up to four years, and 25% stay in treatment for up to six years. The remainder stay in treatment long term, some as intermittent patients. The 2009 NICE Guidelines on Anti-Social Personality Disorder state that such patients require long term treatment.

- 5.3.6 The Clinic is seeing approximately 120 patients at any one time of which approximately 85% come from within London under the Specialist Commissioned Contract. About half this number are seen individually and half in groups, either symptom specific groups (currently: a group for patients suffering from paedophilia, an anti-social personality disordered group, and two groups for pre- and post-operative transsexual patients) or in generic groups. The first two of the symptom specific groups are being researched – see below.
- 5.4 The following figures, giving some details of child and adolescent referrals, are taken from the last audit carried out of child and adolescent referrals.
- 5.4.1 86% of child and adolescent referrals are adolescents, i.e. over 11 years of age.
- 5.4.2 80% of those referred are boys, but there is a very noticeable recent increase in the referral rate for girls, having doubled in the last few years.
- 5.4.3 41% of referrals come from Social Services.
- 5.4.4 33% come from medical consultants and secondary care
- 5.4.5 8% come from GPs
- 5.4.6 Just under half of the referrals were 'looked after' children.
- 5.4.7 86% of the children / adolescents referred have had previous contact with mental health services
- 5.4.8 37% of the children / adolescents referred have had previous contact with the criminal justice system
- 5.4.9 40% of referrals involve self-harming behaviours.
- 5.5 Just under 75% of referrals have presenting problems of a sexual nature with the most common cited being that of inappropriate sexual behaviour and assault (33%) and sexual abuse (27%). 50% presented with problems of criminality. 30% presented with all three Portman tickets of entry. The most striking increase in reasons for referral was addiction to internet pornography, now specified in 22% of referrals, but which did not even register in the 2004 Audit.

- 5.6 The Clinic has a steady flow of referrals requesting court reports for both family and criminal courts and for risk assessments. There is regular collaboration over court reports with the Monroe Family Assessment Service. Based on this court work the Clinic has designed and is beginning to establish a new clinical and educational service (see below).
- 5.7 Details of income from clinical activity (together with that from consultancy and teaching activities) are given in Appendix 1 at the end of the paper.

## **6 Teaching, Training and Consultancy**

- 6.1 Starting from a low baseline, the Portman Clinic is developing its training, teaching and CPD activities, and its organisational and clinical consultancy. Most activity in this area is delivered through consultancy rather than more traditional teaching.
- 6.2 Many forensic / personality disordered patients and offenders are cared for in institutional settings, in low / medium / high secure hospitals or prisons or, if managed in the community, are often known to a multidisciplinary team. This institutional and team treatment setting for these patients, together with the emotional impact they have on those around them, results in the 'training of choice' often being that of clinical consultancy in the treatment setting with the multi-disciplinary team. Through reflective practice group sessions, the team can build up their shared knowledge and integrated understanding of their patient, whose fragment mental state can result in partial and differentiated relationships to different members of the staff team. In addition, consulting to the managers and service leads (i.e. organisational consultancy) can protect the institution and the managerial functions from being similarly affected by the emotional impact of the management and care of these patients/offenders, as well as ensuring that resources are made available for the practitioners to be able to access the reflective practice sessions.
- 6.3 Currently, such organisational and clinical consultancy is taking place in medium and low secure, and prison, settings, as well as in Community Mental Health Teams, in a number of services in London, and across the UK most intensively in Nottingham, Wakefield and Leeds. A consultancy to the wing psychotherapists at Grendon Prison is being developed into joint teaching/CPD activities and a research project (see below).

- 6.4 The income for this consultative activity in 2010/11 was £111,601, compared to £108,894 in 2009/10 and £70,200 in 2006/07, an increase in that period of 59%. Whether it will be possible to sustain this overall level of growth in the current financial climate is doubtful of course, as indicated in the very modest growth in the last year. However, whilst some contracts have been lost, a number have been renewed with an uplift in value.
- 6.5 There has very recently been agreement reached for increased activity and income in relation to organisational/administrative and teaching activity related to the national delivery of the Personality Disorder Knowledge and Understanding Framework (PDKUF).
- 6.6 The Clinic participates in a number of Trust courses and trainings as well as offering supervision and consultancy to Trust colleagues. There is no payment received for this activity. In addition, the Clinic runs a number of courses, CPD lecture series and seminars. These include a very well received course on Risk Assessment and Management which has also been delivered in an adapted form in Birmingham and Nottingham (twice), a regularly oversubscribed Seminar on Enactment, a new CPD event targeted at colleagues working with adolescents and a course for colleagues working at the interface with the legal services.
- 6.7 Developing its teaching programmes is one area that the Clinic needs to continue to focus on. This has started with a number of meetings already held with the SAMHS Associate Dean with some leading to new teaching/CPD programmes now being offered and recruited to. The Clinic responds regularly to various short teaching interventions requested by colleagues in forensic/ PD services.
- 6.8 Jointly with the West London Mental Health Trust, the Clinic runs a medical training in forensic psychotherapy. Psychiatrists undertake a 'dual' training in forensic psychiatry and medical psychotherapy and graduate as Consultant Forensic Psychiatrists.
- 6.9 The income from these various training activities is growing and has probably doubled in the last two to three years. The continued request for the refining and clarification of these figures for training activities is overdue.
- 6.10 Details of income from consultancy and teaching activities (together with that from clinical activity) are given in Appendix 1.
- 6.11 With the freezing and likely reduction in clinical activity as a result of the downturn in the value of the clinical London Specialist



Commissioned Contract, resources will continue to be freed up to further develop teaching, training and consultancy projects, though the reduction in the size of the staff group will limit this impact.

## **7 Research, Publication and Audit**

- 7.1 The Portman Clinic employs two staff members with posts specifically designated as consultant adult psychotherapists / researchers. Together with other colleagues and an Assistant Psychologist (reduced in 2010/11 from two posts) they have significantly developed the research mindedness of the clinic resulting in regular audits and a growing number of research projects.
- 7.2 Regular audits are carried out of both child and adolescent and adult referrals. Other recent audits include recidivism amongst patients in treatment; the nature of requests for advice and consultation from potential referrers as opposed to referral for treatment; looking at referred patients who had major drug and alcohol addictions and were, for this reason, not taken into treatment but encouraged to access addiction services and then be re-referred; an audit in relation to referrals and treatment of female patients; and, at the request of the Department of Health, an outcome audit with multidisciplinary staff teams participating in ward based reflective practice groups, conducted by Portman staff, on seven wards in two medium secure hospitals in south London.
- 7.3 There are a number of active current research projects, including:
  - 7.3.1 Evaluation of an Mentalisation Based Treatment group for men with ASPD, in partnership with Anthony Bateman, Peter Fonagy and colleagues on other sites;
  - 7.3.2 Evaluation of group psychotherapy for patients with convictions for sexual offences against children;
  - 7.3.3 A comparison of adult attachment patterns between Portman (outpatient) patients' and Broadmoor patients' who have committed sexual offences against children;
  - 7.3.4 A study, in partnership with Cardiff University and Grendon Prison, using the Implicit Association Test to test psychoanalytic assumptions about types of violence

- 7.4 Funding is being sought for a research project to examine pathways to Internet offending.
- 7.5 Recent publications include a book of lectures on violence, perversion and delinquency; a book on violence; and a book describing a number of institutional frameworks in community settings supporting work with antisocial patients and their mental health needs. Recent contributions to books and journals include papers/chapters on consultancy, on internet pornography, and on patients' experience of forensic psychotherapy.

## **8 Conclusions**

- 8.1 There are major threats to the work and morale of the Clinic (and the Trust) over the next three or four years. Whilst addressing these, it is crucial that pursuing realistic new developments can also be attended to. Sustaining such a stance will allow for seeing opportunities that may become available in the changes brought about by a turbulent environment and, in addition, will, perhaps crucially, contribute to underpinning and nurturing staff morale which is already substantially affected by the anxieties brought about by the financial cuts to the NHS. The significant reduction in the size of the staff group in the last year had and continues to have difficult reverberations on the remaining staff group.
- 8.2 There are a number of threats and a number of opportunities which the Clinic is facing.
- 8.3 Threats
  - 8.3.1 The major threat is in relation to the Clinic's (to date) robust London Specialist Commissioned Contract. As a result of much good liaison with the lead Specialist Commissioner, the contract value for 2011/12 for the Clinic was increased by 2% and not cut as had been threatened earlier in the year. A number of outcome and other quality measures were agreed with the commissioners as part of this contract negotiation. Though we are still over-performing on this contract and referral rates have increased, it is not likely that this contract will remain as secure as it has been in the past. The other uncertainty is how forensic specialist services will be commissioned in the new commissioning landscape. The current value of the London Contract to the Portman Clinic is £997,864 (£978,325 in 2010/11).
  - 8.3.2 The likely reduction in the funding of all mental health providers in the next few years will have an impact

on their ability to access training and consultancy. This would obviously have a negative impact on the growing teaching,

- 8.3.3 The departure of clinically minded colleagues from the Department of Health Personality Disorders Unit leaves civil servants and Ministers less well informed about practice matters and at risk of developing policies and promoting practice driven solely by financial considerations rather than by the needs of PD patients and the staff groups working with them.
- 8.3.4 The possibility of developments in relation to offenders and the criminal justice system following the 2009 Bradley Report, which addresses the diversion of mentally ill offenders from the prison system and perhaps even from court appearance, has faded with the change of Government 12 months ago.
- 8.3.5 The current financial and political climate will inevitably impact on management and staff morale. The relentlessness of the pressure on costs which the Trust has already addressed in the last few years, together with a seemingly constant increase in demands for reporting to external scrutinising bodies, has the danger of eroding the clinical, educational and research function of the Trust as senior and middle managers become increasingly occupied by meeting these bureaucratic / political demands.

#### 8.4 Opportunities

- 8.4.1 Though they are not immune from the planned cuts in public services, it is possible that there may be a less drastic cut in forensic and personality disorder services and the criminal justice system, than in generic mental health services.
- 8.4.2 The Clinic's growing reputation in relation to its clinical and organisational consultancy work meets the needs of community and especially institutional forensic and anti-social PD services as they increasingly take on the care of acting out and disturbing patients who previously would have been contained in services offering higher levels of security or in prisons. This has resulted in a steady flow of requests from different services to provide such consultancy. The Portman Clinic has been involved in a recent series of consultations held by the Department of Health and the Ministry of Justice as they design improved pathways for personality disordered offenders requiring prison or secure hospital care. This

involved the presentation of a paper on relational security to the Clinical Security Practice Forum in the Department of Health which advises Ministers on security matters in the secure estates.

- 8.4.3 Physical security and procedural security do not sufficiently take care of the risks and dangerousness of forensic patients and offenders, and relational security is increasingly being recognised as necessary. Regular, mandatory, team reflective practice sessions for the often multidisciplinary teams who are managing and working with these difficult patients enables them to develop a more integrated picture of the nature of the patient/offender and how he functions, including the pressures and stresses he is put under which may result in disturbing or dangerous acting out. The creation of a more mindful milieu within which the patient/offender is cared for results in patients/offenders being better contained and feeling better understood by those charged with their care. This is a central part of the Clinics 'teaching' activities as described above.
- 8.4.4 The Clinic has a number of new projects in development which adds to the morale of the Clinic staff as well as proving the possibility of income from new activities and new funding sources. These include:
- 8.4.5 A new project based on the court report writing activity. This involves the development of teaching, CPD and training activities aimed at the legal profession and at mental health, social care and criminal justice colleagues engaged in the interface between patients / offenders and the courts; it involves the development of brief clinical interventions with families engaged in legal / child care proceedings, a service requested on a regular basis by solicitors and socials service departments; and also audit and research projects, including the investigation of the outcomes of court decisions.
- 8.4.6 Discussions have started with colleagues in Leeds about the possibility of establishing a possible partnership for the setting up a psychotherapy service for forensic and personality disordered patients. Very initial discussions have also commenced with colleagues from another city.
- 8.4.7 The Clinic has a growing wealth of knowledge about the compulsive use of internet pornography, which as stated

above, is a fast growing problem presented in referrals or discovered during assessment for treatment. A programme has been developed which includes a time-limited clinical service and also programmes, beyond the lectures and seminars which have already been offered. This is now to be piloted.

- 8.4.8 Discussions have been ongoing about the possibility of establishing a forensic service to families involved in a Mother and Baby unit in East London.

Stanley Ruszczynski  
Clinical Director, Portman Clinic  
17<sup>th</sup> June 2011

# Appendix 1

## Portman Clinic Budget Comparison 2010/11 and 2011/12

	Actual Y-E 2010/11	Estimates / Budget <sup>3</sup> 2011/12
Income		
Direct		
Portman Central	331,988	343,000
PDKUF	6,104	30,000
Clinical		
SLA	1,107,091	1,096,646
Training		
Junior Doctors	61,799	61,799
National Contract	72,484	72,484
Course Fees	22,164	22,164
CPD	17,378	17,378
LCCPD	9,704	9,704
Consultancy		
Consultancy	111,601	180,000
Research		
Research	11,036	11,036
Buildings		
Buildings	4,036	4,036
<b>Total Income</b>	<b>1,755,384</b>	<b>1,848,247</b>
Operating Expenditure (exc. Depreciation)		
Clinical Directorates		
Portman Central	-1,542,701	-1,486,183
PDKUF	-1,110	0
Other Training Costs		
Junior Doctors	-5,298	-5,298
Visiting Lecturers	-1,827	-1,827
Research		
Research	-17,898	-17,898
Buildings		
Buildings	-197,454	-197,454
<b>Total Expenditure</b>	<b>-1,766,289</b>	<b>-1,708,660</b>

<sup>3</sup> Figures in red are known budget plans and estimates for income and expenditure changes for the current financial year

	Actual Y-E 2010/11	Estimates / Budget <sup>3</sup> 2011/12
<b>Contribution</b>	<b>-10,905</b>	<b>139,587</b>
DET		
Income	9,630	9,630
Expenditure	-34,689	-34,689
Central Functions		
Income	37,450	37,450
Expenditure	-303,879	-303,879
<b>Retained Surplus</b>	<b>-302,392</b>	<b>-151,901</b>
Surplus as % of income	-18%	-8%
Contribution as % of income	-1%	8%

## Board of Directors : June 2011

**Item : 16**

**Title : Staff Survey Results 2010**

### **Summary:**

A number of key areas where the Trust scored better this year than in 2009 include:

- An increased score for overall staff engagement
- reductions in staff witnessing potentially harmful errors, near misses or incidents
- reductions in staff experiencing work-related stress
- reductions in staff stating their intention to leave their job

Some areas have not improved since 2009 and these include:

- An increase in numbers of staff working extra hours
- A reduction in numbers of staff receiving equalities training

Top four ranking scores were in:

- Health and wellbeing
- Staff witnessing harmful errors, near misses and incidents
- Staff reporting good communication between senior management
- Staff using flexible working options

The Trust's bottom four scores were in:

- Staff working extra hours
- Staff receiving health and safety and Equality training
- Staff believing equal opportunities in career progression exists

Points for discussion

- The Trust's overall survey results



- Outcomes for disabled staff
- Staff undertaking mandatory equalities and Health & Safety training

**This report focuses on the following areas:**

*(delete where not applicable)*

- Patient / User Experience
- Equality

**For :** Discussion

**From :** Director of Human Resources

## Staff Survey Results 2010

### 1 Introduction

- 1.1 This document provides a summary of the **2010** NHS annual staff survey results, commissioned by the Care Quality Commission (CQC), which took place during October to December 2010.
- 1.2 The Trust has once again done well in this year's survey and shown better than average scores for a majority of survey questions, including a high score in terms of overall staff engagement. Higher than average scores were also identified in areas such as flexible working, the trust's commitment to work-life balance and staff reporting good communication from senior management. These positive results in a number of areas continue to show that the Trust remains a good employer in its sector with the trust being rated in the highest best for factors such as job satisfaction and staff intention to leave.
- 1.3 This year however, there has been a reduction in the number of staff taking part in the survey as compared with previous years. This year, the Trust's response rate was 51%, compared with a MHLTD response rate of 54% and a response rate of 57% in 2009. The MHLTD response rate for all Mental Health Trusts overall has also seen a decline this year from 55% in 2009 to 54%.
- 1.4 The first part of this report focuses on the areas identified as requiring improvement from the 2009 survey, for which action plans were drawn up and monitored during 2010. The 2009 survey results are then compared with this year's survey outcomes, for those areas, to assess whether the actions taken have secured improvements.
- 1.5 The second section summarises the results from this year's survey, highlighting key findings. Relevant findings for specific demographic or work groups e.g. managers or BME staff are also discussed. Action plans are proposed for areas where it is identified that the Trust needs to improve. These action plans include timescales for completion and it is anticipated that actions will link into Trust requirements to meet Care Quality Commission standards and NHS Litigation Authority requirements and inform staff training and development needs.
- 1.6 For this survey, as in previous years, the Tavistock is classified as a mental health/learning disability (MHLTD) Trust, and therefore it is compared with other MHLTD Trusts across the country. MHLTD Trusts

are therefore the 'MHLA average' or 'national average' comparators used.

## **2 Key Areas of concern from the 2009 Survey**

2.1 Due to the Trust's results in 2009 being exceptionally good, only three main/major areas were highlighted as requiring improvement from the 2009 survey. These are listed below:

- The number of staff receiving job relevant training
- The number of staff working extra hours
- The number of staff receiving health and safety training in the past 12 months

2.2 These three major areas have been compared with the 2010 survey outcomes in order to see whether improvements have been achieved and these are discussed below.

2.3 In addition, other areas (minor) from the 2009 survey results, where it was identified that the Trust could improve upon, are also discussed and compared with this year's results.

### **2.4 Area/s showing marked Improvements**

#### **2.4.1 *Percentage of staff receiving job relevant training***

2.4.1.1 One major area where the Trust did not do so well in the 2009 survey was in relation to the numbers of staff stating that they had received job relevant training in the past 12 months. The Trust's score of 81% in 2009 was rated as average. Measures taken this past year to secure improvements have included extensive work by the Trust's Staff Training Committee to identify relevant training from teams and departments, as well as working in conjunction with directors to identify specific directorate training needs. Bidding for NHS London Training funds has taken place in conjunction with directorate leads, and the funds secured have been made available directly to specific departments and staff. This ensures that staff and teams actually identify their own specific development needs and that these are prioritised.

2.4.1.2 This year, the Trust's score has improved for this question, with the Trust's score of 87% rated as

being in the highest best for mental health Trusts. This improvement it seems has been achieved through the measures taken through the year, to ensure job-relevant training is being provided.

#### **2.4.2 *Communication between senior management and staff***

2.4.2.1 In the 2009 survey, while the number of staff stating that good communication existed between senior management and staff was rated as good, it was agreed that further work should be undertaken in this area, as the Trust's score of 56% could still be improved upon. This wasn't however identified as a major area of concern.

2.4.2.2 In order to secure even further improvements, communication mechanisms such as open forums, staff meetings, newsletters, briefings, mail outs and increased staff involvement groups continued throughout 2010. This increased communication meant the Trusts overall score this year moved up to 62%, with the Trust also rated as being in the highest best for this category. While the Trust's scores for some demographic groups had not shown similar improvements, such as the lower number of women and disabled staff reporting good communication between management and staff, the results for those two demographic groups were still significantly higher than the MHLD average of 31%. Some further work may therefore still be required in this area.

#### **2.4.3 *Work related stress***

2.4.3.1 In 2009, the survey results showed that the number of staff experiencing work place stress had reduced dramatically from 46% in 2008 to 26% in 2009. This was also below the MHLD average of 30% that year. While this was seen as a good result, the Trust felt that the harmful effects of staff working extra hours and its link to work place stress should not be ignored. As a result, it was agreed that further work should be undertaken in this area. Measures such as the provision of stress awareness briefing sessions and time and workload training events were put in place. Managers and staff were encouraged through e-mail notifications and

bulletins to prioritise staff attendance at these training sessions.

- 2.4.3.2 This year, the number of staff stating that they experienced work related stress has reduced from 26% to 17%. The Trust was also rated as being in the lowest best category for this question, with the decrease also seen as being statistically significant. This is also a good outcome this year.

## 2.5 Area/s showing no improvement

### 2.5.1 *Staff receiving Health and Safety training in the last 12 months*

- 2.5.1.1 From the 2009 survey, it was identified that the number of staff receiving health and safety training in the past 12 months at 59%, was below the average for MHL D Trusts. It was noted at the time, that staff were only required to attend mandatory Health and Safety training as part of the Trust's INSET day, once every two years, therefore there was an expectation that figures should be low for this question. In addition the Trust's compliance rate for attendance at INSET training has over the years, been relatively low. Therefore measures taken to improve on this in the past year have included provision of adhoc health and safety briefings as well as the introduction of sanctions for non-attendance at mandatory training. However due to the late introduction of these measures, for example, sanctions for non-attendance were introduced in April 2011, the benefits of these measures it seems have yet to be realised.

- 2.5.1.2 In this years' survey the Trust's score of 58%, while not significantly less than the 2009 score of 59%, is still a reduction. However, the MHL D average this year of 80% makes this low score seem even more significant. It is therefore essential that further work is undertaken in this area, which should include stringent application of sanctions for non-attendance at training as well as continuing to explore innovative ways of providing health and safety updates regularly to staff.

### 2.5.2 *Percentage of staff working extra hours*

- 2.5.2.1 Responses from the previous two surveys (2008 and 2009), showed that a higher proportion of staff in comparison with the MHL D average for MHL D Trusts, were working additional hours in order to fulfil their job roles. While work undertaken to improve the Trust's scores in this area have secured some improvements, these improvements have not been significant and each year the number of staff indicating that they are working extra hours at the Tavistock has consistently been higher than the MHL D average.
- 2.5.2.2 Measures taken this past year have included stress and time management training sessions, discussions at CEO forums and stress awareness e-mail briefings in order to make staff aware of the link between working long hours and work place stress.
- 2.5.2.3 In this years' survey 83% of respondents stated that they were working extra hours, in comparison with 75% in 2009 and 85% in 2008. While the Trust's score this year is lower than what it was in 2008, it is still a significant increase in comparison with the Trust score in 2009. This year's score is also much higher than the MHL D average of 53% (the MHL D average in 2009 was 63%). While it is noted that stress levels seem to be decreasing, further work is required in this area and this is discussed in detail later in this report.

### 3 Findings and Action Plans (2010 survey)

- 3.1 The staff survey this year (2010) once again has been structured around the four pledges contained in the NHS constitution with the inclusion of two additional themes. This means results can be easily compared with previous years. The four pledges and two additional themes are summarised below:

- **Pledge 1:** *clear roles and responsibilities and rewarding jobs*
- **Pledge 2:** *personal development, access to appropriate training*
- **Pledge 3:** *maintaining staff health, well-being and safety*
- **Pledge 4:** *staff involvement and engagement*

- **Theme 1: Staff Satisfaction**
- **Theme 2: Equalities and Diversity**

3.2 The main findings from the 2010 survey are summarised below. **Appendix 1** provides a graphical representation of pledge findings including comparisons with the 2009 survey results. Significant demographic and group findings have also been discussed and shown graphically where relevant.

#### **4 Pledge 1: Clear roles, responsibilities, and rewarding jobs**

4.1 The Trust scores in eight out of nine elements for this pledge were in the best 20% of MHLTD Trusts in England. While this is a similar outcome to last year, the Trust's score was not as good as last year in three areas, even though those particular areas were rated as being in the highest best for MHLTD Trusts. The positive and negative findings are summarised below:

##### **4.2 Positive findings**

4.2.1 The Trust's scores in all eight areas were seen as extremely good in comparison with the average for MHLTD Trusts, with a top ranking score for the number of staff accessing flexible working options. The Trust's score for 'commitment to work life balance' had also significantly improved in comparison with 2009 scores.

4.2.2 Other areas that the Trust scored well include:

- Staff agreeing that their roles make a difference to patients
- Staff feeling valued by colleagues
- Staff feeling that effective team working exists in the Trust

4.2.3 Further analysis of demographic, occupational and ethnic responses for this pledge, highlighted the following useful key positive points:

- A higher proportion of black and minority ethnic (BME) and disabled staff and women, stated that they were taking advantage of flexible working options.
- A higher proportion of BME staff stated that they feel valued by work colleagues and felt the Trust was committed to their work life balance

- There was a substantial drop in the number of administrative staff working additional hours in comparison with last year (a drop from 60% to 49%).

#### **4.3 Negative Findings**

- 4.3.1 As in previous years, the Trust showed a negative result this year in relation to the number of staff stating that they are working extra hours in order to fulfil their roles. As already mentioned in the preceding section, the Trust's score this year has not only increased significantly in comparison with last year's score, but it is also higher than the average for MHLD Trusts (see section 2.1.1). In addition, the Trust's score for 'work pressure felt by staff' has also increased, though still well below the average for MHLD Trusts.
- 4.3.2 As in previous years, the figure for staff working additional hours this year is also higher for clinical staff as compared with non-clinical staff.
- 4.3.3 Other significant demographic findings (negative findings) for this pledge include:
- Lower numbers of admin and clerical staff indicating that they used flexible working options (65% compared with around 90% for clinical staff and 79% for general management staff)
  - Lower numbers of disabled staff indicating that they feel valued by their work colleagues
  - Higher numbers of disabled staff indicating that they are feeling work pressure

#### **4.4 Action**

- 4.4.1 The findings from this year's survey show that while staff are working additional hours, the numbers of staff suffering work related stress is quite low (see 2.1.3). However, the fact that the work pressure felt by staff is also on the increase means some action needs to be taken.
- 4.4.2 In order to improve on these results, further time and workload management interventions will need to be put in place in the coming year. This will include training on workload and time management for staff and managers, as well targeted support and assistance for disabled staff, such as e-mail briefings and disability notifications, covering details of the support and assistance available for disabled staff across the Trust.



4.4.3 The Trust's flexible working policy will also be updated this year and cascaded to all staff, with targeted briefing sessions for administrative staff where the policy benefits can be highlighted. This should improve awareness and encourage staff to take advantage of available flexible working practices.

4.4.4 *Responsibility for Action: Director of Human Resources.  
Completion Date: April 2012*

## **5 Pledge 2: Personal development and access to training**

5.1 In 2009, the Trust was rated as being in the highest best for **five** out of **six** areas for this pledge, with one area being rated as average. This year the Trust was rated in the highest best for **four** out of **six** areas for this pledge and rated as above (better than) average in two areas. The Trust was also rated as being in the highest best this year, for the numbers of staff receiving job relevant training. This was an area identified as average last year.

### **5.2 Positive findings**

5.2.1 The Trust received high scores in all six areas for this pledge with one area identified as having improved significantly from 2009. This was in relation to the number of staff stating that they felt there was support from their immediate managers.

5.2.2 Other areas where the Trust showed positive results this year include increases in the number of staff having appraisals and PDPs, as well as a higher than average number of staff stating that they were having well-structured appraisals.

5.2.3 Other positive findings in relation to demographic statistics include a higher proportion of BME staff in comparison with non-BME staff stating that they had received job relevant training or learning in the past 12 months. Also, a higher proportion of administrative and central services/support staff this year stated that they felt there were good opportunities at the Trust to develop their potential. The figure for this question had increased for administrative staff from 33% in 2009 to 46% this year and from 45% for support staff to 56% this year. These figures were however, still lower than the response rates for clinical staff this year of 78%.

### 5.3 *Negative Findings*

5.3.1 Two areas that had shown a dip in comparison with 2009 response rates, but were still rated as in the highest best and better than average this year include:

- The numbers of staff stating that there are good opportunities to develop their potential. This had fallen from 75% in 2009 to 64% this year.
- The number of staff appraised with personal development plans in the last 12 months. This had also dropped from a response rate of 85% in 2009 to 76% this year.

5.3.2 In addition, an analysis of the demographic findings for this pledge showed that response rates for disabled staff was much lower in all six areas when compared with other demographic groups. This includes -

- A much lower number of disabled staff in comparison with other groups felt that there are good opportunities to develop their potential (30% of disabled staff stating this compared with 63% for non disabled staff and women and 55% for men).
- A much lower number of disabled staff in comparison with other demographic groups stated that they had received job relevant training in the last 12 months (57% of disabled staff stated this compared with 84% for non-disabled staff and 87% for BME staff)

### 5.4 *Action*

5.4.1 Further appraisal training will need to be rolled out to staff and managers this year, to ensure that effective appraisals take place. Focus should be placed on ensuring that Personal Development Plans and existing objective setting processes are utilised effectively.

5.4.2 Methods of ensuring that the various positive interventions available such as support from line managers, appraisal processes, opportunities for career development and career enhancement, impact positively on disabled staff will need to be explored further. This should include a discussion at the equalities committee, about what positive measures that can be put in place to enhance the overall experience of disabled staff in the Trust.

5.4.3 *Responsibility for Action: Director of Human Resources; Chair of Equalities Committee. Completion Date: January 2012*

## **6 Pledge 3: Maintaining staff health and wellbeing**

6.1 The Trust showed good scores in 12 out of the 14 areas for this pledge. The Trust's results last year (2009) were slightly better with 13 good scores out of a possible 14. The only area listed as not good in 2009, in relation to the numbers of staff attending health and safety training, was also seen as not good this year. The areas where the Trust displayed high scores this year are discussed below, including the two areas, where the Trust did not do so well.

### **6.2 Positive findings**

6.2.1 Positive findings include extremely low numbers of staff stating that they had suffered work related stress and work related injury in the past 12 months. The Trust score for staff experiencing stress was actually lower than it was in 2009, showing a drop from 26% to 17%, which is a good result.

6.2.2 Other areas noted as good or having improved include:

- A decrease in the number of staff witnessing potential harmful errors, near misses and incidents
- Low percentage of staff in comparison with the MHLA average, suffering work related injury in the last 12 months (3% Trust score compared to MHLA average of 8%)
- A much higher percentage of staff in comparison with the MHLA average stating that hand washing materials are always available (A Trust score of 69% compared to a 58% MHLA average)
- A low percentage of staff stating that their health and wellbeing was impacting on their ability to perform work. The Trust score in this area had actually improved significantly in comparison with 2009 scores.

6.2.3 Positive areas to highlight in relation to other demographic statistics and groupings include:

- A higher proportion of BME staff in comparison with non-BME staff stating that they had received Health and Safety training in the past 12 months (73% compared to 62% of non-BME staff).

- Lower numbers of staff in central services and support functions stating that they have suffered work related stress in the past 12 months.

### **6.3 Negative Findings**

- 6.3.1 The two main areas where the Trust did not do so well are in relation to the low numbers of staff stating that they had undertaken health and safety training in the past year and a poor score for the percentage of staff reporting errors, near misses or incidents witnessed in the last month.
- 6.3.2 While the poor responses for attendance at health and safety training, can be somewhat explained by the requirement to attend INSET training biennially, work still needs to be undertaken in this area. Another area that needs to be looked into is the fact that the Trust's score for the reporting of errors, near misses and incidents had not changed significantly from a score of 99% in 2009 to 96% this year, but was still below the average score of 97% for MHLDS.
- 6.3.3 Other areas of note include -
- A higher proportion of disabled staff suffering work related stress and experiencing harassment, bully and abuse from staff in comparison with other groups
  - A higher proportion administrative staff also stating that they suffered work related stress in the last 12 months (39% for admin staff compared with around 20% for Clinical staff)

### **6.4 Action**

- 6.4.1 As mentioned earlier, the newly introduced sanctions for non-attendance at INSET training should increase attendance and improve the Trust's score in terms of Health and Safety training in the coming years. As well as this, it is also important that the Trust continues to explore innovative ways of providing mandatory training updates such as alerts, briefing handouts, flyers and e-learning material. This should ensure that staff are continuously aware of health and safety procedures and that learning does not just take place at INSET days.
- 6.4.2 Incident reporting training should continue to be provided to all staff frequently throughout the year. This could also be in the form of e-mail notifications with details of incident reporting procedures and Q&As included as information briefings.

6.4.3 Stress awareness briefings and training for managers on recognizing and managing stress should also take place throughout the year. Poor outcomes for disabled staff in relation to stress and harassment should also be considered by the Trust equality group with further action devised to address this issue.

6.4.4 *Responsibility for Action: Director of Human Resources; Governance & Risk Lead; Health & Safety Manager; Chair of Equalities Committee. Completion Date: June 2012*

## **7 Pledge 4: Staff involvement and engagement**

7.1 Similar to last year's results, once again this year, the Trust has been rated as being in the best 20% of MHL D Trusts for the two areas of this pledge.

### **7.2 Positive findings**

7.2.1 The Trust's score of 62%, for the percentage of staff reporting good communication between senior management and staff, was significantly higher than its score of 56% in 2009 and substantially higher than the MHL D average score of 31%. This is a very good result. In addition, an analysis of the demographic data showed no major disparities apart from a slightly lower score for BME staff regarding communication as compared with Non-BME. The score for BME staff had however not changed in comparison with 2009 figures, while the number of non-BME (white) staff reporting good communication had actually dropped from 64% in 2009 to 59% this year.

7.2.2 The second main positive finding is in relation to the number of staff stating that they are able to contribute towards improvements at work. The Trust's score of 74% for this area was higher than the MHL D average of 67%, but was lower than the Trust's 2009 score of 90%. Some other areas where the Trust could improve further in relation to this question include evidence that a slightly lower proportion of staff in administrative and support functions felt they were able to contribute to work improvements.

7.2.3 While there are no main negative findings in relation to this pledge, this year the Trust should continue to improve its communication processes, seeking to make them as inclusive

as possible, to ensure staff from various groups feel they are able to be involved and contribute meaningfully.

## **8 Additional Theme 1: Staff Satisfaction**

- 8.1 The Trust's scores were also in the highest best for all four questions for this theme. This is a similar score to that in 2009. Two areas had also improved significantly and this is in relation to 'staff intention to leave' and 'staff motivation at work'. Measured on a scale of 1- 5 (5 being best), the Trust's score for staff motivation of 4.03 was also the highest score for MHL D Trusts.
- 8.2 While the Trust ranked high for job satisfaction and staff recommending the Trust as a good place to work or receive treatment, these two areas had however decreased slightly in comparison with 2009 scores. Demographic statistics also show that job satisfaction was highest for BME staff when compared with non-BME staff and other staff groups. On the other hand, staff intention to leave jobs was highest for disabled staff, when compared with other groups.

## **9 Additional Theme 2: Equalities and Diversity**

- 9.1 The Trust's scores for this theme were not so good this year when compared with last years' results. In 2009, the Trust's scores in two areas of this pledge were rated in the best 20% of MHL D and one area was rated above average, however this year, the Trust was rated in the best for one area and lowest (worst) for two areas.
- 9.2 ***Positive Findings***
- 9.2.1 The one positive finding for this theme is in relation to the low numbers of staff experiencing discrimination at work in the last 12 months. The Trust's score of 6% was seen as in the lowest best for MHL D Trusts and much lower than the MHL D average of 14%.
- 9.2.2 One positive area in terms of demographic and group statistics is the increase in the percentage of administrative and support staff stating that they had equalities and diversity training this year when compared to 2009 results.

### **9.3 *Negative Findings***

- 9.3.1 The two main areas where the Trust did not do well are in relation to:

- The number having equalities and diversity training in the last 12 months
- The number stating that they believe the Trust provides equal opportunities for career progression or promotion.

9.3.2 Both these areas were lower than the average for MHLDS and they had both shown worse outcomes this year, when compared with 2009 results. For example the number having equality and diversity training had decreased substantially from 52% in 2009 to 38% this year. The average MHLDS score for this question was 47%.

9.3.3 Staff perceptions in relation to equal opportunities in career progression does also need to be looked into. In 2008, this area was highlighted as below average, however improvements were seen in 2009 with this area highlighted as being in the highest best. However this year scores have deteriorated from 94% in 2009 to 79%, with the average for MHLDS this year being 89%. Analysis of demographic statistics also shows the outcomes for disabled and BME staff were not so good for this question, with a lower proportion of disabled and BME staff stating that they believed the Trust provided equal opportunities for career progression (59% and 70% respectively, compared with outcomes of 93% for non-disabled and white staff)

#### 9.4 **Action**

9.4.1 In order to secure improvements in these two areas, the Trust should provide further equalities and diversity training throughout the year aside from that already provided at the twice yearly INSET sessions. This training should be provided innovatively for example at team meetings, department away days, staff meetings etc. this will ensure a wider reach and audience.

9.4.2 Work has already been undertaken by the equalities committee in terms of analysing staff progression data across the trust. Regular updates regarding this work should take place in the coming year and findings analysed and discussed. Thought should be given to devising positive methods of providing career and progression support to specific groups of staff including minority and disabled staff.

9.4.3 *Responsibility for Action: Director of Human Resources; Chair of Equalities Committee. Completion Date: June 2012*





## 10 Conclusion

- 10.1 This year's overall survey result is good. Improvements have been identified in many areas when compared with 2009 results and once again, the Trust scores are one of the best within its sector. However there are still a number of areas that are not as good as last year and areas where staff experience has gotten worse. This includes staff working extra hours and low numbers undertaking health and safety training. Further work is therefore necessary in these areas.
- 10.2 Stress at work has improved significantly, this is a good result especially as staff intention to leave is very low and staff feel that their health and wellbeing is also good while working for the Trust. The work undertaken by the Trust as a direct response to the 2009 survey has also seemingly secured improvements in areas such as communication between staff and management and staff receiving job relevant training. These outcomes are clearly attributable to work, undertaken through the year.
- 10.3 The overall response rate in terms of the numbers completing the survey has dipped this year. Increasing staff participation is an area the trust will need to focus on for the next survey. Extensive promotional work will need to be take place and the benefits of completing the survey should be highlighted at every possible opportunity across the organisation.
- 10.4 Work will also need to take place to address the poor outcomes for disabled staff, identified for a number of questions in this survey. This is a difficult area, especially in deciding how much emphasis to place on some of the outcomes, due to the very small numbers of disabled staff in the Trust, as low numbers of respondents may potentially skew data. Additionally, the Trust undertook an exercise in 2010 to identify the numbers of disabled staff in the Trust and the nature of their disability. This exercise may have also had some impact on the responses in this survey. The responses for this group needs to be looked into and the action plans already discussed in this document should address some of these issues.
- 10.5 Finally, this year, as in 2009, unadjusted (un-weighted)\* scores have not been used in this report when making comparisons. From

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\*For survey purposes, the Tavistock is classified as a MHLTD Trust. Each classification is assumed to have a normal mix of occupations, where a Trust's actual mix differs from the norm (such as the Tavistock), figures are adjusted up and down to account for this difference. Nursing is given quite a high weighting in this process, with a significantly low number of nurses at the Trust, the nationally reported results have sometimes been less reliable in analysing survey outcomes.

previous reports, using raw unadjusted scores to analyse this Trust's data has usually improved the Trust's outcomes for most questions. Notwithstanding this, our results this year, without un-weighted scores, still show that the Trust continues to improve and outperform many other Trusts in its sector. The Trust's overall engagement rating of 4.02 (on a scale of 1-5), compared with a MHLDT Trusts rating of 3.64 further confirms this.

10.6 Overall, the Trust's staff survey results for 2010 are good.

Human Resources

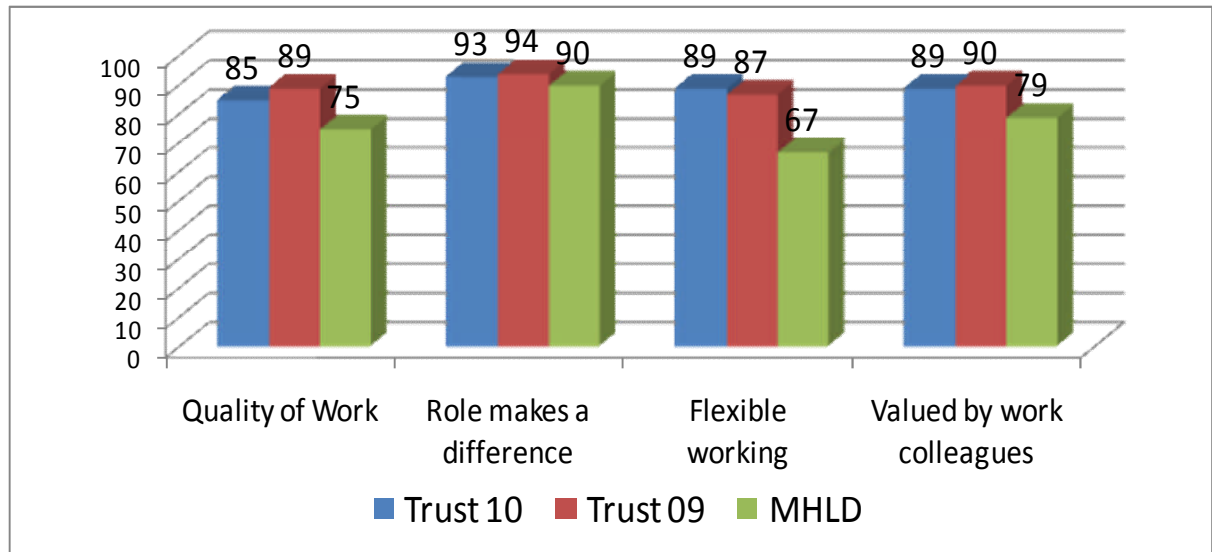
17<sup>th</sup> June 2011

## Appendix 1

### Summary Results Findings and Action Plan

#### ***Pledge 1: Clear Roles, Responsibilities, and Rewarding Jobs***

**Image 1: Pledge 1 – Positive Findings**



**Image 2: Pledge 1 – Negative Findings (a)**

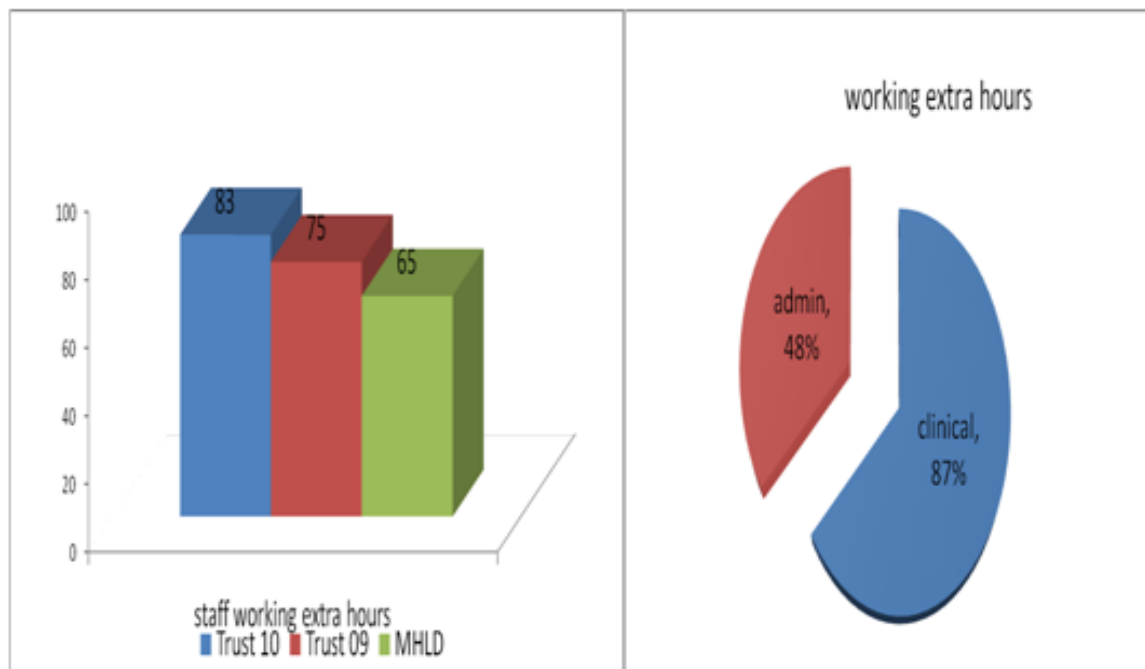
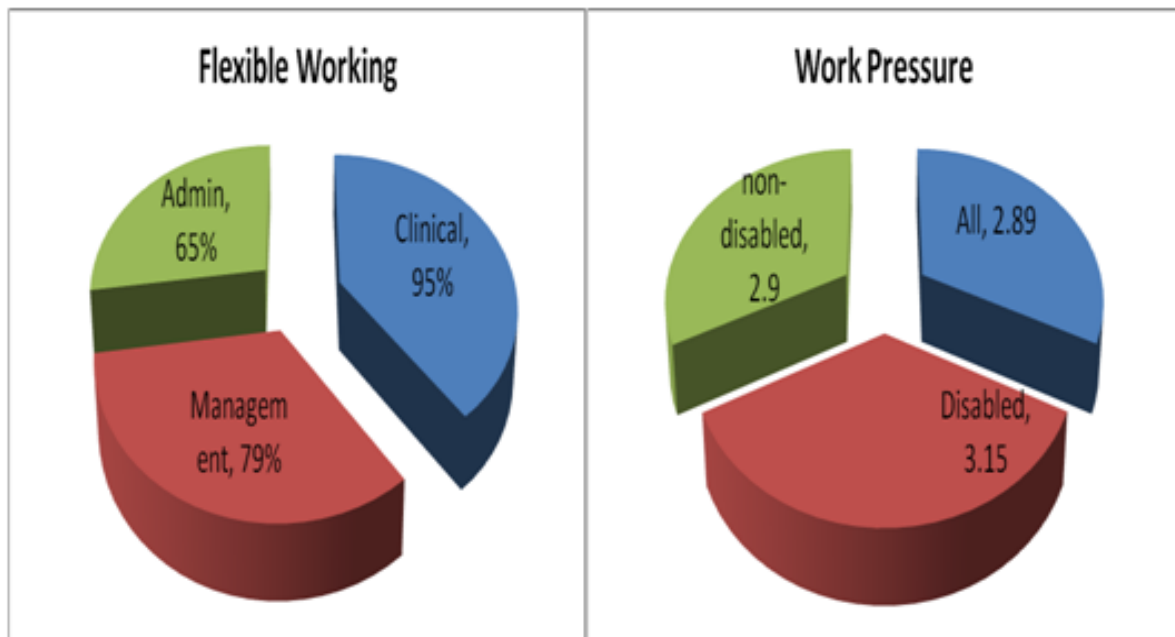


Image 3: Pledge 1 – Negative Findings (b)



### ***Pledge 2: Personal Development & Access to Training***

Image 4: Pledge 2 – Positive Findings

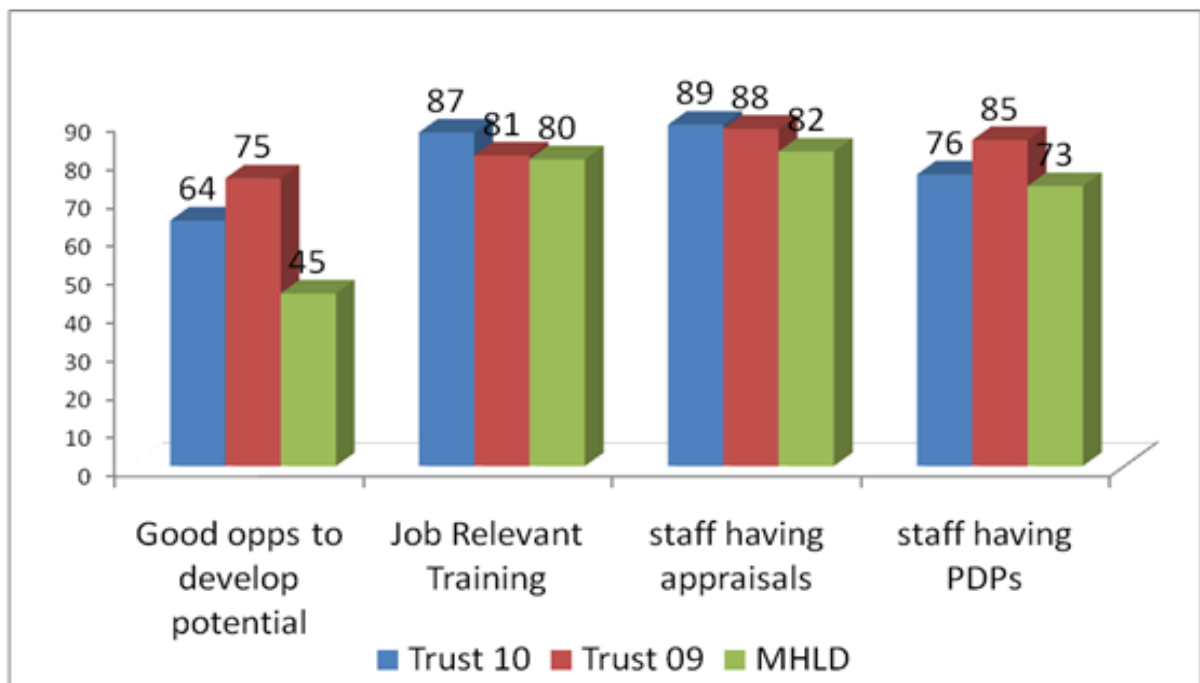
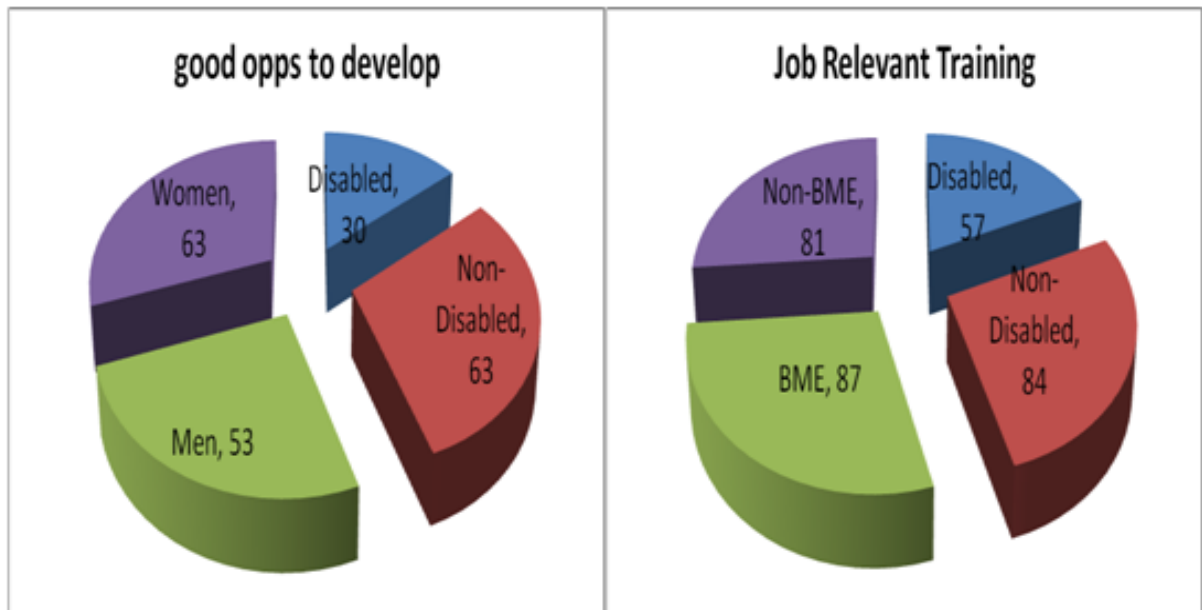


Image 5: Pledge 2 – Negative Findings



### ***Pledge 3: Maintaining Staff Health & Wellbeing***

Image 6: Pledge 3 – Positive Findings

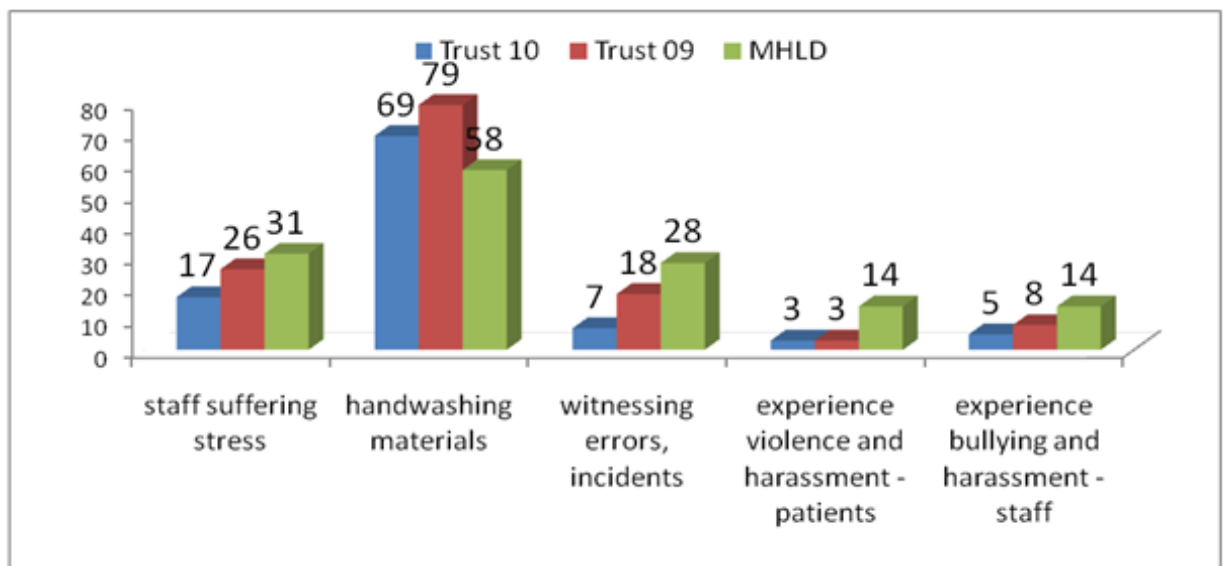


Image 7: Pledge 3 – Negative Findings (a)

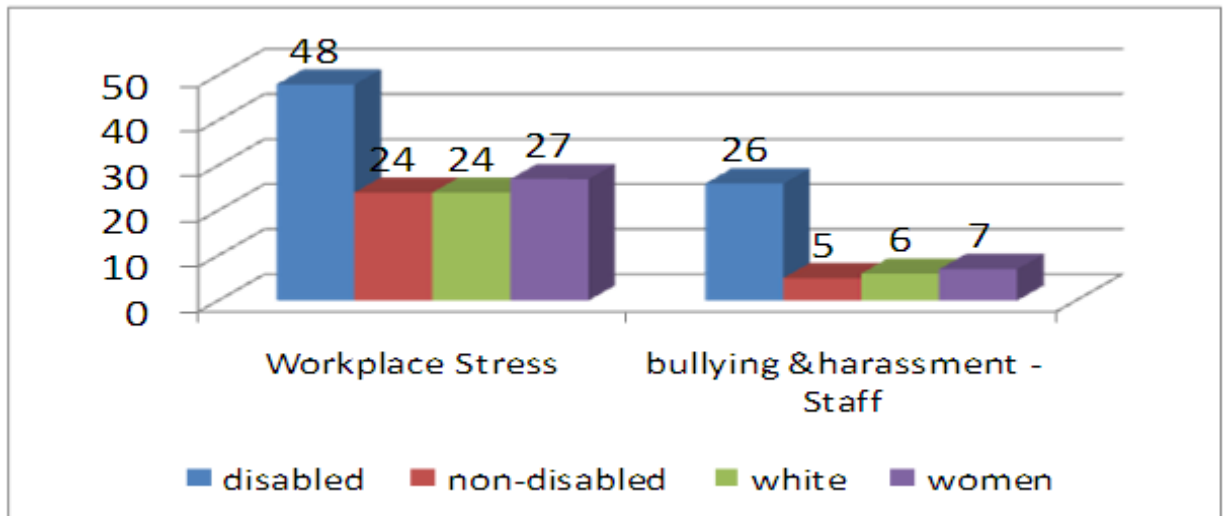
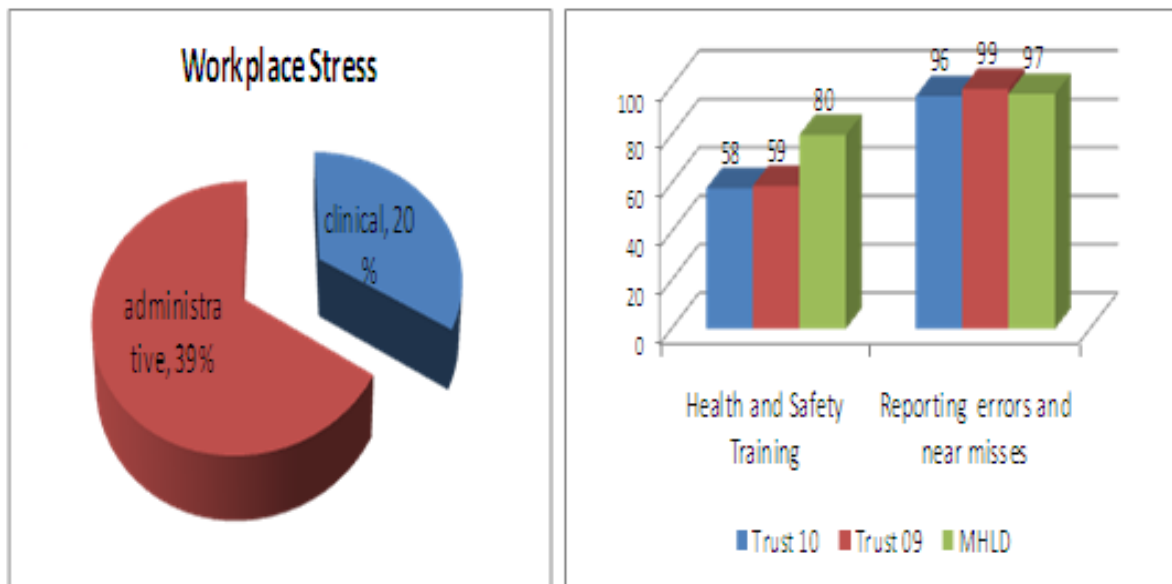
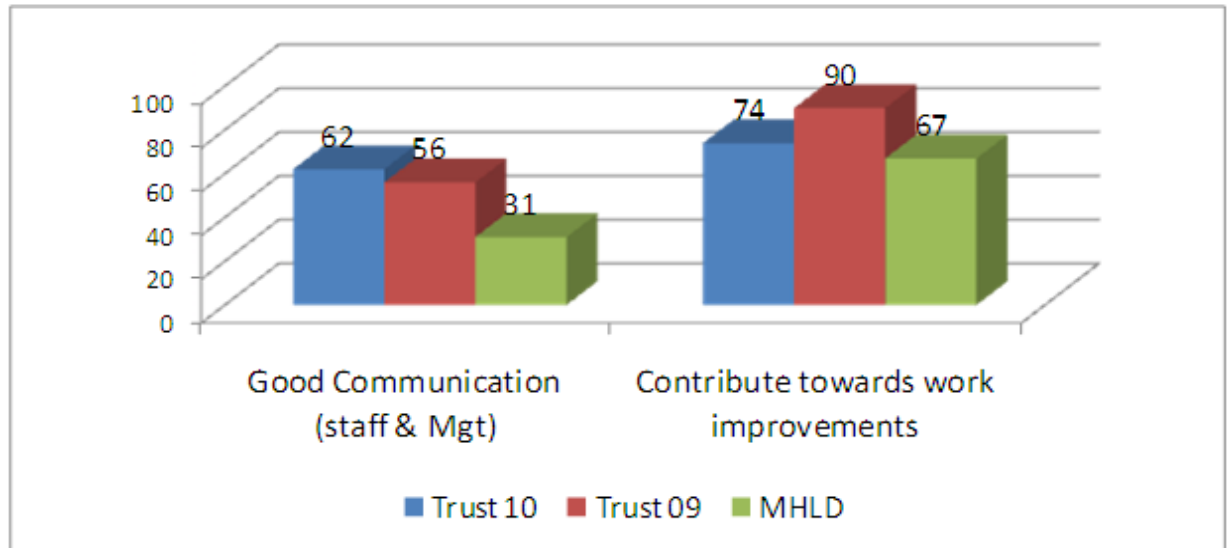


Image 8: Pledge 3 – Negative Findings (b)



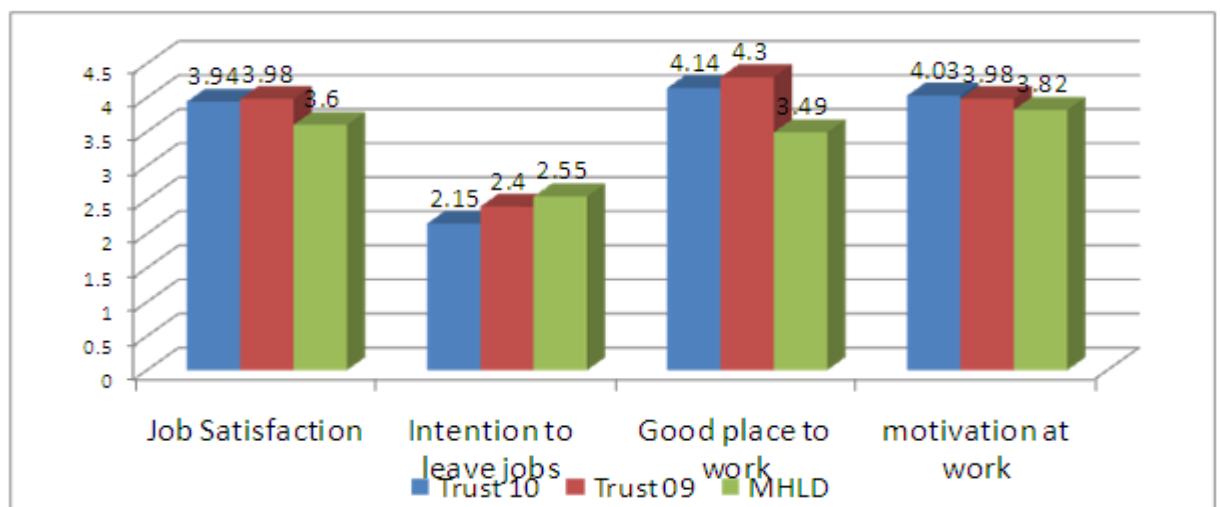
## Pledge 4: Staff Involvement & Engagement

Image 9: Pledge 4– Findings



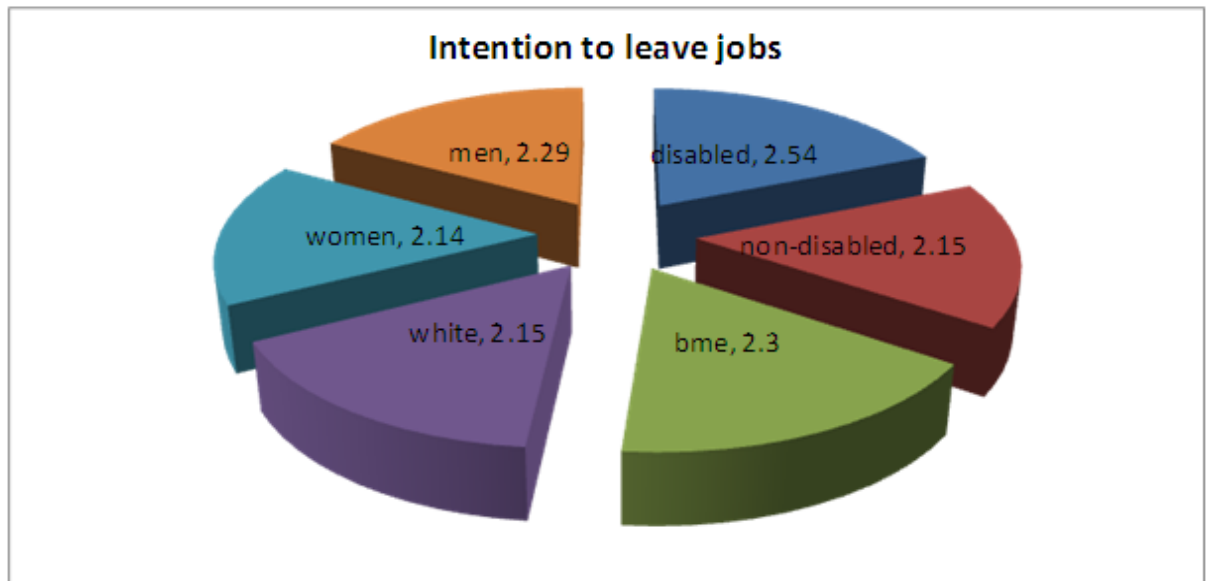
## Theme 1: Staff Satisfaction

Image 10: Theme 1 – Findings (a)<sup>1</sup>



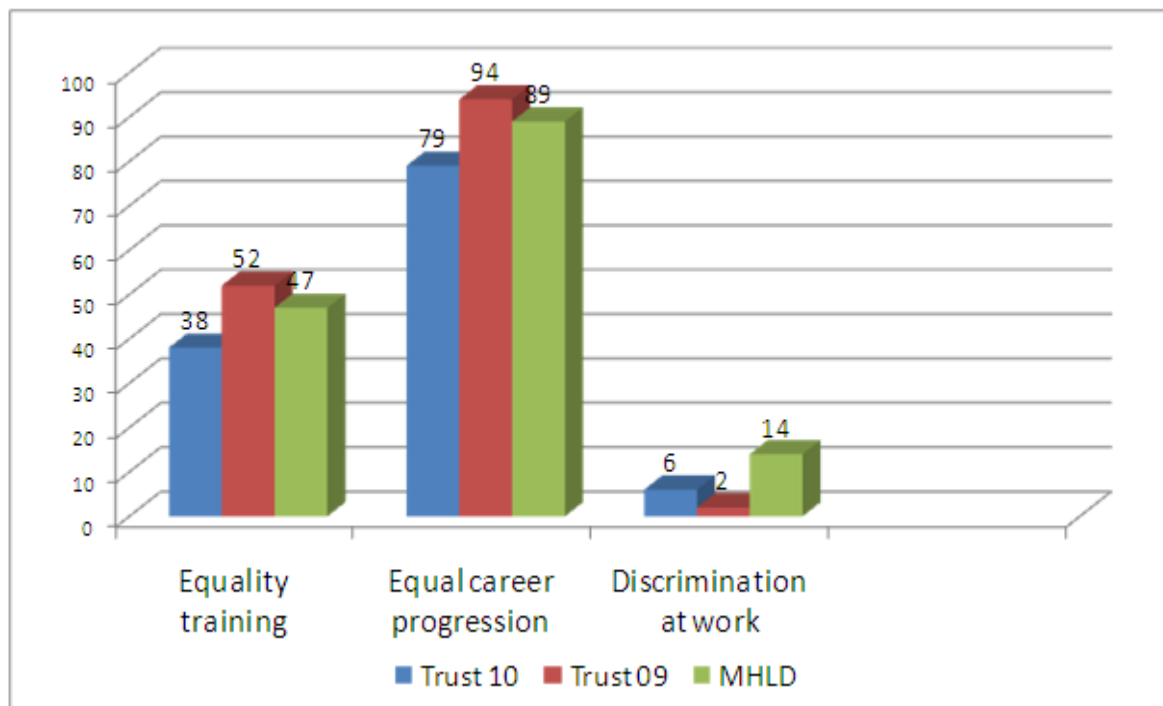
<sup>1</sup> Scale is from 1 – 5. A lower score in terms of intention to leave is positive, while higher scores for others are positive.

Image 11: Theme 1 – Findings (b)



## Theme 2: Equality & Diversity

Image 12: Theme 1 – Findings





## Board of Directors : June 2011

**Item :** 17

**Title :** Workforce Statistics

**Summary:**

The Trust has again grown in the past year, going from a headcount of 527 to 548. The rate of growth was lower than in the previous year, at 4%, down from 6.7%.

This year NHS London has provided a comprehensive resource for benchmarking, which has allowed us to compare our staffing structure to that of London Trusts as a whole. It is clear we have a quite different structure with markedly more Band 8s than is the norm, due to our specialist services.

We were also able to compare ourselves to the ethnic profile of the NHS in London, and again there are marked differences, again probably due to the specialist staff groups we employ.

Turnover and sickness rates continue to be lower than the NHS average. Our sickness rate is 1.5% compared to 3.5 for London, and our turnover is 10.9% compared to 13.1% for London.

The information covers data extracted from the Electronic Staff Record payroll / HR system for 1<sup>st</sup> April 2010 to 31<sup>st</sup> March 2011.

**This report focuses on the following areas:**

*(delete where not applicable)*

- Patient / User Experience
- Equality

**For :** Discussion

**From :** Director of Human Resources

## Workforce Statistics

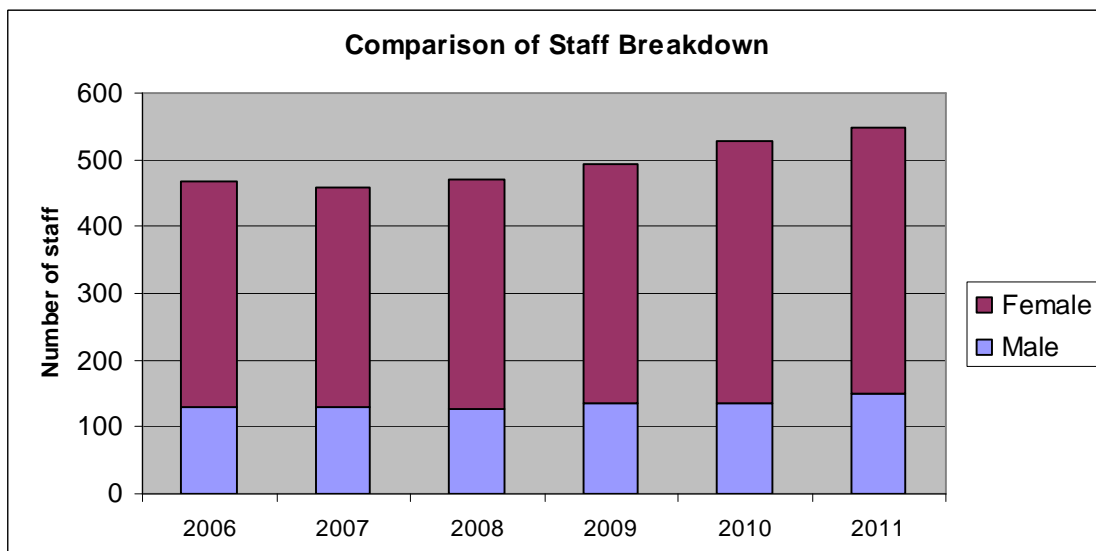
### 1 Staff Breakdown

Table 1: Staff breakdown by Gender and Discipline (headcount as of 31 March 2011)

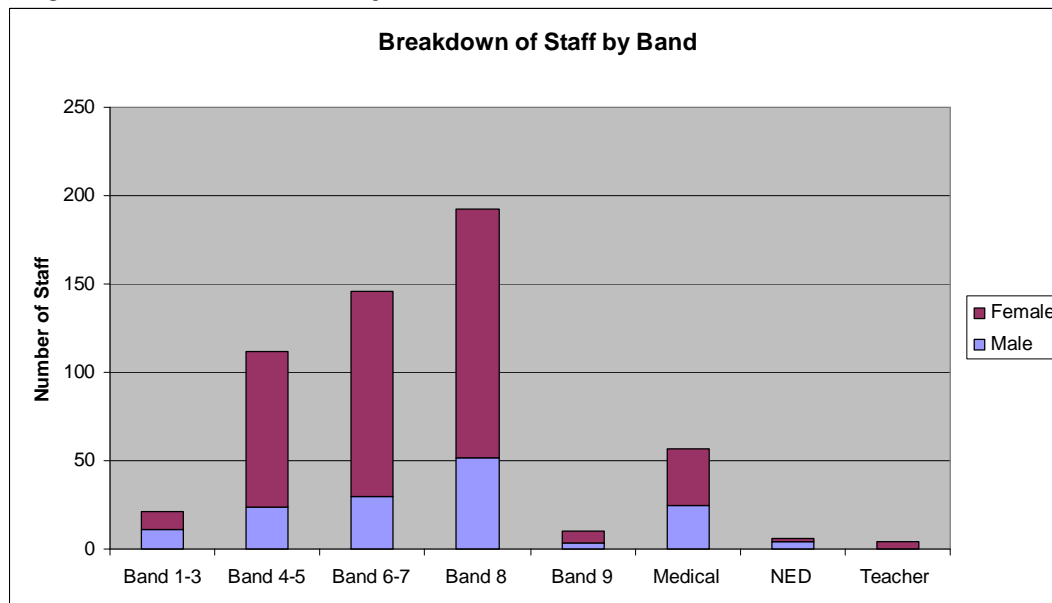
Staff	Male	Female	Total
Clinical	92	267	359
Non-Clinical	57	132	189
<b>Total</b>	<b>149</b>	<b>399</b>	<b>548</b>

1.1 The Trust's headcount has increased 4% over the past year, from 527 to 548 staff. This is third year in a row that we have grown, although by less than last year where the increase was 6.7%. Our equivalent WTE is 426.

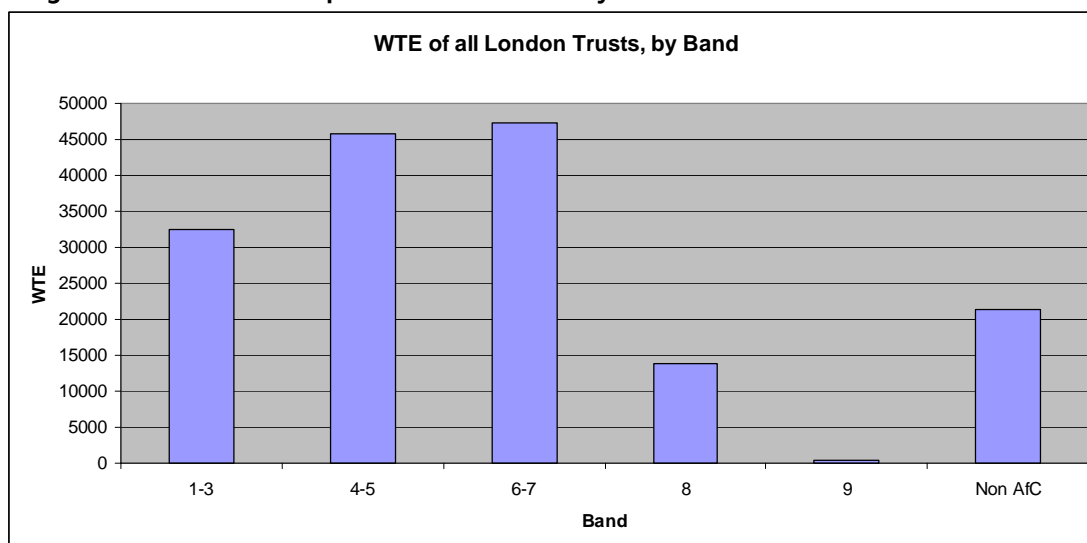
Image 1: Comparison of Staff Breakdown



**Image 2: Breakdown of staff by band as at 31 March 2011**



**Image 3: NHS London Comparative Breakdown by Band as at March 2011**



1.2 The figures given by the NHS for workforce benchmarking are based on WTE rather than headcount as we have traditionally used here. They also give all non-AfC staff as a single unit whereas for some of our non-AfC staff we translate their pay to an equivalent AfC band for reporting purposes (i.e. the TCS consultants), or separate them out into medical and teachers. Despite these differences it is possible to compare ourselves to the London figures and it is evident that we have a quite different staffing structure, due to the specialist nature of the services we provide.

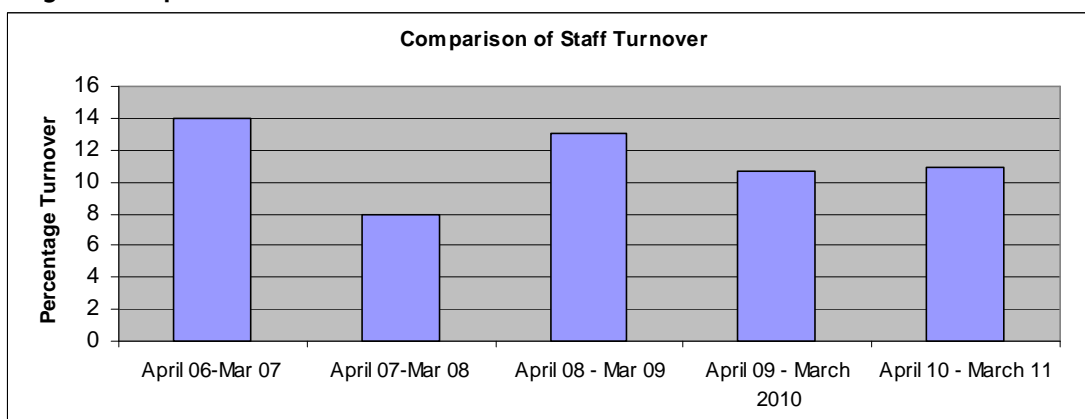
## 2 Turnover Data

**Table 2: Turnover data by Department April 2010 – March 2011**

Department	No. of Leavers	Total No. of Staff Employed	% Turnover by Department
Adolescent	3	61	4.9
Adult	6	84	7.1
Chair & NEDs	1	7	14.3
Chief Executive Office	0	6	0.0
Child and Family	33	249	13.3
Clinical Governance	0	3	0.0
Corp. Gov. & Facilities	2	28	7.1
Day Unit	4	21	19.0
DET	2	31	6.5
Finance	2	12	16.7
Human Resources	1	12	8.3
ICT	1	11	9.1
Library	1	13	7.7
MFAS	2	18	11.1
Portman	4	33	12.1
PPI/Comms	1	5	20.0
Research & Development	1	4	25.0
Service Development	1	9	11.1
TCS	2	8	25.0
<b>Total</b>	<b>67</b>	<b>615</b>	<b>10.9</b>

2.1 By comparison the 12 month rolling rate of staff turnover for London Trust as a whole was 13.1%.

**Image 4: Comparison of Staff Turnover**



2.2 Our turnover rate is almost identical to last year.

**Table 3: Turnover Data by Discipline April 2010 – March 2011**

Staff Groups	No. of Leavers	Total No. of Staff Employed	Turnover %
Clinical	47	406	11.6
Non Clinical	20	209	9.6



### 3 Ethnicity Data

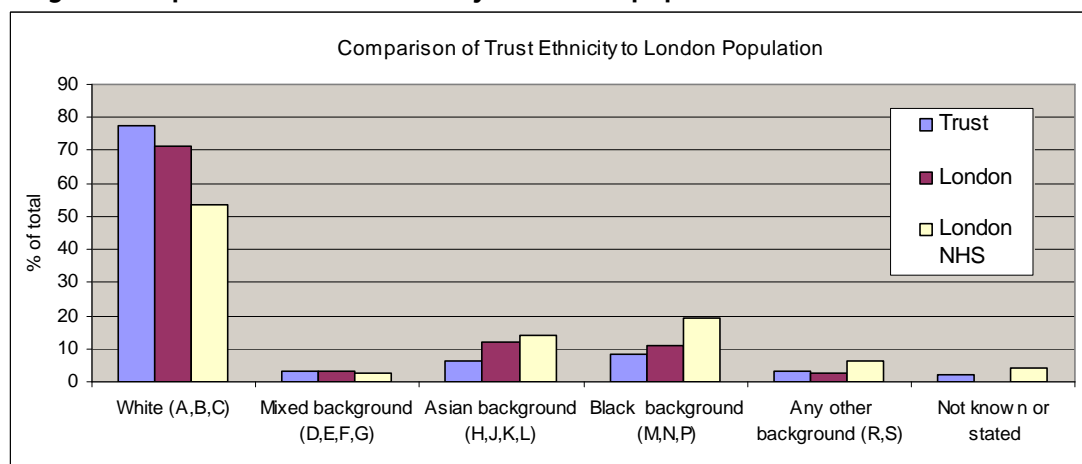
Table 4: Ethnic breakdown of staff in post 31 March 2011

Ethnic Code	Ethnic Description	Band 1-3	Band 4-5	Band 6-7	Band 8	Band 9	Medical	NEDs	Teacher	Total
A	White – British	6	55	71	124	10	27	5	3	301
B	White - Irish	2	4	1	5	-	4	-	1	17
C	Any other White background	1	21	32	35	-	17	-	-	106
D	White & Black Caribbean	1	1	4	-	-	-	-	-	6
E	White & Black African	-	-	2	1	-	-	-	-	3
F	White and Asian	-	-	2	-	-	-	-	-	2
G	Any other Mixed background	-	1	4	1	-	-	-	-	6
H	Asian - Indian	1	5	5	4	-	1	-	-	16
J	Asian - Pakistani	-	-	3	-	-	3	1	-	7
K	Asian - Bangladeshi	-	-	1	1	-	-	-	-	2
L	Any other Asian background	1	2	2	3	-	1	-	-	9
M	Black - Caribbean	-	10	5	8	-	-	-	-	23
N	Black -African	4	7	7	3	-	-	-	-	21
P	Any other Black background	-	1	-	-	-	-	-	-	1
R	Chinese	-	-	3	1	-	1	-	-	5
S	Any other Ethnic group	3	2	2	4	-	1	-	-	12
U	Not known	1	1	2	2	-	-	-	-	6
Z	Not Stated	1	2	-	-	-	2	-	-	5
	<b>Total</b>	<b>21</b>	<b>112</b>	<b>146</b>	<b>192</b>	<b>10</b>	<b>27</b>	<b>6</b>	<b>4</b>	<b>548</b>

**Table 5: Ethnicity of staff in post 31 March 2010 shown in comparison to ethnicity of London (Census 2001)**

Ethnic Code	Ethnic Description	Trust %	London %	NHS in London %
A	White - British	54.9	59.8	42.2
B	White - Irish	3.1	3.1	3.1
C	Any other White background	19.3	8.3	8.4
D	White & Black Caribbean	1.1	1	0.6
E	White & Black African	0.5	0.5	0.5
F	White and Asian	0.4	0.8	0.5
G	Any other Mixed background	1.1	0.9	0.9
H	Asian - Indian	2.9	6.1	6.7
J	Asian - Pakistani	1.3	2	1.2
K	Asian - Bangladeshi	0.4	2.1	1.0
L	Any other Asian background	1.6	1.9	5.3
M	Black - Caribbean	4.2	4.8	5.7
N	Black -African	3.8	5.3	11.3
P	Any other Black background	0.2	0.8	2.3
R	Chinese	0.9	1.1	1.3
S	Any other Ethnic group	2.2	1.6	4.8
Z	Not Stated	1.1	0	4
	Not Known	0.9	0	0
	<b>Total</b>	<b>100.0</b>	<b>100</b>	<b>100</b>

**Image 5: Comparison of Trust ethnicity to London population**





**Table 6: Ethnicity of leavers April 2010 – March 2011**

<b>Ethnic Code</b>	<b>Ethnic Description</b>	<b>Number of leavers</b>	<b>Total employed over period</b>	<b>Leavers as % of total employed</b>
A	White - British	39	340	11.5
B	White - Irish	1	18	5.6
C	Any other White background	14	120	11.7
D	White & Black Caribbean	0	6	0.0
E	White & Black African	0	3	0.0
F	White and Asian	1	3	33.3
G	Any other Mixed background	1	7	14.3
H	Asian - Indian	2	18	11.1
J	Asian - Pakistani	1	8	12.5
K	Asian - Bangladeshi	1	3	33.3
L	Any other Asian background	1	10	10.0
M	Black - Caribbean	1	24	4.2
N	Black -African	2	23	8.7
P	Any other Black background	0	1	0.0
R	Chinese	0	5	0.0
S	Any other Ethnic group	1	13	7.7
Z	Not stated	2	8	25.0
	Undefined	0	5	0.0
	<b>Total</b>	<b>67</b>	<b>615</b>	<b>10.9</b>

**Table 7: Ethnic origin of staff involved in grievance of disciplinary procedures April 2010 – March 2011**

<b>Procedure</b>	<b>Number of Occurrences</b>	<b>Ethnic Origin of staff</b>
Disciplinarys or Grievances	2	1 x L (Any other Asian background) 1 x A (White – British)

## 4 Absence Data

**Table 8: Absence (sickness) statistics April 2010 – March 2011**

Department	No. of Staff in post 31 <sup>st</sup> March	No. of Staff off sick	No. of days lost to sickness	% Sickness
Adolescent	58	18	179	0.8
Adult	78	32	297	1.0
Chair and Non-Executive Directors	6	0	0	0.0
Chief Executive Office	6	1	12	0.5
Child and Family	216	85	1097	1.4
Clinical Governance	3	0	0	0.0
Corp. Gov. & Facilities	26	19	381	4.0
Day Unit	17	12	124	2.0
DET	29	25	147	1.4
Finance	10	7	34	0.9
Human Resources	11	9	82	2.0
ICT	10	7	81	2.2
Library	12	8	39	0.9
MFAS	16	8	8	0.1
Portman	29	14	420	4.0
PPI/Comms	4	3	5	0.3
Research & Development	3	1	6	0.5
Service Development	8	6	39	1.3
TCS	6	4	57	2.6
<b>Total</b>	<b>548</b>	<b>259</b>	<b>3008</b>	<b>1.5</b>

4.1 Our sickness rate continues to be low compared with other NHS organizations. For example, the sickness rate across the whole of London in March 2011 was approximately 3.5%.

**Table 9: Clinical and Non-Clinical Absence April 2010 – March 2011**

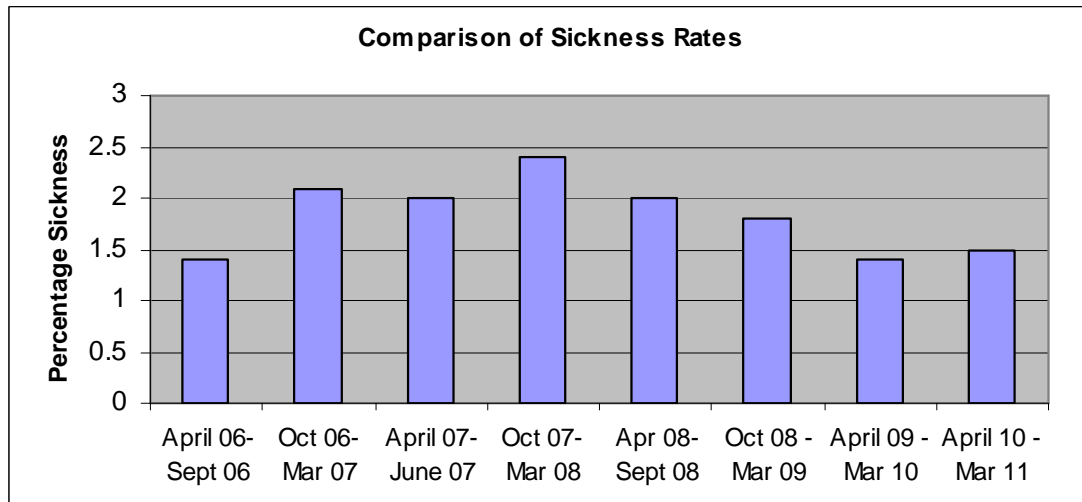
Staff	No. of staff in group 31 <sup>st</sup> March	Total days lost to sickness	% sickness
Clinical Staff	359	1,395	1.1
Non-Clinical Staff	189	1,613	2.3

4.2 Trust total sickness percentage for period is 1.5%<sup>1</sup>

4.3 In the Annual Plan we also now report absence in the FMA format. By this weighted calculation we have 3.48 days sickness absence per FTE employed. By comparison, for NHS organisations as a whole the range stretches from 1.2 to 17 with an average of 9.6 days.

<sup>1</sup> Calculation = days lost / (365 days x number of staff)

**Image 6: Comparison of sickness rates**



- 4.4 Our sickness rate continues to be well below the NHS average. Figures for December 2009 published by the Information Centre showed the average for the NHS in London was 3.9%, whilst across the country the average for Mental Health Trusts was 5.55%.

## 5 Age Profile of Trust

**Table 10: Age profile of Trust staff by grade as at 31<sup>st</sup> March 2011**

Age Group	Band 1-3	Band 4-5	Band 6-7	Band 8	Band 9	Medical	NED	Teacher	Total
<20	-	-	-	-	-	-	-	-	0
20-29	2	24	9	1	-	1	-	-	37
30-39	5	36	64	19	-	29	-	3	156
40-49	5	26	41	53	1	13	1	1	141
50-59	5	19	26	79	8	7	2	-	146
60+	4	7	6	40	1	7	3	-	68
<b>Total</b>	<b>21</b>	<b>112</b>	<b>146</b>	<b>192</b>	<b>10</b>	<b>57</b>	<b>6</b>	<b>4</b>	<b>548</b>

5.1 The Trust has a balanced workforce profile across all age groups. The majority of our workforce is within the age group of 30 -39 (156) as at 31<sup>st</sup> March 2011 out of the total of 548 across all age ranges. By comparison on 31<sup>st</sup> March 2010 the majority of the workforce was in the 40- 49 age group, 147 out of the total 527.

**Table 11: Length of service of staff by band and discipline as at 31<sup>st</sup> March 2011<sup>2</sup>**

Staff	Band 1-3	Band 4-5	Band 6-7	Band 8	Band 9	Medical	Teacher
Clinical	-	1.6	2.4	7.7	14.9	4.5	-
Non-Clinical	8.1	6.6	7.9	8.9	12.8	-	1.3
<b>Total</b>	<b>8.1</b>	<b>5.8</b>	<b>4.0</b>	<b>7.8</b>	<b>13.9</b>	<b>4.5</b>	<b>1.3</b>

<sup>2</sup> Average length of service for Trust is 6.2 years

## 6 Recruitment Data

**Table 12: Recruitment: Equal Opportunities Information for Non-Clinical Posts April 2010 – March 2011**

		Number of posts: 23		
		Applications Received	Shortlisted	Appointed
Gender	Male	755	65	8
	Female	1099	117	10
	Undisclosed	2	0	0
Age	16 – 19	16	2	0
	20 – 29	866	85	8
	30 – 39	512	49	7
	40 – 49	309	33	2
	50 – 59	141	11	0
	60 +	12	2	1
	Undisclosed	0	0	0
Ethnicity	A	386	52	7
	B	21	2	0
	C	169	13	3
	D	14	3	0
	E	11	1	1
	F	8	0	0
	G	36	6	1
	H	260	25	0
	J	89	9	0
	K	72	6	0
	L	87	8	0
	M	122	11	1
	N	434	35	3
	P	33	4	1
	R	14	0	0
	S	57	2	1
	Undisclosed	43	5	0
Disability	Yes	59	6	0
	Not	1785	175	18
	Undisclosed	12	1	0
<b>Total</b>		<b>1856</b>	<b>182</b>	<b>18</b>

**Table 13: Recruitment: Equal Opportunities Information for Clinical Posts April 2010 – March 2011**

Number of posts: 23				
		Applications Received	Shortlisted	Appointed
Gender	Male	493	59	17
	Female	2351	227	58
	Undisclosed	1	0	0
Age	16 – 19	5	0	0
	20 – 29	1811	63	10
	30 – 39	634	112	32
	40 – 49	295	71	23
	50 – 59	95	38	9
	60 +	4	2	1
	Undisclosed	1	0	0
Ethnicity	A	1243	126	32
	B	128	10	2
	C	676	86	23
	D	20	3	1
	E	13	3	1
	F	21	3	0
	G	66	7	2
	H	179	6	3
	J	41	0	0
	K	30	3	0
	L	39	3	0
	M	76	9	0
	N	129	9	3
	P	22	3	1
	R	45	4	1
	S	84	6	2
	Undisclosed	33	5	4
Disability	Yes	131	8	1
	Not	2691	275	73
	Undisclosed	23	3	1
<b>Total</b>		<b>2845</b>	<b>286</b>	<b>75</b>