

# Board of Directors

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

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

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

**Board of Directors**  
2.30pm – 4.30pm, Tuesday 29<sup>th</sup> November 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 noting*

*p.8*

**7. Finance & Performance**

*Mr Simon Young, Director of Finance*

*(Report attached)  
For discussion*

*p.14*

**8. Clinical Quality, Safety, & Governance Committee  
Quarter Two Report**

*Dr Rob Senior, Medical Director & Committee Chair*

*(Report attached)  
For discussion*

*p.22*

**9. Charitable Fund Annual Report & Accounts**

*Ms Angela Greatley, Trust Chair & Committee Chair*

*(Report attached)  
For approval*

*p.29*

***Corporate Governance***

**10. Trust Policies**

**a. Consent Policy**

*Dr Rob Senior, Medical Director*

*(Policy attached)  
For approval*

*p.46*

**b. Appraisal for Medical Revalidation**

*Dr Jessica Yakeley, Associate Medical Director*

*(Policy attached)  
For approval*

*p.74*

**11. Committee Reports & Minutes**

*For noting*

## Quality & Development

- |  |   |              |
|--|---|--------------|
| <b>12. Annual Plan</b><br><i>Mr Simon Young, Director of Finance</i>                                       | <i>(Report attached)</i><br><i>For discussion</i> | <i>p.120</i> |
| <b>13. Service Line Report – Camden CAMHS</b><br><i>Dr Andy Wiener, Associate Clinical Director, CAMHS</i> | <i>(Report attached)</i><br><i>For discussion</i> | <i>p.124</i> |
| <b>14. Education &amp; Training Report</b><br><i>Ms Trudy Klauber, Dean</i>                                | <i>(Report attached)</i><br><i>For discussion</i> | <i>p.134</i> |

## Conclusion

### 15. Any other business

### 16. Notice of future meetings

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 (TBC)  
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 from 2012 onwards will be from 2pm until 5pm, 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 – 4pm, Tuesday 25<sup>th</sup> October 2011

Present:			
Ms Angela Greatley Trust Chair	Mr Martin Bostock Snr Independent Director	Ms Lis Jones Nurse Director	Ms Trudy Klauber Dean
Ms Louise Lyon Trust Director	Ms Joyce Moseley Non-Executive Director	Dr Matthew Patrick Chief Executive	Dr Rob Senior Medical Director
Mr Richard Strang Deputy Trust Chair	Mr Simon Young Director of Finance		
In Attendance:			
Miss Louise Carney Trust Secretary	Dr Rita Harris CAMHS Director (participating)	Ms Mary Burd Governor – Public: Camden (observing)	
Apologies:			
Mr Altaf Kara Non-Executive Director	Dr Ian McPherson Non-Executive Director		

## Actions

AP	Item	Action to be taken	Resp	By
1	4	Ms Lyon to update Board of Directors on under-performance	LL	Nov 11
2	7	Mr Young to produce quarterly F&P reports with more detail	SY	Jan 12
3	7	Mr Young to investigate whether the Trust is receiving cash for Big White Wall	SY	Nov 11
4	7	Mr Young to speak to Tavistock Consulting about invoicing processes	SY	Nov 11
5	7	Mr Young to report on Named Patient Agreements and Haringey Service	SY	Jan 12
6	8b	Ms Lyon to add a comment on the development of the link between the AC and CQSG	LL	Jan 12
7	9	Annual Plan to be moved into separate section	LC	Immed
8	9	Management Committee to discuss reporting on changes implemented as part of Productivity Programme	MP	Nov 11
9	9	Board paper cover sheets to includes names, as well as job titles	LC	Immed
10	9	Ms Thomas to produce short explanation of staffing grades at the Trust	ST	Jan 11
11	10	Mr Strang and Mr Young to discuss internal controls around the Scheme	SY/RSt	Jan 11
12	11	Miss Carney to circulate CEO objectives electronically	LC	Immed

### 1. Trust Chair's Opening Remarks

Ms Greatley welcomed everyone to the meeting, including Dr Rita Harris, who was participating in the Board meeting, and Ms Mary Burd, a Public Governor for Camden, who was observing.

### 2. Apologies for Absence

As above.

### 3. Minutes of the Previous Meeting

Approved.

Miss Carney explained that the minutes were lengthier this time, and welcomed comments on this.

## 4. Matters Arising

Miss Carney explained that all actions were detailed on page seven, including actions from the September meeting and actions carried forward from previous meetings.

### ***Item 7. Finance and Performance Report***

Dr Patrick noted that the Management Committee had requested separate action plans for all areas of underperformance in relation to contract activity and income. Mr Young explained that this would be reported to the Board of Directors via Finance and Performance Reports. **Ms Lyon to update Board of Directors in November.**

AP1

### ***Outstanding Action 4: Ms Klauber to review policy on chasing student debt***

Ms Klauber assured the Board that this was being taken seriously, and it was agreed to remove this from this list.

### ***Outstanding Action 7: Responsible office to produce annual report of activity***

Dr Senior noted his obligation to report to the Board but explained that the conditions around revalidation of doctors has not yet come into full force and it did not make sense to report before them.

### ***Outstanding Action 8: Ms Lyon to investigate drop in court report income***

The downturn in the Portman Clinic were related to disputes over pricing and funding for legal aid certificates, which has made solicitors hesitant to commission work.

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

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

Ms Greatley and Mr Strang had attended a King's Fund meeting on governance. Ms Greatley had attended a further FTN meeting on governance.

## 6. Chief Executive's Report

Dr Patrick noted that the Health & Social Care Bill was at Committee Stage. The public health debate seemed most focused on the notion of integrated care and how this can be delivered in a system divided by organisational boundaries. A meeting of the North Central Sector had discussed how commissioners could align incentives and reduce perverse incentives in the system to allow greater integration of care.

Dr Patrick suggested that the health sector will only be able to meet its financial challenges if it can find productivity solutions that span organisational boundaries and that are on a system-wide scale.

The Operating Framework is due for publication in November. The Trust, along with a number of other organisations, has been trying to get key messages

related to the mental health strategy included in the Framework.

Dr Patrick noted the good discussions at the AGM, at which Hugo Manassei from Participal had spoken.

Ms Jones discussed the CQC report on care for the elderly. Ms Jones noted poor quality of training, and access problems. Ms Jones noted that the Trust has a role to play in developing training and providing support for nurses, and noted in particular the work of Marcus Evans and Sue Hickman in this, but noted that sustaining this work is difficult in the challenging healthcare environment.

Ms Jones had attended a workshop run by BPS on IAPT, and was a member of a small working group looking into long-term conditions.

Ms Lyon noted, in relation to the IAPT programme, that Heather Wood, the Trust's lead on Personality Disorders, had been put forward to the Severe and Enduring Mental Illnesses group, and Brian Rock from the Trust's City & Hackney Service was involved in the Medically Unexplained Symptoms group.

## 7. Finance & Performance Report

Mr Young noted that a supplementary statement of financial position had been circulated to the Board, and tabled an explanatory table on actual performance.

Mr Young noted that the surplus at Month Six was £68k, and he expected to reach the target of £150k by year-end. Mr Young went into detail on the explanatory document he had tabled. The middle table – "First six months" – noted that the Plan, as submitted to Monitor was to have a surplus of £27k by Month Six, the revised budget was £160k, and the actual is £68k. The differences in these figures related to how the Trust treats its contingency reserve, noting that a small amount of the reserve has thus far been used, although most of it is still in reserve. Had the Trust not used any of its reserve, its surplus would be £160k (as per the revised budget). The Trust does still have £286k in reserve, and expects this to be sufficient to meet the target of £150k at year end. Mr Strang suggested that future reports distinguish between performance against the revised budget and performance against Plan. **Mr Young to produce more detailed report on quarterly basis.**

AP2

Mr Young noted that there were number of areas of risk in the forecast, and each of these will be subject to a thorough review with the budget holders.

Mr Young explained that variances on the statement of financial position are largely due to timing issues.

Capital expenditure to date was presented. Mr Young noted the new boiler and Seminar Room renovation, and highlighted that there was further IT work to be undertaken in the next two months.

Mr Young addressed the shortfall in CAMHS departmental consultancy, referred to in Paragraph 4.2, noting that offsetting that was the fact that training income was ahead by a similar amount.

Mr Young noted that the cash position was satisfactory.

AP3 Mr Strang queried whether the Trust was receiving cash for the Big White Wall.  
**Mr Young to investigate.**

AP4 Mr Strang made reference to a report on Tavistock Consulting being presented to Part Two of the Board of Directors this month, and noted that income was reported as higher than in Mr Young's report. Mr Strang explained that he understood this was for work carried out in September that was invoiced in October. Mr Strang queried whether the Trust's processes for invoicing were rigorous enough. **Mr Young noted that the Trust does have systems for this, and would to speak to Tavistock Consulting about this issue.**

Mr Bostock noted that paragraph 3.1.1 explained that the Adult Department was currently over-performing by 42%, but the contract only allows for 2.5% to be paid, and asked for an explanation. Ms Lyon noted that both the Adult and Adolescent Departments were seeing more patients than the contracts allow for. Mr Bostock queried whether the Trust was giving away its services for free. Ms Lyon noted that plans were in place to reduce this and she expected to a reduction shortly, but also explained that the Trust needed a high number of patients to satisfy its training contract.

AP5 Mr Bostock noted that paragraph 3.1.3 noted what the shortfall would be without action, and queried whether the Trust would be taking action. Mr Young explained that action had already been taken some months ago, and this area was currently subject to a rigorous review. **Mr Young to report in more detail on this and Haringey in January.**

## 8. Quarterly Declarations

### **8a. Quarter Two Governance & Finance Declarations**

Approved.

Ms Lyon noted her satisfaction that "Registered GP Practice" was up to 100%.

### **8b. Quarterly Quality Declaration**

Ms Lyon highlighted that the Trust is expected to demonstrate how the Trust operates in relation to quality in the same way that applicant foundation trusts must.

Ms Lyon noted that the report was not exhaustive. The Board noted that it was a very helpful and interesting report.

Mr Strang noted that there was no reference to quality with regard to education and training. Ms Lyon explained that this was because it was dealt with separately, and the Trust had been reporting on the quality of its education and training since the early 1990s.

- AP6 Ms Lyon to add a comment about the development of the link between the Audit and Clinical, Quality, Safety & Governance Committees to next report.**

Dr Patrick queried how the Trust might add a layer outside of the system to check on quality. The Board noted the role of Governors on the CQSG Committee, Non-Executive Director links with clinical Departments, and Secret Shoppers, which were being introduced to the Trust. Ms Lyon noted the importance of people voicing any concerns they have.

Approved.

## 9. Board Paper Review

- AP7 Miss Carney to moved Annual Plan into its own section.** Mr Strang referred to a recent Directors' Conference, noting that he had felt very involved in the planning process, and suggested this be scheduled into the Annual Plan timetable.

Ms Greatley noted that the Board of Directors would receive exception reports on all items.

- AP8 Dr Harris noted that the timetable of Service Line Reports may need amending following service redesign. Management Committee to discuss reporting on changes implemented.**

- AP9 Board paper cover sheets to include names, as well as Job Titles.**

- AP10 Ms Thomas to produce short explanation of staffing grades at the Trust.**

Approved.

## 10. Scheme of Delegation of Powers

Mr Strang queried whether the Internal Auditors review the Scheme. Mr Young noted that they review whether the Trust is following the Scheme. **Mr Strang**

- AP11 and Mr Young to discuss internal controls.**

Approved.

## 11. Objectives – Chief Executive

Ms Greatley explained that the objectives were written by the Trust Chair and Chief Executive and circulated to the Board of Directors, and comments had been taken on board.

- AP12 Approved. Miss Carney to circulate electronically.**

## 12. National Training Contract Update

Ms Klauber reported that the Trust had received a letter from Helen Jameson at NHS London confirming a two and a half year extension of the training contract

from October 2011. The Board congratulated Ms Klauber and Mr Young on securing this extension. Ms Klauber and Mr Young would be attending a meeting to discuss the Trust's hopes for a level funding agreement. Ms Klauber informed the Board that the Trust may well face a reduction in its National Training Contract.

Ms Klauber noted that NHS London have a separate annual Learning Development Agreement, split between four contracts, the national training contract, child psychotherapy, psychiatry, and CPPD. This Agreement will end after 2013. This will be a real loss to the Trust.

Ms Klauber noted that the Commissioner for Medical Education England has been appointed the Health Education England Chief Executive Designate.

### **13. Any Other Business**

None.

### **14. Notice of Future Meetings**

Noted.

## Board Actions Part 1

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date
1	Oct-11	9. Board Paper Review	Annual Plan to be moved into separate section	Louise Carney	Oct-11
2	Oct-11	9. Board Paper Review	Board paper cover sheets to include names as well as job titles	Louise Carney	Oct-11
3	Oct-11	11. Objectives - Chief Executive	Miss Carney to circulate CEO objectives electronically	Louise Carney	Oct-11
4	Oct-11	4. Matters Arising	Ms Lyon to update Board of Directors on under-performance	Louise Lyon	Nov-11
5	Oct-11	7. Finance & Performance Report	Mr Young to investigate whether the Trust is receiving cash for Big White Wall	Simon Young	Nov-11
6	Oct-11	7. Finance & Performance Report	Mr Young to speka to Tavistock Consulting about invoicing processes	Simon Young	Nov-11
7	Oct-11	9. Board Paper Review	Management Committee to discuss reporting on changes implemented as part of Productivity Programme	Matthew Patrick	Nov-11
8	Oct-11	7. Finance & Performance Report	Mr Young to produce quarterly F&P reports with more detail	Simon Young	Jan-12
9	Oct-11	7. Finance & Performance Report	Mr Young to report on Named Patient Agreements and Haringey Service	Simon Young	Jan-12
10	Oct-11	8b. Quarterly Quality Declaration	Ms Lyon to add a comment on the development of the link between the Audit and CQSG Committees	Louise Lyon	Jan-12
11	Oct-11	9. Board Paper Review	Ms Thomas to produce short explanation of staffing grades at the Trust	Susan Thomas	Jan-12
12	Oct-11	10. Scheme of Delegation of Powers	Mr Strang and Mr Young to discuss internal controls around the Scheme	Simon Young / Richard Strang	Jan-12
13	Mar-11	8. Health & Social Care Bill Update: Governance in NHS Foundation Trusts	Miss Carney to investigate insurance policies for Directors	Louise Carney	Apr-12
14	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

Red denotes actions overdue  
Amber denotes actions due this month

## Board Actions Part 1

Progress Update / Comment
Completed
Completed
Completed
Scheduled
Scheduled
Waiting for final version of Health & Social Care Bill
I think we will need advice from the SoS. We can't get guidance until after Royal Assent

## Board of Directors : November 2011

**Item :** 6

**Title :** Chief Executive's Report

### **Summary :**

This paper covers the following items:

1. Introduction
2. Westminster Family Services
3. Circle and Hinchingsbrooke Hospital
4. 2012/13 Operating Framework
5. Wednesday 30 November
6. Shadow NHS Commissioning Board
7. Corporate Manslaughter
8. And Finally...

**For :** Discussion

**From :** Dr Matthew Patrick, Chief Executive

## Chief Executive Report

### 1. Introduction

- 1.1 I would like to begin this report by marking the fact that this month is Trudy Klauber's last Board of Directors meeting.
- 1.2 Trudy has now held the role of Dean for more than seven and a half years. During that time her contribution to the organisation has been tremendous. Amongst many other achievements she has overseen significant growth in our training and education activity; has shaped and led the development of our CPD programmes; and more recently has been instrumental in our move towards e- and blended-learning.
- 1.3 Beyond this, however, Trudy has been a tremendously strong voice for training and education within the Trust, when clinical discourse can sometimes dominate. She has also been a real advocate for quality, for the articulation of what quality really means in the context of our work, and what it means to us as an organisation; highlighting the transformational potential of relational models of learning and the central importance of work discussion within all of our work.
- 1.4 I would like to say a personal thank you to Trudy, the two of us having worked together over many years. I would also like to say a heartfelt thank you on behalf of the Board of Directors and on behalf of the organisation as a whole.
- 1.5 As you know Trudy will be stepping down to a role more focused on clinical and training activity, but retaining some Trust-wide responsibilities including the chairing of the Equalities Committee and time devoted to the promotion of quality both in training and education, and in clinical services.

### 2. Westminster

- 2.1 The past month has seen our new family service centres in Westminster going live. The time period between agreement of contracts and go live was only three weeks, and the fact that an extension to this timeframe was not required is a real testament to all those involved. For the services to bed down properly will obviously take much longer.

2.2 I would, however, like to take the opportunity to welcome those staff who have joined the organisation as a part of our taking on this work. I know that colleagues are looking forward to learning from the expertise and experience that you will bring to the Trust.

### **3. Circle and Hinchingsbrooke**

3.1 This month has seen the signing of the contract for the first takeover of the management of an NHS hospital by an independent provider. Circle was chosen in November 2010 as the preferred bidder to run Hinchingsbrooke Hospital in Huntingdonshire, following a thirteen-month procurement process. It has taken a further year to conclude the contract, and from 1<sup>st</sup> February 2012 Circle will take over management of the hospital, which serves a population of 161,000 and has a debt of £40m.

3.2 Under the contract, Hinchingsbrooke will remain an NHS hospital, its buildings and assets will remain in the NHS, and its staff will continue to be employed by the NHS.

3.3 Circle is a 49.9% employee-owned social enterprise, forming the largest partnership of clinicians in Europe. Circle is co-owned and managed by the doctors, nurses and staff who work in their hospitals, treatment centres and clinics.

3.4 Although private sector firms already operate many units that treat NHS patients, such as hip replacement centre, Circle is the first non-state provider to manage a full range of NHS district general hospital services.

3.5 There are twenty other hospitals which have been named as unviable in their current form, and people will be watching Hinchingsbrooke with interest to see if it is a viable and appropriate solution for failing NHS organisations.

#### **4. 2012/13 Operating Framework**

- 4.1 On 24<sup>th</sup> November, the Department of Health will publish the NHS operating framework. The framework sets out key areas of priority for the coming year, and also the financial context including expected levels of efficiency and productivity. It is, therefore, a key document for all NHS organisations.
- 4.2 Over recent weeks and months a great deal of energy and activity has gone in to trying to ensure that some aspects of mental health policy and strategy are included. The importance of such inclusion is that it potentially provides something of a framework for implementation of the mental health strategy. As you know there is much in the mental health strategy that is supportive of our values and mission.
- 4.3 There is also a conference for NHS Chief Executives in 24<sup>th</sup> November. We will provide an update on the Operating Framework and the conference at the Board meeting.

#### **5. Wednesday 30 November**

- 5.1 Several unions have voted to take strike action on 30<sup>th</sup> November, in protest against the Government's plans to change public sector pensions. We are expecting a significant number of Trust staff to strike on this day. Schools will also be affected, resulting in some staff needing to look after their children. It is not yet known whether public transport will be affected.
- 5.2 The Trust is taking action to continue patient services and training courses on that day where possible, and to notify patients and students where this is not expected to be possible.
- 5.3 Action plans will also be in place to ensure the safety and security of patients, students, staff, visitors and premises on that day.

#### **6. Shadow NHS Commissioning Board**

- 6.1 The NHS Commissioning Board Authority went live on 31<sup>st</sup> October, in shadow form. The main focus of this authority will be to design a business model for the Commissioning Board, with patients and clinical leadership at the centre of this model. The Board will also plan and create the infrastructure for the new clinical commissioning groups (CCGs). It is expected that the Board will become fully operational on 1<sup>st</sup> April 2013.

6.2 The Board is chaired by Professor Malcolm Grant CBE. Sir David Nicholson is the Chief Executive and Bill McCarthy is the Managing Director. The Board will have overall responsibility for the £80bn NHS budget, the majority of which will be allocated to the CCGs. It will also be responsible for a range of broader public health issues.

6.3 As an independent body, the Commissioning Board will be able to determine its own structure and methods of working, whilst at the same time being accountable to the Secretary of State. The responsibilities of the NHS Commissioning Board will be:

- Supporting continuous improvements in the quality and outcomes of NHS-funded services
- Promoting and extending public and patient involvement and choice
- Ensuring a comprehensive system of GP consortia, supporting them and holding them to account, including working in partnership with local government and other organisations
- Directly commissioning certain services
- Allocating and accounting for NHS resources
- Promoting equality and reducing inequalities in access to healthcare, in co-operation with Public Health England

6.4 The main concern raised by commentators has been that the Board will not be seen as accountable to the public. As such it has been noted that there will be a great deal of pressure to show that the Board will not retain too much power or weigh down the commissioners with over-regulation.

## **7. Corporate Manslaughter**

7.1 On 1<sup>st</sup> September 2011, the Government brought into force section 2(1)(d) of the Corporate Manslaughter and Corporate Homicide Act 2007, extending the scope of the Act to include the deaths of detained mental health patients, prisoners in custody, detained asylum seekers and persons living in secure accommodation.

7.2 From that date, an NHS organisation (or private healthcare provider) can be convicted of a corporate manslaughter offence if the way in which its activities were managed or organised caused a person's

death and amounted to a gross breach of the duty of care owed to the deceased by virtue of that person being held in custody, detained in a mental health hospital, a detention centre or secure accommodation. The maximum penalty for such an offence is an unlimited fine.

7.3 The offence of corporate manslaughter is committed by an organisation if the way in which its activities are managed or organised:

- causes a person's death; *and*
- amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased.

7.4 On top of these requirements, the role of the organisation's senior management must be a "substantial element" of the breach of duty for an offence to have been committed.

7.5 Whilst we hope that our own areas of work will not invoke such legislation, it is important that the board is properly informed.

## 8. Any Finally...

8.1 Many of you will know that our Family Drug and Alcohol Court service was shortlisted for an award by the Royal College of Psychiatrists. I am delighted to say that they have won their category of Psychiatric Team of the Year. This represents a tremendous achievement and one that is richly deserved. The Family Drug and Alcohol Court comprises an innovative partnership between the NHS, the voluntary sector, family courts and local authorities. The outcomes delivered are excellent, and implementation of the service model actually saves local authorities money; a genuine expression of quality, innovation, productivity and prevention. Many congratulations.

Dr Matthew Patrick  
Chief Executive Officer  
November 2011

## Board of Directors : November 2011

**Item : 7**

**Title : Finance and Performance Report**

### **Summary:**

After seven months a surplus of £17k is reported (before restructuring costs). There are income shortfalls on Directorate Consultancy and "other", offset by under spends in Training and Central Functions.

The Trust aims to achieve the budgeted £150k surplus for the year (before restructuring costs). Actions are being taken to deliver this result.

An update on service line reporting is provided separately.

The cash balance at 31 October was £2,316k which is above Plan. Cash will reduce – as planned – due to the payment of redundancy and early retirement costs, but the balance is projected to remain satisfactory.

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

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

- Finance

**For : Information**

**From : Simon Young, Director of Finance**

## Finance & Performance Report

### 1. **External Assessments**

#### 1.1 **Monitor**

1.1.1 Monitor is currently reviewing our quarter 2 return. It is expected that the Trust will retain its green Governance Rating and Financial Risk Rating of 3, in line with Plan.

1.1.2 It is currently expected that both ratings will remain unchanged in subsequent quarters.

### 2. **Finance**

#### 2.1 **Income and Expenditure 2011/12**

2.1.1 After seven months, the Trust is reporting a surplus of £17k. Due to the budgeted reserves being profiled into the final quarter the expenditure budget is understated at Month 7. Therefore Appendices A&B indicates a target surplus of £265k which will reduce as the budgeted reserves are released.

2.1.2 Income is £344k below budget, and expenditure £97k below budget. Some of these variances are due to timing, but some significant variances are expected to continue in the remainder of the year: see 2.1.5 below regarding the full year forecast.

2.1.3 Consultancy income is £122k under budget, with departmental consultancy under by £160k, offset by Tavistock Consulting over target by £38k. Other income is £183k below target mainly due to under achieved productivity schemes in Adult (£104k) and Adolescent (£51k). Clinical Income is £59k below target: this includes the Day Unit being £12k above Plan, Big White Wall £50k below and PHP income £45k below Plan. These main income sources and their variances are discussed in sections 3, 4 and 5 below.

2.1.4 The cumulative expenditure underspend of £97k includes lower child psychotherapy trainee numbers and the lower than planned staffing in GIDS. These have been offset by an overspend of £189k in CAMHS, of which £113k relates to the vacancy savings factor which was budgeted (in addition to the savings on specific posts) but has not been achieved. Tavistock Consulting is also over spent by £73k due to associate fees.

2.1.5 The forecasts for the year have been fully reviewed. Some of the adverse variances – notably the areas of income shortfall – are now expected to continue in the remaining months. These forecasts are shown in the Full Year columns of Appendix B. In order to achieve the planned £150k surplus, we have to develop action plans to

improve the forecasts by £445k. These actions are being agreed by management and are likely to be in the following areas:

- Clinical contract income (cost and volume);
- Other clinical and consultancy income;
- Vacancy savings and temporary staff.

An update will be given at the meeting.

## 2.2 Cash Flow (Appendix C)

2.2.1 The actual cash balance at 31 October was £2,316k, £915k above the revised Plan of £1,401k. The main reason for the deviation from Plan is that payments to suppliers were lower than expected over the summer and also redundancy payments have not yet all been paid. The year-to-date receipts and payments are summarised in the table below.

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

	Cash Flow year-to-date		
	Actual £000	Plan £000	Variance £000
Opening cash balance	4,712	4,712	0
Operational income received			
NHS (excl SHA)	5,984	5,573	411
General debtors (incl LAs)	3,493	3,803	(310)
SHA for Training	6,462	6,437	25
Students and sponsors	1,208	1,550	(342)
Other	301	126	175
	<u>17,448</u>	<u>17,489</u>	<u>(41)</u>
Operational expenditure payments			
Salaries (net)	(8,889)	(9,418)	529
Tax, NI and Pension	(6,377)	(6,262)	(115)
Suppliers	(4,162)	(4,562)	400
	<u>(19,428)</u>	<u>(20,242)</u>	<u>814</u>
Capital Expenditure	(228)	(320)	92
Interest Income	5	6	(1)
Payments from provisions	0	(51)	51
PDC Dividend Payments	(193)	(193)	0
Closing cash balance	<u>2,316</u>	<u>1,401</u>	<u>915</u>

## 2.3 Training

2.3.1 Training income is £46k above budget in total; the majority of the October variance relates to a budget movement of £388k for bursary income which was not previously included. Other income lines are close to budget. There is a shortfall on Child Psychotherapy Trainees

but this is due to slightly lower numbers, and is offset by lower costs. Conference income is £63k above budget, thanks to three successful recent additional events.

2.3.2 Income from university partners is expected to be close to budget. At this stage, fee income from students and sponsors is expected to be slightly short of budget; this is covered in detail in the Education and Training report.

#### 2.4 **Better Payment Practice Code**

2.4.1 The Trust has a target of 95% of invoices to be paid within the terms. Up to 31 October, we achieved 93% for all invoices processed cumulatively, or 2,740 out of 2,959 within the terms. This is slightly higher than in previous years (2010/11 full year 90%; 2009/10 89%).

### 3. **Patient Services**

#### 3.1 **Activity and Income**

3.1.1 Total contracted income for the year is in line with budget. After seven months, there is a small adverse variance on cost and volume activity of £10k. However, this includes an under performance of £51k with Haringey. The Camden Adult service is currently over performing by 40% but the contract only allows for 2.5% to be paid. Part of the budgeted income for the year is dependent on meeting our CQUIN<sup>†</sup> targets agreed with commissioners and achievement is reviewed on a quarterly basis.

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

3.1.3 The income for named patient agreements (NPAs) was £118k after seven months which is £17k below budget, with £10k shortfalls in Adult and Portman. The forecast for the year without action is a shortfall of £40k.

3.1.4 Court report income is budgeted at £285k for the year, of which £210k is for the Portman. After seven months, however, we are £69k below budget overall; the Portman is £52k below target and CAMHS are £13k below. Forecast for the year is £100k below budget.

3.1.5 Monroe income is above budget by £9k after 7 months. The annual budget was reduced from £780k to £504k this year, with a corresponding reduction in staffing which has now taken place.

3.1.6 Day Unit is £12k above target year-to-date. There are currently 11 pupils this term, against a budgeted target of 12.5; but this fall is less than expected.

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

3.1.7 Project income is £57k above budget year-to-date, including some one-off items. The forecast is £50k above budget for the year.

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	5,555	5,521	-0.6%		-33	Small under-achievement due to CQUIN element; plus old year credit notes, offset by £55k b fwd
Cost and vol variances	5	-10			-19	Haringey £45k under offset by other over performances.
NPAs	134	118	-12.4%	-29	-40	
Projects and other	1,106	1,135		-	50	Income matched to costs, so variance is largely offset.
Day Unit	616	627	1.9%	20	0	
Monroe	274	283	3.2%	16	6	
FDAC 2nd phase	238	243	2.1%	8	0	Income matched to costs, so variance is largely offset.
Court report	166	98	-41.3%	-118	-100	
<b>Total</b>	<b>8,094</b>	<b>8,014</b>		<b>-103</b>	<b>-136</b>	

#### 4. **Consultancy**

4.1 Tavistock Consulting income was £389k up to October, compared to the budget of £352k. Our forecast for the year assumes a shortfall in November, followed by the budget achieved for the remaining four months. Expenditure is currently £73k above budget, but this overspend is not expected to continue.

4.2 Departmental consultancy is £160k below budget after seven months. The majority of the shortfall is within CAMHS which is currently £127k below target, partly offset by additional income from conferences and other training activities.

Simon Young  
Director of Finance  
22 November 2011

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

APPENDIX A

	Oct-11			CUMULATIVE			FULL YEAR 2011-12		
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST OUTTURN £000	BUDGET VARIANCE £000
<b>INCOME</b>									
1 CLINICAL	1,163	1,142	(21)	8,094	8,014	(80)	13,899	13,818	(81)
2 TRAINING	1,643	1,255	(388)	10,447	10,492	46	16,830	16,831	1
3 CONSULTANCY	126	91	(35)	793	670	(122)	1,361	1,093	(267)
4 RESEARCH	14	22	8	98	93	(4)	160	160	0
5 OTHER	71	32	(39)	480	297	(183)	837	556	(281)
<b>TOTAL INCOME</b>	<b>3,018</b>	<b>2,542</b>	<b>(476)</b>	<b>19,911</b>	<b>19,567</b>	<b>(344)</b>	<b>33,086</b>	<b>32,458</b>	<b>(628)</b>
<b>OPERATING EXPENDITURE (EXCL. DEPRECIATION)</b>									
6 CLINICAL DIRECTORATES	1,450	1,415	34	10,227	10,260	(33)	17,378	17,460	(81)
7 OTHER TRAINING COSTS	793	479	313	4,721	4,637	84	7,251	7,294	(43)
8 OTHER CONSULTANCY COSTS	49	73	(24)	356	434	(78)	599	677	(78)
9 CENTRAL FUNCTIONS	548	551	(2)	3,826	3,691	135	6,553	6,417	135
10 TOTAL RESERVES	0	(0)	0	0	0	0	271	(445)	716
<b>TOTAL EXPENDITURE</b>	<b>2,839</b>	<b>2,518</b>	<b>322</b>	<b>19,130</b>	<b>19,021</b>	<b>109</b>	<b>32,052</b>	<b>31,402</b>	<b>650</b>
<b>EBITDA</b>	<b>178</b>	<b>24</b>	<b>(154)</b>	<b>780</b>	<b>546</b>	<b>(235)</b>	<b>1,034</b>	<b>1,056</b>	<b>21</b>
<b>ADD:-</b>									
12 BANK INTEREST RECEIVED	1	1	0	6	5	1	11	10	(1)
<b>LESS:-</b>									
11 DEPRECIATION & AMORTISATION	42	44	(2)	297	309	(12)	509	529	(20)
13 FINANCE COSTS	0	0	0	0	0	0	0	0	0
14 DIVIDEND	32	32	(0)	225	225	(0)	386	386	0
<b>SURPLUS BEFORE RESTRUCTURING COSTS</b>	<b>105</b>	<b>(51)</b>	<b>(155)</b>	<b>265</b>	<b>17</b>	<b>(248)</b>	<b>150</b>	<b>150</b>	<b>0</b>
15 RESTRUCTURING COSTS	0	0	0	1,000	993	7	1,000	993	7
<b>SURPLUS/(DEFICIT) AFTER RESTRUCTURING</b>	<b>105</b>	<b>(51)</b>	<b>(155)</b>	<b>(735)</b>	<b>(977)</b>	<b>(241)</b>	<b>(850)</b>	<b>(843)</b>	<b>7</b>
<b>EBITDA AS % OF INCOME</b>	<b>5.9%</b>	<b>1.0%</b>		<b>3.9%</b>	<b>2.8%</b>		<b>3.1%</b>	<b>3.3%</b>	

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

**APPENDIX B**

	Oct-11			CUMULATIVE			FULL YEAR 2011-12		
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST £000'S	REVISED BUDGET VARIANCE £000
<b>INCOME</b>									
NHS LONDON TRAINING CONTRACT	605	605	0	4,232	4,221	(11)	7,254	7,244	(11)
TRAINING FEES & OTHER ACA INC	753	416	(337)	4,384	4,486	102	6,314	6,371	57
POSTGRADUATE MED & DENT'L EDUC	12	9	(2)	82	56	(26)	141	115	(26)
JUNIOR MEDICAL STAFF	81	93	12	564	627	63	966	1,029	63
CHILD PSYCHOTHERAPY TRAINEES	193	132	(61)	1,185	1,102	(83)	2,155	2,072	(83)
R&D	14	22	8	98	93	(4)	160	160	0
CLINICAL INCOME	962	928	(34)	6,746	6,659	(87)	11,554	11,512	(42)
DAY UNIT	88	72	(16)	616	627	12	1,055	1,055	0
MONROE	48	50	2	274	283	9	504	510	6
FDAC	42	61	19	292	347	55	500	555	55
TCS INCOME	57	51	(6)	352	389	38	613	613	0
DEPT CONSULTANCY INCOME	69	40	(29)	441	281	(160)	747	480	(267)
COURT REPORT INCOME	24	31	7	166	98	(69)	285	185	(100)
EXCELLENCE AWARDS	10	10	0	68	68	0	116	116	0
OTHER INCOME	62	23	(39)	413	230	(183)	721	440	(281)
<b>TOTAL INCOME</b>	<b>3,018</b>	<b>2,542</b>	<b>(476)</b>	<b>19,911</b>	<b>19,567</b>	<b>(344)</b>	<b>33,086</b>	<b>32,458</b>	<b>(628)</b>
<b>EXPENDITURE</b>									
EDUCATION & TRAINING	578	309	268	3,382	3,445	(63)	4,832	5,022	(190)
PORTMAN CLINIC	115	118	(3)	796	780	16	1,366	1,366	0
ADULT DEPT	250	252	(2)	1,818	1,783	36	3,060	3,024	36
MEDNET	21	19	2	144	125	18	246	228	18
ADOLESCENT DEPT	147	117	30	995	1,007	(12)	1,729	1,696	34
C & F CENTRAL	679	691	(12)	4,807	4,996	(189)	8,128	8,377	(249)
MONROE & FDAC	70	83	(13)	554	601	(46)	905	952	(46)
DAY UNIT	63	58	4	445	439	6	751	774	(23)
SPECIALIST SERVICES	98	72	26	618	507	111	1,108	997	111
COURT REPORT EXPENDITURE	7	4	3	50	21	29	85	46	39
TRUST BOARD & GOVERNORS	9	10	(1)	62	64	(3)	106	108	(3)
CHIEF EXECUTIVE OFFICE	26	24	2	181	168	13	311	297	13
PERFORMANCE & INFORMATICS	69	64	5	440	414	26	785	759	26
FINANCE & ICT	101	121	(20)	709	752	(44)	1,215	1,259	(44)
CENTRAL SERVICES DEPT	183	189	(6)	1,275	1,291	(15)	2,186	2,201	(15)
HUMAN RESOURCES	57	47	9	433	400	33	718	685	33
CLINICAL GOVERNANCE	38	28	11	260	224	37	439	402	37
TRUST DIRECTOR	32	33	(2)	229	208	20	387	366	20
PPI	19	19	0	135	103	32	231	199	32
SWP & R+D & PERU	22	25	(3)	154	129	25	264	239	25
R+D PROJECTS	0	0	0	0	0	0	0	0	0
PGMDE	5	2	3	37	28	8	63	55	8
NHS LONDON FUNDED CP TRAINEES	193	159	35	1,185	1,074	111	2,155	2,044	111
TAVISTOCK SESSIONAL CP TRAINEES	7	7	0	51	48	3	88	84	3
FLEXIBLE TRAINEE DOCTORS	9	2	8	66	42	24	113	89	24
TCS	44	65	(22)	323	396	(73)	542	615	(73)
DEPARTMENTAL CONSULTANCY	5	7	(2)	33	38	(5)	57	62	(5)
DEPRECIATION & AMORTISATION	42	44	(2)	297	309	(12)	509	529	(20)
PROJECTS CONTRIBUTION	(7)	(9)	1	(51)	(62)	11	(87)	(98)	11
IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	(0)	0	0	(0)	0
CENTRAL RESERVES	0	(0)	0	0	0	0	271	(445)	716
<b>TOTAL EXPENDITURE</b>	<b>2,882</b>	<b>2,562</b>	<b>320</b>	<b>19,427</b>	<b>19,331</b>	<b>97</b>	<b>32,561</b>	<b>31,931</b>	<b>630</b>
<b>OPERATING SURPLUS/(DEFICIT)</b>	<b>136</b>	<b>(20)</b>	<b>(156)</b>	<b>483</b>	<b>236</b>	<b>(247)</b>	<b>525</b>	<b>527</b>	<b>1</b>
INTEREST RECEIVABLE	1	1	(0)	6	5	(1)	11	10	(1)
UNWINDING OF DISCOUNT ON PROVISION	0	0	0	0	0	0	0	0	0
DIVIDEND ON PDC	(32)	(32)	(0)	(225)	(225)	(0)	(386)	(386)	0
<b>SURPLUS/(DEFICIT) BEFORE RESTRUCTURING</b>	<b>105</b>	<b>(51)</b>	<b>(156)</b>	<b>265</b>	<b>17</b>	<b>(248)</b>	<b>150</b>	<b>150</b>	<b>0</b>
RESTRUCTURING COSTS	0	0	0	1,000	993	7	1,000	993	7
<b>SURPLUS/(DEFICIT) AFTER RESTRUCTURING</b>	<b>105</b>	<b>(51)</b>	<b>(156)</b>	<b>(735)</b>	<b>(977)</b>	<b>(241)</b>	<b>(850)</b>	<b>(843)</b>	<b>7</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	4,770	4,010	3,316	2,872	2,366	1,607	1,401	1,422	1,118	1,572	1,505	4,712
Operational income received													
NHS (excl SHA)	541	623	659	976	1,007	890	877	1,008	888	877	1,009	888	10,243
General debtors (incl LAs)	742	374	560	519	425	650	533	485	450	839	565	472	6,614
SHA for Training	914	934	914	914	933	914	914	934	914	914	934	914	11,047
Students and sponsors	300	150	150	100	0	200	650	250	100	500	100	100	2,600
Other	18	18	18	18	18	18	18	18	18	18	18	18	216
	2,515	2,099	2,301	2,527	2,383	2,672	2,992	2,695	2,370	3,148	2,626	2,392	30,720
Operational expenditure payments													
Salaries (net)	(1,209)	(1,210)	(1,209)	(1,210)	(1,209)	(1,710)	(1,661)	(1,162)	(1,161)	(1,162)	(1,161)	(1,161)	(15,225)
Tax, NI and Pension	(900)	(894)	(894)	(894)	(894)	(894)	(894)	(858)	(858)	(858)	(858)	(858)	(10,554)
Suppliers	(349)	(756)	(849)	(761)	(687)	(576)	(584)	(595)	(605)	(614)	(615)	(613)	(7,604)
	(2,458)	(2,860)	(2,952)	(2,865)	(2,790)	(3,180)	(3,139)	(2,615)	(2,624)	(2,634)	(2,634)	(2,632)	(33,383)
Capital Expenditure	0	0	0	(100)	(100)	(60)	(60)	(60)	(50)	(60)	(60)	(109)	(659)
Interest Income	1	1	1	0	1	1	1	1	1	0	1	1	10
Payments from provisions	0	0	(45)	(6)	0	0	0	0	0	0	0	0	(51)
PDC Dividend Payments	0	0	0	0	0	(193)	0	0	0	0	0	(193)	(386)
Closing cash balance	4,770	4,010	3,316	2,872	2,366	1,607	1,401	1,422	1,118	1,572	1,505	963	963

### 2011/12 Actual/Forecast

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	4,712	3,376	3,516	2,536	2,445	2,208	2,132	2,316	2,129	1,626	1,879	1,812	4,712
Operational income received													
NHS (excl SHA)	691	725	341	871	603	1,568	1,185	1,008	888	877	1,009	888	10,654
General debtors (incl LAs)	618	238	279	691	724	350	593	485	450	839	565	472	6,304
SHA for Training	0	1,707	968	876	1,061	1,013	837	934	914	914	934	914	11,072
Students and sponsors	198	92	162	39	77	261	379	250	100	500	100	100	2,258
Other	4	22	30	68	47	40	90	18	18	18	18	18	391
	1,511	2,784	1,780	2,545	2,512	3,232	3,084	2,695	2,370	3,148	2,626	2,392	30,679
Operational expenditure payments													
Salaries (net)	(1,243)	(1,210)	(1,202)	(1,255)	(1,355)	(1,459)	(1,165)	(1,362)	(1,361)	(1,362)	(1,161)	(1,161)	(15,296)
Tax, NI and Pension	(900)	(917)	(926)	(906)	(902)	(896)	(930)	(866)	(858)	(858)	(858)	(858)	(10,676)
Suppliers	(705)	(497)	(542)	(463)	(469)	(709)	(777)	(595)	(605)	(614)	(615)	(613)	(7,204)
	(2,848)	(2,624)	(2,670)	(2,624)	(2,726)	(3,064)	(2,872)	(2,823)	(2,824)	(2,834)	(2,634)	(2,632)	(33,176)
Capital Expenditure	0	(21)	(91)	(13)	(23)	(51)	(29)	(60)	(50)	(60)	(60)	(121)	(579)
Interest Income	1	1	1	1	0	0	1	1	1	0	1	1	9
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	0	0	0	0	0	(193)	0	0	0	0	0	(193)	(386)
Closing cash balance	3,376	3,516	2,536	2,445	2,208	2,132	2,316	2,129	1,626	1,879	1,812	1,259	1,259

## Board of Directors : November 2011

**Item : 8**

**Title : CQSG Report, Quarter Two**

**Purpose:**

The purpose of this report is to give an overview of performance of clinical quality, safety, and governance matters.

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 has been reviewed by the following Committees:

- Management Committee, 17<sup>th</sup> November 2011

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

- Quality
- Patient / User Experience
- Patient / User Safety
- Risk
- Finance
- Productivity
- Communications

**For : Discussion**

**From : Rob Senior, CQSG Chair**

## CQSG Report, Quarter Two

### 1. Introduction

- 1.1 The overview summary of areas already considered by the CQSG is set out in the Appendix. The Board of Directors is reminded that ratings are not given in the same way as for the Risk Registers. RAG ratings are not weighted – a red rating may not necessarily imperil the Trust, and a green rating does not confirm there is no work to be done. A red rating may indicate a more distant date towards which progress is at an early stage.
- 1.2 The focus in this narrative is on areas of concern and interest of which the Board should pay particular attention; it is not simply a repetition of red and amber related elements.

### 2. Findings

#### 2.1 Corporate Governance and Risk

- 2.1.1 Improvements in data returns are expected to generate better outcomes to be reflected in the Q3 report.
- 2.1.2 Failure to achieve the IG training target has become the greatest risk.

#### 2.2 Clinical Outcomes

- 2.2.1 There had been no improvement in Q2
- 2.2.2 The MC has commissioned proposals for a new CO delivery system.
- 2.2.3 Contracts are at long-term risk if progress is not made
- 2.2.4 The CQC and commissioners will look for evidence that outcome monitoring is influencing development and planning.

#### 2.3 Clinical Audit

- 2.3.1 This is proceeding well and as expected.

## **2.4 Quality Reports**

- 2.4.1 The production of some elements of CQUIN data is delayed pending developments in Outcome Monitoring.
- 2.4.2 The arrival of final guidance on quality reporting from Monitor / DH late in the year is unhelpful

## **2.5 Patient and public involvement**

- 2.5.1 The CQSG expects to see evidence that users are being engaged in the planning and development of patient services
- 2.5.2 The lack of outcome monitoring information is a long term risk to new business if competitors are making information available
- 2.5.3 A review of workload across this and other work streams is to be considered

## **2.6 Information Governance**

- 2.6.1 The Trust has made good progress in the short time available, but there has been some slippage in some areas including the management of information assets and mandatory training.

## **3. Conclusion**

- 3.1 This report gives a comprehensive overview and summary of CQSG's findings: good progress has been made in many areas but outcome monitoring systems are to be comprehensively overhauled, elements of IG in relation to quality management have not been started due to late decisions on ownership, and there is a need to ensure that elements of PPI are held in the most appropriate work streams.

Rob Senior  
CQSG Committee Chair  
November 2011

## Appendix 1

Work Stream and task	Q1	Q2	Action plan for amber and red risks
<b>Corporate Governance and Risk Work stream</b>			
To maintain CQC registration without qualification	G	A	Provider Compliance Assessment forms are currently being reviewed by leads to ensure completeness.
To maintain a green governance rating with Monitor	G	A	
To maintain a highly effective workforce	R	A	Plan reported in Q1 (implementation of sanctions and appointment of administrator to ensure data quality on training) has shown improvements in attendance figures.
Estates and Facilities infrastructure improvements and CQC and NHSLA compliance	A	G	
Managing responses to recommendations and requirements of external bodies	G	G	
Maintain compliance with current NHSLA rating	G	G	
Non-clinical incident reports	G	G	
Specific case reports (serious incidents / SUIs)	G	G	
Central alert broadcast advice	A	G	
Operational Risk Register	G	G	
Relocation of Day Unit	A	A	Efforts to secure a new site are on-going with September 2012 deadline agreed.
CGR IG compliance	A	A	Action plan is in place as agreed in IG Work stream.
<b>Clinical Outcomes Work Stream</b>			
Development of outcome monitoring	A	R	MC has commissioned full proposal for a new system

			based on centralised data collection. To be agreed December 2011.
Outcome monitoring procedure compliance	A	A	Current system not effective, see above.
Patient Reported Outcome Measures	A	A	Plans to increase return rates and manage data better are in place.
Outcome monitoring of specific populations	G	G	
<b>Clinical Audit work stream</b>			
Development of Clinical Audit Process and Clinical Audit Annual plan	A	A	Plan for better engagement of clinicians to be developed. Report in Q3.
NICE compliance	G	G	
Confidential inquiries	G	G	
Completion of annual case note audit	G	G	
CA IG compliance	G	G	
<b>Patient Safety and Clinical Risk Work stream</b>			
Clinical incidents	G	G	
Specific case reports (serious incidents / SUIs)	G	G	
Hospital acquired infection	G	G	
Complaints responses	New Clinical claims	G	G
Serious complains update	G	G	
PSCR NHSLA compliance	G	G	
PSCR CQC compliance	G	G	
Central Alert Broadcast advice	G	G	
Supervision of clinicians	G	G	
Revalidation	G	G	
PSCR risk review	G	G	

Safeguarding children	A	R	The introduction of RiO required the reversion to paper based monitoring, the lead has been commissioned to propose a new system.  There will be a robust system in place by Q3.
Safeguarding adults	A	A	Recruitment to a new post has now taken place.
<b>Quality work stream</b>			
Quality report section of the AR is produced to a high standard	G	G	
Arrangements to deliver CQUIN are fit for purpose	A	A	Timescales to be aligned and agreed with data producers by Q3.
That data to be collected has been agreed	G	G	
That data quality procedure is implemented	A	A	Agreed programme of audits will generate evidence of compliance.
That QR components of the AR are submitted on time and in the correct format	G	G	
That QR requirements of IG are completed	A	R	These are not complete; there has been a subsequent re-allocation of requirements and progress will be reported in Q3.
<b>PPI work stream</b>			
Providing assurance that the trust adheres to all PPI related policies and procedures	G	G	
Providing a forum of PPI related matters	A	G	
Discussing the findings of the 2010/11 patient survey	A	G	
Ensuring that the action plan developed to address the finding of the patient survey is implemented	A	G	
Ensuring the involvement of patients in service improvement	A	G	
To improve the patient experience of	A	G	

diverse groups			
To hold 3 meetings with stakeholders			
<b>Information Governance Work Stream</b>			
Summary of IG9 compliance status	Not published	R	The requirements were published in Q2 so progress by 30 <sup>th</sup> September was limited; however, on 31.10.11 the Trust reported its interim results to DH showing it had achieved 49% compliance ytd, with plans in place to achieve compliance on the remainder. Risk assessments on the overall, and several individual components have also been received. The MC is receiving progress reports in the interim.

## Board of Directors : November 2011

**Item : 9**

**Title : Charitable Fund Report & Accounts 2010/11**

### **Summary:**

The Trust is the corporate trustee for the Tavistock and Portman Charitable Fund.

The Report and Accounts for the Charitable Fund for the year ended 31 March 2011 have been examined by HW Fisher and Company, our Independent Examiner. They were reviewed by the Charitable Fund Committee on 23 November, and are presented here to the Board of Directors for approval.

Following approval by the Board of Directors, they will be submitted to the Charity Commission.

The Report contains a brief review of the Fund's finances. Pages 1 and 8 of the accounts give further details of the income and expenditure in 2010/11.

The Report also sets out the main duties as listed in the Terms of Reference of the Charitable Fund Committee. This Committee has recently only been meeting once a year, due to the limited current activity of the Fund.

**For : Approval**

**From : Simon Young, Director of Finance**

# Tavistock & Portman Charitable Fund

## Annual Report and Accounts 2010/11

# Tavistock & Portman Charitable Fund

## Annual Report of the Trustee 2010/11

### 1. Reference and Administrative Details

The Tavistock and Portman Charitable Fund was established by a Declaration of Trust dated 4 September 1995, to contain all the funds held on trust by the Tavistock and Portman NHS Trust (since 1 November 2006, an NHS Foundation Trust).

*Its objects cover any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by the Tavistock and Portman Clinics.*

Two legacies are registered as separate charities under the “umbrella” of the Charitable Fund, and are included in its accounts.

**Correspondence** should be addressed to:

Miss Louise Carney  
Trust Secretary  
Tavistock and Portman NHS Foundation Trust  
120 Belsize Lane  
London, NW3 5BA

**Independent Examiner:**

HW Fisher and Company  
The Fisher Organisation  
Acre House  
11-15 William Road  
London, NW1 3ER

**Bankers:**

National Westminster Bank plc  
3<sup>rd</sup> Floor  
Argyll House  
246 Regent Street  
London, W1R 6PB

**Charity Registration No. 1049530**

## 2. Structure, Governance and Management

The Tavistock and Portman NHS Foundation Trust is Trustee of the Charitable Fund. The Trust's Board of Directors has appointed a Charitable Fund Committee, whose main duties as listed in its Terms of Reference are:

- To agree and recommend to the Board of Directors a strategic policy for utilising the assets of the Fund in pursuit of its stated purposes; and to review that policy at least every three years.
- To consider and approve any proposals for expenditure above £20,000 from the Fund, except where these relate to external grants awarded for specific purposes.
- To agree and recommend to the Board of Directors an investment policy for the Fund; and to review that policy at least every three years.
- To review the financial statements of the Fund annually, and more frequently if appropriate.<sup>1</sup>

The Directors of the NHS Foundation Trust during 2010/11 were as follows:

<b>Trust Chair</b>	Ms Angela Greatley*
<b>Non-Executive Directors</b>	Mr Altaf Kara Ms Emma Satyamurti (until 31 October 2010) Mr. Martin Bostock Ms. Joyce Moseley Dr Ian McPherson (from 1 November 2010) Mr Richard Strang
<b>Executive Directors</b>	Dr Matthew Patrick – Chief Executive* Ms Lis Jones, Nurse Director (from 6 September 2010) Ms Trudy Klauber – Dean of Postgraduate Studies Ms Louise Lyon – Trust Clinical Director Dr Robert Senior – Medical Director Mr Simon Young – Director of Finance*

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<sup>1</sup> Charitable Fund Committee Terms of Reference, November 2010

\* indicates the members of the Board's Charitable Fund Committee

The Trust Chair and the Non-Executive Directors are appointed by the Board of Governors of the NHS Foundation Trust.

The Chief Executive is appointed by the Trust Chair and the Non-Executive Directors. The other Executive Directors are appointed by the Trust Chair, the Non-Executive Directors, and the Chief Executive.

### 3. Objectives and Activities

In pursuit of the objects set out on Page 3, the main activities of the Fund in 2010/11 were research relating to the Clinics' services; the Tavistock Society of Psychotherapists; and smaller projects for the welfare of patients, staff and trainees.

### 4. Achievements and Performance

The Fund does not actively raise funds at present, but will continue to manage grants, donations and legacies towards the important objectives of the Trust, especially its research projects.

### 5. Financial Review 2010/11<sup>2</sup>

Income was £172,000 (2009/10 £158,000), and expenditure £119,000 (£144,000).

No new investments were made during the year.

Overall, funds increased by £53,000, compared to a £14,000 increase in 2009/10. The Fund's current policy is not to hold significant general reserves, since the commitments to projects do not exceed the funds specifically held for those projects. The total value of the Fund at 31 March 2011 was £376,000, comprising £306,000 in restricted funds and £70,000 in unrestricted funds.

The Independent Examiner, HW Fisher and Company, has carried out an examination on the 2010/11 Accounts, copies of which can be obtained from the address on Page 2.

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<sup>2</sup> 2009/10 figures in brackets for comparison

## 6. Plans for Future Periods

Very limited funds remain available for the outcome research project. The Charitable Fund Committee welcomes further donations or legacies, which are likely to be directed towards this or similar projects as part of the Trust's future research strategy.

External grants and the Tavistock Society of Psychotherapists' funds will continue to be used for their intended purposes.

### Signed:

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Dr Matthew Patrick  
Chief Executive

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Mr Simon Young  
Director of Finance

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Date

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Date

**Independent examiner's report to the trustees of the Tavistock and Portman Charitable Fund**

I report on the accounts of the trustee and the accounts of the Trust for the year ended 31 March 2011.

**Respective responsibilities of trustees and examiner**

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year under section 43(2) of the Charities Act 1993 (the 1993 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 43 of the 1993 Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 43(7)(b) of the 1993 Act; and
- to state whether particular matters have come to my attention.

**Basis of independent examiner's report**

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

**Independent examiner's statement**

In connection with my examination, no matter has come to my attention:

(1) which gives me reasonable cause to believe that in any material respect the requirements:

- to keep accounting records in accordance with section 41 of the 1993 Act; and
- to prepare accounts which accord with the accounting records and comply with the accounting requirements of the 1993 Act have not been met; or

(2) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

**A. G. Rich**

Chartered Accountant

H.W Fisher & Company

Chartered Accountants

Acre House

11-15 William Road

London

NW1 3ER

Date:

**Tavistock and Portman Charitable Fund**

**Accounts for the year ended**

**31 March 2011**

**Statement of Financial Activities for the year ended 31 March 2011**

	Note	Unrestricted Funds £000	Restricted Funds £000	2010-11 Total Funds £000	2009-10 Total Funds £000
<b>Incoming resources</b>					
Incoming resources from generated funds					
Donations and Gift Aid		0	1	1	(1)
Grants receivable:	2.1				
Other grants receivable			73	73	25
Investment income		0	0	0	0
Total Incoming resources from generated funds		0	74	74	24
Operating Activities					
Charitable activities		2	96	98	134
Total Operating Activities		2	96	98	134
<b>Total incoming resources</b>		<b>2</b>	<b>170</b>	<b>172</b>	<b>158</b>
<b>Resources expended</b>					
Charitable expenditure	4.1	4	109	113	138
Governance	4.2	1	5	6	6
<b>Total resources expended</b>		<b>5</b>	<b>114</b>	<b>119</b>	<b>144</b>
Net incoming/(outgoing) resources before Transfers		(3)	56	53	14
Gross transfer between funds		0	0	0	0
<b>Net incoming/(outgoing) resources</b>		<b>(3)</b>	<b>56</b>	<b>53</b>	<b>14</b>
Fund balances brought forward at 31 March 2010		73	250	323	309
<b>Fund balances carried forward at 31 March 2011</b>		<b>70</b>	<b>306</b>	<b>376</b>	<b>323</b>

The notes at pages 3 to 9 form part of this account.

**Balance Sheet as at 31 March 2011**

	Notes	Unrestricted Funds £000	Restricted Funds £000	<b>Total at 31 March 2011 £000</b>	Total at 31 March 2010 £000
<b>Current Assets</b>					
Debtors	5	43	16	<b>59</b>	115
Cash at bank and in hand		31	359	<b>390</b>	256
<b>Total Current Assets</b>		<u>74</u>	<u>375</u>	<u><b>449</b></u>	<u>371</u>
Creditors: Amounts falling due within one year	6.1	4	69	<b>73</b>	48
<b>Net Current Assets</b>		<u>70</u>	<u>306</u>	<u><b>376</b></u>	<u>323</u>
<b>Total Assets less Current Liabilities</b>		<u>70</u>	<u>306</u>	<u><b>376</b></u>	<u>323</u>
<b>Total Net Assets</b>		<u>70</u>	<u>306</u>	<u><b>376</b></u>	<u>323</u>
<b>Funds of the Charity</b>					
Income Funds:					
Restricted	7.2		306	<b>306</b>	250
Unrestricted		70		<b>70</b>	73
<b>Total Funds</b>		<u>70</u>	<u>306</u>	<u><b>376</b></u>	<u>323</u>

The notes at pages 3 to 9 form part of this account.  
All the above results are derived from continuing operations

Approved and authorised for issue by the Board on ..... and signed on its behalf by

Signed:

Date:

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**Notes to the Account****Accounting Policies****1****1.1 Accounting Convention**

The financial statements have been prepared under the historic cost convention and in accordance with applicable United Kingdom accounting standards and the Statement of Recommended Practice "Accounting and Reporting by Charities" issued by the Charities Commissioners in 2005.

**1.2 Incoming Resources**

a) All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors can be met:

- i) entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable;
- ii) certainty - when there is reasonable certainty that the incoming resource will be received;
- iii) measurement - when the monetary value of the incoming resources can be measured with sufficient reliability.

b) Legacies

Legacies are accounted for as incoming resources once the receipt of the legacy becomes reasonably certain. This will be once confirmation has been received from the representatives of the estates that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

**1.3 Resources Expended**

The funds held on trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

The Fund's main expenditure is on research and other activities in furtherance of its objectives. As shown in the Statement of Financial Activities on page 1, a small amount is spent on administration and there has been to date no expenditure on fundraising.

Governance costs include a charge of £5,000 from the Tavistock and Portman NHS Foundation Trust.

#### **1.4 Structure of funds**

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds. Other funds are classified as unrestricted funds.

#### **1.5 Pooling Scheme**

An official pooling scheme is operated for investments relating to the following funds:

Tavistock and Portman Charitable Fund  
Dean Legacy  
Shaw Legacy

The Scheme was registered with the Charity Commission on 17 March 1998.

<b>Material grants received by category</b>	<b>2</b> <b>2.1</b>		Amount received in aggregate 2011 £000	Amount received in aggregate 2010 £000
		The Charitable Fund gratefully acknowledges receipt of the following grants:-		
		The Baily Thomas Charitable Fund	<u>60</u>	0
		Centre for Family Social Work Research, University of East London	<u>10</u>	18
		Informa UK (Ltd) - (Taylor & Francis Group)	<u>3</u>	7
		<b>Total</b>	<u><b>73</b></u>	<u><b>25</b></u>

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**Details of Resources Expended - Grants**      **3**  
**3.1**

**Grants Payable:**

There were no grants payable in the year 2010/11.

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TAVISTOCK AND PORTMAN CHARITABLE FUND ACCOUNTS - 2010/11

<b>Details of Resources Expended - Other</b>	<b>4</b>	Unrestricted Funds	Restricted Funds	<b>Total 2011 Funds</b>	Total 2010 Funds
	<b>4.1</b>	£000	£000	<b>£000</b>	£000
Other:					
Patients welfare and amenities		0	0	<b>0</b>	0
Staff welfare and amenities		3	21	<b>24</b>	16
Staff training, education and development			42	<b>42</b>	43
Research		1	46	<b>47</b>	73
Governance		<u>1</u>	<u>5</u>	<b><u>6</u></b>	<u>6</u>
		<b><u>5</u></b>	<b><u>114</u></b>	<b><u>119</u></b>	<b><u>138</u></b>

No staff are employed directly by the Charitable Fund. Instead, they are employed by the Tavistock and Portman NHS Foundation Trust and this is reimbursed as shown in note 10.

<b>Analysis of Governance Costs</b>	<b>4.2</b>	Unrestricted Funds	Restricted Funds	<b>Total 2011 Funds</b>	Total 2010 Funds
		£	£000	<b>£000</b>	£000
Independent examiner's fee		0	1	<b>1</b>	1
Legal and Professional fees		<u>1</u>	<u>4</u>	<b><u>5</u></b>	<u>5</u>
		<b><u>1</u></b>	<b><u>5</u></b>	<b><u>6</u></b>	<b><u>6</u></b>

TAVISTOCK AND PORTMAN CHARITABLE FUND ACCOUNTS - 2010/11

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<b>Analysis of Debtors</b>	<b>5</b>		<b>31 March 2011</b>	31 March 2010
	<b>5.1</b>	Amounts falling due within one year:	<b>£000</b>	£000
		Other debtors	<u>51</u>	<u>101</u>
		Total debtors falling due within one year	<u>51</u>	<u>101</u>
	<b>5.2</b>	Amounts falling due over one year:		
		Other debtors	<u>8</u>	<u>14</u>
		Total debtors falling due after more than one year	<u>8</u>	<u>14</u>
		<b>Total debtors</b>	<u><b>59</b></u>	<u><b>115</b></u>

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<b>Analysis of Creditors</b>	<b>6</b>		<b>31 March 2011</b>	31 March 2010
	<b>6.1</b>	Amounts falling due within one year:	<b>£000</b>	£000
		Other creditors	<u>67</u>	<u>48</u>
		Accruals	<u>6</u>	<u>0</u>
		Total creditors falling due within one year	<u>73</u>	<u>48</u>
		<b>Total creditors</b>	<u><b>73</b></u>	<u><b>48</b></u>

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**Analysis of Funds** 7

**7.1 Endowment Funds**

There are no endowment funds held.

**7.2 Restricted Funds**

	Balance 31 March 2010 £000	Incoming Resources £000	Resources Expended £000	Transfers £000	Gains and Losses £000	Balance 31 March 2011 £000
<b>Material funds</b>						
Outcome Research	10	0	(6)			4
The Unconscious at Work	9	0	(1)			8
Shaw Legacy	26	0	(1)			25
Hosp and Hosp Drs Research	16	2	(1)			17
Suicide in adolescents	71	40	(32)	15		94
Journal for Social Work Practice	18	18	(4)	(15)		17
Change in Autism	5	4	(5)			4
Tavistock Soc. of Psychotherapists	47	40	(43)			44
Baily Thomas Fund		60	(13)			47
Others (24 funds)	48	6	(8)			46
<b>Total</b>	<b>250</b>	<b>170</b>	<b>(114)</b>	<b>0</b>	<b>0</b>	<b>306</b>

**Details of material funds - restricted funds**

**7.3 Name of fund**

**Description of the nature and purpose of each fund**

Shaw Legacy	Purposes connected with the Tavistock Clinic, namely for research and grants for students.
Outcome Research	This fund was established in 2000, to support the Tavistock Adult Depression Study, a randomised controlled research trial.
Common Investment Fund	Has no funds of its own. Exists as a vehicle for the pooling scheme, to allow the Charitable Fund, the Dean Legacy and the Shaw Legacy to act jointly in investing their funds (ref. Section 24 of the Charities Act 1993).

**Contingencies** 8 The Directors of the Tavistock and Portman NHS Foundation Trust are not aware of any material contingent liabilities relating to the Charitable Fund.

**Commitments, Liabilities and Provisions** 9 There were no commitments under capital expenditure contracts or under charitable projects at the balance sheet date.

**Trustee and Connected Persons Transactions** 10  
10.1

**Details of transactions with trustees or connected persons**

The Charitable Fund reimburses the Tavistock and Portman NHS Trust for staff and other expenses borne on its account.

2010-11		2009-10	
Total charge for the year	Balance due to the Trust at 31 March (net)	Total charge for the year	Balance due to the Trust at 31 March
£000	£000	£000	£000
74	48	5	3

No trustee received any remuneration during the year and there were no other expenses reimbursed to any trustee other than those shown above.

No staff are employed directly by the Charitable Fund. Instead, they are employed by the Tavistock and Portman NHS Foundation Trust and this is reimbursed as above.

**10.2 Trustee Indemnity Insurance**

The Charitable Fund provided no indemnity insurance cover during the year.

**Loans or Guarantees Secured against assets of the charity** 11

There were no loans or guarantees secured against assets of the charity.

**Connected Organisations** 12

There were no transactions with connected bodies, except as disclosed in note 10.1 above.

**Related party transactions** 13

**Related party transactions**

The Charitable Fund has made revenue payments to the Tavistock and Portman NHS Foundation Trust which is the sole trustee of the Fund. Details are given in note 10.1 above.

## Board of Directors : November 2011

**Item :** 10a

**Title :** Consent Policy

### **Purpose of Paper:**

The Consent Policy and Procedure has been fully updated to meet NHSLA and CQC requirements. Key changes are as follows:

1. It now distinguishes agreement to assessment and legal consent for treatment
2. It states that in line with NHS requirements due to the nature of the treatments that we offer written consent is not required
3. It sets out how consent will be recorded (on the revised assessment form)
4. Local variations in practice are set out in the appendices, these all meet the core principles in the policy
5. Mike Shaw's excellent appendix on consent and young people has been retained from 2007 Policy
6. It is in the trust policy template format

The Management Committee have approved the revised policy, which subject to Board ratification will be actively promoted to all clinical staff.

### **The policy focuses on the following areas:**

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

**For :** Approval

**From :** Rob Senior, Medical Director



## Consent Policy and Procedure

Version:	2 (replaces Consent Policy March 2007)
Bodies consulted:	Clinical Governance Leads, Clinical Directors, Management Committee
Approved by:	
Date Approved:	
Name of originator/ author:	Jane Chapman Governance and Risk Adviser
Lead Director:	Rob Senior
Date issued:	
Review date:	December 2014

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Appendix 1 Obtaining valid consent Child and Family Directorate

Appendix 2 Obtaining Valid consent Adolescent Directorate

Appendix 3 Obtaining valid consent in Adult and Portman Directorates

Appendix 4 Quick Guide to Parental Responsibility

Appendix 5 Guidance for Clinicians on Competence, Consent, and Refusal of Treatment for Children and Young People

# Consent Policy and Procedure

## 1 Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) offers a range of mental health assessments and treatments to patients and by their very nature a patient's active participation is vital to the *process*. It recognises that consent and voluntary choice are a fundamental principle of the work of the Trust.

In order that a patient can confidently participate in assessment and/or treatment the Trust fully acknowledges the fundamental legal and ethical right of patients to determine what happens to them in the course of their care. Clinical staff at the Trust are committed to ensuring that patients are provided with sufficient information on which to base a valid decision as to whether or not they wish to participate in assessments and treatments.

The Trust does not require a formal consent form to be signed by the patient, however, in all cases the clinician must be confident that the patient has actively agreed to participate in treatment and had been provided with suitable and sufficient information on which to make that decision. The process for obtaining consent is set out at section 7.

## 2 Purpose

This policy and procedure describes the principles and process of obtaining valid consent to treatment. It highlights the need to ensure that sufficient information is given to allow valid consent to be made and it sets out how 'best interests' decisions need to be made for those lacking capacity. (Mental Capacity Act 2005).

This policy is written to ensure that the Trust meets legal , NHSLA and CQC standards of good practice relating to consent in healthcare. It is based on Department of Health Guidance 2009 and sets out the procedures for obtaining and recording consent that operate in the Trust.

It is written with regard to the type of clinical work that the Trust undertakes.

### 3 Scope<sup>1</sup>

This policy and procedure is applicable to all clinical staff seeing patients in the Trust, including; permanent staff; clinical trainees; locums; and honorary clinical staff

The principles and processes of consent in the policy apply specifically to treatment of patients, but the principles of choice of participation also apply to the assessment phase of care.

The policy does not cover consent for participation in a research study; staff should refer to the NHS guide on research consent, (see reference section 10)

### 4 Definitions

The following definitions apply in this policy:

Term	Definition in this policy
<b>Capacity</b>	Applies to persons 16 years and over and is a legal term from the Mental Capacity Act 2005, it means the ability to understand and give legal consent to an action or arrangement .
<b>Competence</b>	Is the equivalent legal term to capacity from the Children Act 1989 and applies to young people under 16 years, it refers to a young person's ability to to understand information about the proposed treatment and make a decision based on that understanding
<b>Presumption of capacity to consent</b>	For anyone over 16 there must be a presumption that the person has a capacity to consent unless it is positively shown that they lack capacity
<b>Right to refuse/ withdraw consent</b>	<ul style="list-style-type: none"><li>• Consent can be withdrawn at any time.</li><li>• Persons over 18 with capacity to consent have the legal right to withdraw consent and or refuse treatment</li></ul>

---

<sup>1</sup> **Notes on scope:**

1. The Trust does not provide any compulsory treatments under the Mental Health Act. (1983 ), however 'approved' Psychiatrists in the Adolescent and CAMHS Directorate may be requested to carry out assessments under the Mental Health Act (Section 12 approved Doctors). Formal consent for such an examination is not required. not required

2. A number of specialist departments provide a court reporting service. In the case that the Court Order that a report to be prepared the individual concerned is under a legal obligation to co-operate and 'formal consent' is not taken.

Term	Definition in this policy
	without the need to offer reasons for their decision.

## 5 Policy Statements

The Trusts accepts the following position on consent for Treatment by trust staff:  
:

### Capacity to consent:

- For those aged 16 years or over capacity to make informed decisions is presumed.
- If a clinician is doubtful about the capacity of an individual then the clinician must prove that the individual lacks capacity.

### Valid Consent:

Consent is a patient's voluntary agreement to receive a particular treatment.

For consent to be valid the patient must:

- have the capacity (for persons 16 years or over) or competence (for young people under 16) to take the particular decision.
- have received sufficient information about the nature , purpose, likely effects and risks of a particular treatment as well as received information and/or had a discussion about alternatives (including no treatment) ,
- not be acting under duress or the influence of another person
- be able to express their decision to the clinician, either verbally or in writing

### Right to refuse treatment and/or withdraw consent

A patient has the legal right to withdraw consent and or refuse consent for treatment without the requirement to explain his actions

## 6 Duties and responsibilities

### Medical Director

The Medical Director has overall responsibility for this policy and procedure and for ensuring that all clinicians understand the procedure. The Medical Director will ensure that the content of this procedure is part of clinical induction for all new staff. The Medical Director is accountable

to the Board of Directors on matters relating to patient consent and is lead for the CQC standard on consent (Standard 5)

## **Clinical Staff**

Clinicians are responsible for ensuring that they obtain consent from each patient and that the patient has sufficient information on the benefits, risks and alternatives of the proposed treatment on which to make an informed decision. Clinicians are responsible for completing the consent section in the standard assessment proforma and for ensuring that records of any concerns relating to consent are kept up to date

# **7 Procedure for obtaining consent**

## **7.1 Consent for Assessment**

A patient can be offered one or a series of appointments at the Trust for the purpose of conducting an assessment to determine what if any of the treatment options available from the Trust would best meet the needs of the patient.

The Trust does not seek formal consent of the patient to undergo an assessment. Consent is implied by the fact the patient chooses to attend the offered appointment and engages with the clinician so that information can be gathered in order to make an assessment. A patient is able to withdraw from the assessment process at any time

## **7.2 Consent for Treatment**

The principles for obtaining valid consent to treatment are that the patient is provided with sufficient information to make an informed decision as to whether to undergo the proposed treatment. This information should include:

- Details of proposed treatment
- Benefits of the treatment
- Risks of the treatment
- Alternatives to treatment proposed (including the option of no treatment)

Due to the nature of the services offered different approaches to practice that operate in the four directorates local procedures apply and these are detailed in Appendices as shown below:

- Appendix 1: Procedure for obtaining valid consent in CAMHS directorate
- Appendix 2 Procedure for obtaining valid consent in the Adolescent Directorate
- Appendix 3 Procedure for obtaining valid consent in the Adult and Portman Directorates
- Appendix 4 Procedure for obtaining valid consent for patients with a Learning Disability
- Appendix 5 Summary guide for clinicians on who can hold 'parental responsibility'.
- Appendix 5 Guidance for all Clinicians on Competence, Consent, Refusal of Treatment and Confidentiality for Children and Young People

### 7.3 Consent and patients whose first language is not English

Patients and or clinical staff can approach PALS for help and support if language is an issue and the PALS service can liaise with clinical staff on behalf of those inquiring. PALS can make arrangements for patients to have access to a translator if required.

## 8 Training Requirements

Training on consent for psychotherapy is considered part of on-going professional development training for all clinical staff, with support being provided both by formal training and through case supervision. Occasional in house training sessions will be provided as needs are identified.

## 9 Process for monitoring compliance with this Procedure

Compliance with this procedure will be monitored and assured in the following ways:

- **Documentation of consent** will be audited as part of the annual audit and reported to the Clinical Audit work stream Any issues with noncompliance

will be escalated via the Patient Safety and Risk Work stream to the Clinical Quality Safety and Governance (CQSG) Committee who will monitor any action plans agreed to address deficiencies

- **Patient Feedback on consent will be** will be collated as part of the annual review of patient feedback prepared by the PPI work stream and reported to CQSG . Any issues with noncompliance will be escalated via the Patient Safety and Risk Work stream to the Clinical Quality Safety and Governance Committee who will monitor any action plans agreed to address deficiencies
- **Review of incidents, complaints and claims** for evidence of issues relating to consent will be undertaken 6 monthly by the Governance and Risk Adviser and reported to the Patient Safety and Risk Work stream. Any issues with noncompliance will be escalated via the Patient Safety and Risk Work stream to the Clinical Quality Safety and Governance Committee who will monitor any action plans agreed to address deficiencies

## 10 References

**General guidance** *Reference guide to consent for examination or therapy:* provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies may be accessed via the web at [www.dh.gov.uk/consent](http://www.dh.gov.uk/consent). See [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_103643](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643) for the most up to date guidance (2009)

**Specific guidance**, incorporating both the law and good practice advice, is available for professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available on the internet at [www.dh.gov.uk/consent](http://www.dh.gov.uk/consent).

There are specific requirements in relation to **consent for research**. The general requirements can be found from the National Research Ethics Service's website <http://www.nres.npsa.nhs.uk/>.

## 11 Associated documents<sup>2</sup>

Medication Management Procedure

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<sup>2</sup> For the current version of Trust procedures, please refer to the intranet.

Patient Advice and Liaison Operational Procedure

Patient Information Procedure

Consent to use of audio-visual recording of patient care

## 12. Equality Impact Assessment

1. Does this Procedure, function or service development impact affect patients, staff and/or the public? **YES**

2. Is there reason to believe that the Procedure, function or service development could have an adverse impact on a particular group or groups? **NO**

This is a policy and procedure that will be applied equally to all patients dependant on their capacity to consent. For patient who have a disability that impairs their capacity to consent specific additional safeguards and arrangements are in place to protect the interest of this group. Special legally binding arrangements are in place to protect the interests of children under this policy.

**Age** – especially younger and older people *No: protected arrangements in the policy*

**Disability** – people with impairments *No: protected arrangements in the policy*

**Race** – people of different ethnic groups *No: protected arrangements in the policy for those whose first language is not English*

3. If you answered **YES in section 2**, how have you reached that conclusion? (Please refer to the information you collected e.g., relevant research and reports, local monitoring data, results of consultations exercises, demographic data, professional knowledge and experience) *n.a*

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

**Positive impact: Medium**

(i.e. likely to promote, or does have some positive impact on equality of opportunity)

Date completed 8.11.11

Name Jane Chapman

Job Title Governance and Risk Adviser

## Appendix 1

### Procedure for obtaining consent in CAMHS Directorate

*Clinicians are referred to Appendix 5 which provides detailed guidelines on considerations that should be made when taking consent from a child and/or young person*

#### **Consent to Treatment**

Treatment of children and young people is complicated by the fact that it is often adults (parents or carers) who are concerned about the young person's symptoms or behaviour and consider them to need help. The young person themselves may not actively want help. The child and young person's understanding of what assessment and treatment entails may be at a different level from the understanding of parents / carers .

While the child/ young person may not be in a position to provide active consent to psychotherapeutic treatment, it is important to establish that they do not actively dissent.

Written consent is not required for a child or young person but the basis for believing that the young person /or the parent acting on behalf of a child not competent to consent for themselves should be written in the file. .The Trust has included a section on the Assessment form to record the consent process

#### **Consent for use of medication:**

On occasions consultant child and adolescent psychiatrists will prescribe medication for a child/young person and may carry out baseline checks of height/weight/blood pressure and pulse following best practice guidelines (e.g. NICE Guidelines for management of ADHD)

The same principles of consent to treatment apply.

## **Procedure for obtaining consent in Adolescent Directorate**

*Clinicians are referred to Appendix 5 which provides detailed guidelines on considerations that should be made when taking consent from a child and/or young person*

### **Opt-In policy for Assessment of young people over 16**

It is the Directorate's usual practice to write to young people aged 16 and over, who have not self-referred, asking them to opt-In and confirm that they would like to be seen here. The Adolescent Department then gives a deadline of one week for the young person to make contact. If no response is received after the first week, a reminder letter is sent with a copy to the referrer and a further week given to await contact.

To minimise the waiting time, the young person has a choice of contacting the Adolescent Department, Referrals Coordinator by telephone or by returning the Opt-In form which is enclosed with the original letter and prompt letters.

If there is no further response after the second letter, the case is closed on the system and the referrer is written to advising them of the outcome.

### **Young People's Rights to Consent to Treatment**

Adults over the age of 18 attending the adolescent department are presumed to have the capacity to consent to treatment

Young persons 16 -17 attending the Adolescent Directorate are regarded as having capacity to give consent to treatment ,in line with the Mental Capacity Act, however in practice adolescents vary greatly in their level of maturity and it is important therefore that when clinicians have any concern about the capacity to consent in a young person aged 16-17 that with the patient's permission the patient/carer may be engaged to participate in the decision . It is usual practice that a different clinician is assigned to carers /parents if they are also being seen at the Trust.

For children **under 16**, under the law clinicians may assess patients and determine whether they have sufficient understanding of what is to be offered, both its risks and benefits, and alternatives to treatment, and if a patient has sufficient understanding

then they can consent to treatment. This is referred to as 'Gillick' or 'Frazer' competence.

For under 16's who are deemed competent it is recommended practice in the Adolescent Directorate for parents of children under 16 to be seen at least once during the course of assessment This is usually discussed with the young person.

If a **child under 16 is not considered competent** to give consent then a parent or legal guardian may consent on behalf of the patient.

### **Providing information and recording consent**

Once it has been determined that the young person has the capacity (over 16) or competence (under 16) to consent to treatment then the basic principles for obtaining valid consent are to be followed i.e.: the therapist must provide the patient with sufficient information on which s/he can decide whether s/he wants to accept the offer of treatment.

This information must include:

- Proposed treatment
- Benefits of the Treatment
- Risks of the treatment ( including the possibility that the situation might get worse before it gets better with as issues they find difficult to think about are opened up in the sessions)
- Alternatives to the proposed treatment (including no treatment)

### **Recording Consent**

Following this discussion if the young person wishes to proceed to treatment their consent must be documented in the file by the clinician completing the Consent section in the Assessment form

### **For young people who are not competent to consent**

In the event that an Adolescent Patient has been assessed as not competent to consent for him/herself then the clinician should obtain consent for a parent/guardian on behalf of the patient. This is to be documented on the Assessment Form

## **Procedure for obtaining consent in Adult and Portman Directorates**

The principles that guide consent in the Adult and Portman<sup>3</sup> Directorates are set out below. It is the responsibility of each clinician offering adult patients the opportunity for treatment to ensure that their patient has sufficient information and time to make a decision as to whether they wish to accept this offer.

### **Capacity to Consent**

All adult patients attending the Trust are normally deemed to have capacity to agree to assessment and consent to treatment. (Certain rare exceptions may apply to patients seeking voluntary treatment but who are subject to a treatment plan the Mental Health Act or to those patients with severe learning difficulties<sup>4</sup>). That said, capacity to consent may be temporarily impaired by trauma or severely disabling emotional responses or physical illness and clinicians must always be aware of this possibility and take it into account if present.

### **'Consent' to assessment**

The Trust does not take formal consent for assessment, however for an assessment to be effective a patient must agree to attend sessions and participate in the assessment process

### **Consent to treatment**

If, following assessment the clinician recommends a course of treatment, which may be individual, group, family or couple therapy, it is the responsibility of the clinician to provide the patient with information on which to base a decision to proceed.

This information must cover:

- Proposed treatment
- Benefits and risk of the proposed treatment
- Alternatives to this treatment (including no treatment)
- That the patient may withdraw his consent at any time

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<sup>3</sup> Portman staff treating under 18's are referred to the *Guidance for Clinicians on Guidance on Competence, Consent, Refusal of Treatment and Confidentiality for Young People* at page \*\*

<sup>4</sup> Refer to Appendix 5 re consent for patients with learning or complex difficulties

In the discussions about treatment the clinician should consider the following:

- Clinicians should be prepared to discuss any treatment offer in relation to current NICE Guidance and other current advice and should encourage their patient to seek additional information if they wish either from Trust publications or via MIND and other relevant organisations.
- Clinicians should always attend to patients concerns and help them to become verbalised and explicit. This includes taking care that so far as possible, the patient understands correctly. This process should begin during an assessment should also be the beginning of establishing the honesty and trustworthiness of the clinician and the Trust, as a basis for psychological treatment.
- Patients should be given time to consider the option of treatment and offered any support they may need to reach a decision

### **Recording consent**

Written consent (i.e. on a consent form signed by a patient ) is **not** required for the types of treatment that the Trust offers, however it is very important that the clinician records consent in the case file, a section in the Assessment Form provides space for this, additional notes can be made in the main record

### **Additional Advice for Clinicians re withdrawal of consent during treatment**

Consent to psychotherapy is complicated by the fact that a patient who has consented to treatment may nevertheless feel ambivalent, anxious, resistant and hostile when faced with the reality of the psychotherapy treatment. If the clinician construes this, prematurely, as withdrawal of consent to treatment, the patient may feel rejected or uncontained.

Clinical judgement is required to gauge whether the patient has consented to treatment but is ambivalent, hostile and / or anxious, or whether the patient's attitude communicates a lack of, or withdrawal of consent to treatment.

## **Guidelines for Obtaining Consent for Treatment for patients with learning and/or complex disabilities<sup>5</sup>**

The guidance below has been informed by the principles and legal framework as underlined by the Mental Capacity Act (2005) and by the General Medical Council guidance notes 'Consent: patients and doctors making decisions together' (June 2008).

The principal aim of this guidance is to ensure and safeguard that vulnerable patients are enabled, to the best of their abilities, to make decisions relating to their health and welfare. Capacity must always be presumed. A patient can only be seen as lacking capacity if it is clear that, having been given all the appropriate help and support, they cannot understand, use or weigh up the information needed to make a decision.

### **Introduction**

The Learning and Complex Disabilities Service (LCDS) is a psychotherapy service and as such, it requires patients to voluntarily engage in the treatment process. Although patients are not likely to engage in psychotherapy against their will, given the vulnerable position of our patient population, it is imperative to avoid the passive acceptance of a form of treatment that the patient may find difficult to tolerate.

### **Practice protocol**

The following practice protocol should help in ensuring that valid consent/ agreement for treatment is obtained.

1. Whenever possible, initiate the assessment process by convening a Network meeting with the referring professionals. This meeting will give the referrer information regarding the nature of Psychoanalytic psychotherapy, its benefits and drawbacks and limitations. Information is also given about the assessment process and the possible destabilising effect it may have on the patient. It is hoped that this information may allow the referrer to explore with the patient whether or not they wish to pursue a referral for assessment for psychotherapy. This meeting can also establish the support available to the patient in order to make a decision regarding consent. At this stage of the referral process it may

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<sup>5</sup>Note: This appendix is also included in the Trust's Vulnerable Adults Policy

be concluded that it is not in the patient's 'best interest' to proceed with an individual assessment. If considering a referral of a child under 16, it is also appropriate at this point to meet the parents or responsible adult in order to impart as much information as possible regarding psychotherapy as a form of treatment.

2. The assessment process itself can act as an important tool in imparting information to the patient regarding the kind of experience he/she is likely to have in the context of psychotherapy and is therefore crucial in enabling patients to give **informed consent**. It is incumbent on the clinician to closely monitor the patient's response to this process, both in terms of verbal and non-verbal communication, to assess both the patient's wishes and their competence with regards to consent. Clarify assessing capacity/competence
3. The assessment process must include clear and direct indication with regards to a patient's competence to give consent ?? and motivation for treatment; these must be clearly stated in the notes and in the relevant consent form. Wherever possible, written consent should be obtained, however oral statements and non-verbal communications regarding consent need to be recorded with equal status
4. If competence for consent is established, treatment can then be offered as appropriate. If the patient is considered to be incompetent, lack capacity a discussion with the referring network and those close to the patient needs to take place with regards to the course of action, which is considered to be in the patient's 'best interest'. Decisions regarding 'best interest' and any points of disagreement regarding this must be clearly recorded in the notes. As far as it is helpful to the patient, the patient should be involved as far as possible in the decision making process.
5. Consent to treatment is not a one off event; a patient may withdraw or give consent at any point during treatment; it is therefore important to be alert to this and to respond accordingly. It is important to bear in mind that Psychotherapy does give rise in patients to many ambivalent feeling about the treatment and that these feelings are an important aspect of the work. Clinicians will need to make a judgment to whether a patient is expressing an ordinary degree of ambivalence, or is in fact withdrawing his/her consent.
6. The consent process is to be recorded on the Assessment form, with additional information recorded in the patient's case file

## Short Guide to Parental Responsibility

### Introduction

In the event that a child is not considered to be old enough and/or mature enough to consent for treatment the trust will seek consent from a person with legal parental responsibility.

The following persons can have parental responsibility:

<b>No order in force</b>	<ol style="list-style-type: none"> <li>1. Biological mother of the child</li> <li>2. Biological father of the child if             <ol style="list-style-type: none"> <li>a. Married to the mother at the time of birth or</li> <li>b. Married to the mother after the birth of the child or</li> <li>c. Is named as the father on the birth certificate (for births after 1.12.2003) or</li> <li>d. Has a signed parental responsibility agreement (PRA) with the mother or</li> <li>e. Has obtained a parental responsibility order (PRO) or</li> <li>f. Has obtained a residence order</li> </ol> </li> <li>3. Is a step parent and has signed a PRA or obtained a PRO</li> </ol>
<b>Care Order</b>	<ol style="list-style-type: none"> <li>1. Local authority (named social worker)</li> <li>2. Mother</li> <li>3. Father if he has a PR under the 'no order' rules above</li> </ol>
<b>Residence order</b>	<ol style="list-style-type: none"> <li>1. The person named in the residence order (RO) plus:</li> <li>2. As under 'no order' above</li> </ol>
<b>Placement order</b>	<ol style="list-style-type: none"> <li>1. Local authority (adoption agency)</li> <li>2. Birth parent(s)</li> <li>3. Prospective adopters (where the child is placed for adoption) NB if the child is subject of a placement order but NOT placed for adoption the foster carers DO NOT have PR</li> </ol>
<b>Special Guardianship order</b>	<ol style="list-style-type: none"> <li>1. The named special guardian(s)</li> <li>2. Anyone holding a RO</li> <li>3. The Local Authority if a care order is in force</li> <li>4. Others as per 'no order' above</li> <li>5. Local authority (adoption agency)</li> <li>6. Birth parent(s)</li> <li>7. Prospective adopters (where the child is placed for adoption) NB if the child is subject of a placement order but NOT placed for adoption the foster carers DO NOT have PR</li> </ol>
<p><b>Note (1)</b>  <i>In law if there are two people with parental responsibility (eg mother and father) consent is only required from one parent ( and this is valid even if the other parent disagrees). If this situation arises the clinician is advised to raise it with the course consultant and/or at supervision.</i></p>	
<p><b>Note (2)</b>  <i>It is the therapists responsibility to ensure that the person from whom consent is sought is authorised in law as holding parental responsibility</i></p>	

## **Guidance for Clinicians on Competence, Consent, and Refusal of Treatment for Children and Young People**

Young people should be involved as much as possible in decisions about their health care. At the same time a balance needs to be struck between autonomy and protection. Young people are entitled to privacy, information, and a level of decision making geared to their maturity. Most young people prefer to share treatment decisions with their parents, but some will wish to exclude their parents, or oppose their parents' and/or clinician's recommendations. Every effort should be made to reach a consensus, including providing more information and time, and the involvement of an independent second opinion. Where agreement is not possible the law provides more than one approach to avoid deadlock. The challenge is choosing which legal framework is most appropriate to the circumstances of the particular case.

The following is an aid to clinicians supporting young people in their decision making. Good practice requires not only an understanding of the legal and ethical framework but also clinical sensitivity.

### **Competence**

#### ***Key Points to consider***

1. *The consent of a young person under the age of 16 years is only valid if a clinician is satisfied that the young person is competent.*
2. *Competence requires adequate information.*
3. *The value of information is increased by an opportunity to ask questions and time to think.*
4. *Competence requires young people to:*
  - *understand fully what is proposed,*
  - *retain an understanding,*
  - *appreciate the importance of information and see how it applies to themselves,*
  - *and weigh the information in the balance.*

5. *The Level of understanding that is sufficient will vary with the complexity and gravity of the decision.*
6. *Young people's competence can be:*
  - *enhanced by support,*
  - *impaired by adverse mental or physical states,*
  - *and undermined by coercion,*
7. *Judgments about competence can only be made on a case-by-case basis.*
8. *In complex cases it is best practice to involve an independent clinician.*

## **Introduction**

Competence is central to the law's approach to consent. Only a competent person can give a valid consent. Adults enjoy a presumption of competence and in practice a similar approach is taken to 16 and 17 year olds. The consent of a young person under the age of 16 years is only valid if a clinician is satisfied that the young person is competent. Competence is about the young person's level of understanding and ability to think about the issues. It varies with the complexity of the decision, the availability of information and time, and the presence of factors that enhance or impair the young person's decision making capacities.

## **Information and Time**

Competence is only possible in the presence of adequate information. The value of information will increase with the opportunity to ask questions and proceed at the young person's own pace (in the absence of an overriding need to act). Translators may be necessary and adaptations made for young people with learning difficulties or deficits in symbolic thinking. Clinicians should make a record of what was shared with the young person and their family.

## **Understanding**

Ruling in the Gillick Case (Gillick v. West Norfolk and Wisbech Area Health Authority), Lord Scarman linked competence to "sufficient understanding and intelligence" to allow a young person "to understand fully what is proposed". (As is well known, this case examined the circumstances in which it would be lawful to give contraceptive advice to a young person under the age of 16 years without parents' permission.) Understanding fully is generally taken to include understanding the nature of what is wrong, the treatment process, the treatment options, the likely risks and benefits of treatment, and the outlook with or without treatment. Alderson (1993) interviewed 120 young people (aged 8-15 years) undergoing elective surgery to relieve chronic orthopaedic pain disability or deformity, she also spoke to their parents. The young people were asked, "How old do you think you were or will be when you're old enough to decide?" (about surgery). Their parents were asked, "at what age do you

think your child can make a wise choice?”. The two groups gave a similar mean age (the young people said 14.0 years, the parents 13.9). But girls and their parents thought they would be ready to decide 2 years earlier (girls: 13.1 years, and girls’ parents: 12.8, compared with boys: 15.0 years; boys’ parents 14.9). However most young people wanted to share the decision with their parents, only a few wanted to be the “main decider” (21 out of 120).

### **Complexity and Gravity if the Decision**

The level of understanding that is sufficient will vary with the complexity and gravity of the decision. Of particular importance are the relative benefits, risks and burdens of the treatment options (where the burdens are the demands, inconvenience or suffering a particular treatment is likely to be required). Greater understanding is expected if the burdens are heavy, the risks high, or the benefits uncertain. Similarly, a higher level of understanding is required if young people refuse treatment.

### **Building on Understanding**

Lord Justice Thorpe’s decision in *Re C (Adult: Refusal of Medical Treatment)* broadened the concept of competence established by Gillick. C was a patient at Broadmoor Hospital suffering from schizophrenia who refused amputation of his gangrenous foot. Ruling that C should decide for himself, the court defined competence as “first comprehending and retaining information, secondly, believing it and thirdly, weighing it in the balance to arrive at a choice”. In this context believing means the young person appreciates the importance of information and sees how it applies to them. A young person may weigh the information differently from their parents or clinician, and unwise choices might be permitted. Pearce (1994) has argued that because: “the consequences of withholding consent are usually much more significant and potentially dangerous...a more stringent test should therefore be applied”. On the other hand it may be more respectful to recognize that a young person is competent but over ride their decision on the basis of welfare (Shaw 2002) (see section on refusal below). Finally, when evaluating young people’s competence it is important not to set a higher standard than would be expected for adults.

### **Enhancing Competence**

Young people’s competence will be enhanced if they feel loved and supported. As mentioned earlier most young people prefer to discuss important decisions with a family member or friend. Equally, discussion with health professionals will be more productive when the relationship is founded on trust and respect.

### **Threats to competence**

Competence can be impaired by disordered mental or physical states. Ruling in the case of MB a woman who refused a caesarean section because of a needle phobia, Lady Justice Butler-Sloss cited "temporary factors...confusion, shock, fatigue, pain or drugs may completely erode capacity...another such influence may be panic induced by fear" (Re MB (Caesarean Section)). Mental illness may render a young person incompetent; however it is important not to assume that all (or even most) mentally ill people are incompetent. Finally, competence can be undermined by coercion (however well intentioned) from family, or even clinicians.

### **Assessing competence**

Judgments about competence can only be made on a case-by-case basis. As Rutter (1999) points out "...there is no universally acceptable level of competence that applies to an individual child. Rather, the question is of a child's competence in a particular context, for a particular type of decision, given particular circumstances". When there is genuine doubt over competence it may be useful to get a second clinical opinion (something that is always required where Section 58 of the Mental Health Act 1983 pertains). In any event clinicians must make a full record of the basis for any judgment about competence. The criteria are derived from Re C and it will be important to indicate whether the young person was not competent because he or she: "is unable to take in and retain the information material to the decision especially as to the likely consequences of having, or not having treatment"; or "is unable to believe the information"; or "is unable to weigh the information in the balance as part of a process of arriving at the decision". (chapter 15 of the Mental Health Act 1983 Code of Practice 1999).

## **Consent**

### ***Key points to consider***

- 1. Outside of emergencies or the Mental Health Act 1983, consent is a prerequisite to treatment.*
- 2. Consent is a voluntary and continuing permission to receive a particular treatment, based on an adequate knowledge.*
- 3. Consent can be withdrawn at any time and patients are not bound by written consent.*
- 4. If a 16 or 17 year old consents, it is unnecessary to seek consent from a person with parental responsibility.*
- 5. A competent person under 16 has an independent right to treatment; however, it is good practice to also seek consent from a person with parental responsibility.*

6. *Where a young person is not competent treatment can proceed with the consent of a person with parental responsibility.*
7. *Sometimes it may be necessary to seek consent from the High Court.*
8. *The basis for believing that a young person gave valid consent should be recorded in the clinical record.*

### **The Requirement for consent**

Other than for emergencies or in the circumstances described in part IV of the Mental Health Act 1983, consent is a necessary prerequisite to the treatment of any person. The Code of Practice for the Mental Health Act defines consent as “the voluntary and continuing permission of the patient to receive a particular treatment, based on adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and any alternatives to it. Permission given under any undue pressure is not consent.” “Giving and obtaining consent is a process not a one-off event” (DoH 2001 Good practice on consent implementation guide). Consent can be withdrawn at any time and patients are not bound by written consent.

It is unlikely that the written consent of the patient will be required for routine assessment and treatment in the Child & Family Department. The Department of Health say “It is rarely a legal requirement to seek written consent, but it is good practice to do so if any of the following circumstances apply: the treatment or procedure is complex, or involves significant risks...; the procedure involves general/regional anaesthesia or sedation; providing clinical care is not the primary purpose of the procedure; there may be significant consequences for the patient’s employment, social or personal life; the treatment is part of a project or programme of research” (DoH Good practice in consent implementation guide 2001). However the basis for believing that the young person gave valid consent should be recorded in the file. This will include that they were competent and gave consent: free of “unfair or undue pressure”; and “based on an adequate knowledge of the purpose, nature, likely risks of that treatment including the likelihood of its success and any alternatives to it”; and “the patient was invited to ask questions”; and that the patient has been “told that his or her consent to treatment can be withdrawn at any time” (chapter 15 of the Mental Health Act 1983 Code of Practice 1999).

### **Who can give Consent?**

Where a young person is competent we would normally seek their consent. “Even where children are not able to give consent for themselves it is very important to involve them as much as possible in decision about their own health” (DoH 2001 Seeking consent: working with children). Alderson, (see section on competence above) cites: out of respect for the young person; to answer questions and help the young

person know what to expect; to reduce anxiety; to help the young person make sense of their experience; to prevent misunderstandings or resentment; to promote confidence and courage; and increase compliance.

Where the young person is not competent treatment can proceed with the consent of a person with parental responsibility (including the local authority with a care order). In exceptional circumstances the High Court may be asked to consent on behalf of a young person. "It is good practice to involve all those close to the child in the decision making process" (DoH 2001 Seeking consent: working with children). Where one person with parental responsibility consents but their decision is opposed by another person with parental responsibility the onus is on the objecting parent to obtain a court order blocking treatment (Children Act 1989 s2 (7)).

It would normally be inappropriate for a parent who has abused a child to give consent on that child's behalf. Where the young person is not already in the care of the local authority (who will then hold parental responsibility), the High Court's authority should be sought. In the case of an unaccompanied minor unable to give valid consent, outside of an emergency the young person will need to be taken into care or the authority of the Court should be sought.

### **Those aged 16 or 17**

The Law Reform Act 1969 lowered the age of majority to 18 years, and gave 16 and 17 year olds the same right of consent as adults (s8 [1]). This means that if a 16 or 17 year old person consents it is unnecessary to seek consent from a person with parental responsibility. (However, see the section on refusal, below.)

### **Those under 16**

As described above, the competence of a young person under the age of 16 years is considered in light of the Gillick decision (see above). It gives under 16 year olds with sufficient understanding ("Gillick competent") an independent right to consent to treatment. In his ruling in the Gillick case, Lord Fraser set out five preconditions that would justify a doctor prescribing contraceptives to a young woman under the age of 16 years without her parents' consent:

- That the girl (although under the age of 16 years) will understand the doctor's advice.
- That the doctor cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice.
- That she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment.

- That unless she receives contraceptive advice or treatment, her physical or mental health or both is likely to suffer.
- That her best interests require the doctor to give her contraceptive advice or treatment, or both, without parental consent.

Clinical experience predicts that treatment will be less effective if parents are excluded. The principals of Lord Fraser's preconditions help delineate a small group of young people where treatment may still be appropriate. Although there is no legal age limit, Bailey and Harbour suggest that it would rarely be appropriate for a young person under the age of 13 years to consent to treatment without their parents' involvement

## Refusing Treatment

### *Key Points to consider*

1. *Every effort should be made to reach a consensus, including providing more information and time, and the involvement of an independent second opinion.*
2. *The Mental Health Act 1983 goes further to protect the rights of young people treated against their wishes.*
3. *The consent of a person with parental responsibility will override the refusal of the young person.*
4. *But the power to over-rule a competent young person's refusal should be used very rarely and it would be appropriate to seek legal advice before proceeding.*
5. *And it would be inappropriate to use parental authority where young people have been abused or neglected by their parents.*
6. *Occasionally the court needs to intervene where parents withhold treatment.*

### Finding a way forward

Young people will sometimes refuse treatment despite the most sensitive and skilled approach of clinicians and parents. Pearce (1994) suggests that "every effort should be made to reach consensus, however protracted this process may be – so long as this does not involve taking unacceptable risks with the child's future health...It is usually better to delay treatment until attitudes and relationships have changed – which could just as easily be the professional's attitude as the patient's". Again it may be useful to get a second opinion from an independent clinician and it is essential that the basis for any decision is fully recorded.

Where agreement is not possible the law provides more than one approach to avoid deadlock. The challenge is choosing which legal framework is most appropriate to the circumstances of the particular case.

### **The Mental Health Act 1983**

The Mental Health Act 1983 may be used to treat people of any age. With its requirement for a second opinion, time limited application and opportunity for independent review, the Mental Health Act 1983 goes further than common law (see below) to protect the rights of young people treated against their wishes. However there is still a stigma attached to treatment under the Mental Health Act. Furthermore because treatment can proceed with the consent of a person with parental responsibility (see below) there are difficulties meeting the Mental Health Act 1983's requirement that "treatment...cannot be provided unless he is detained" (s3 (2) (c)). The new draft Mental Health Bill proposes that for 16 or 17 year olds "refusal to consent or resistance may not be overridden by the giving of consent by a person who has parental responsibility for him" (s202 (5)). While under 16 year olds are treated with parental consent but with various safeguards (part 6 Chapter 2).

### **Adults' right to Refuse**

Other than the circumstances described in part IV of the Mental Health Act 1983, once a person has reached the age of 18 years they have a right to refuse treatment "for reasons which are rational or irrational, or for no reason" (Sidway v. Board of Governors of Bethlem Royal Hospital and Maudsley Hospital).

### **The Children Act 1989**

The Children Act 1989 explicitly gives those who are under 16 years old and competent the right to refuse assessment and treatment in the very limited circumstances of care proceedings (s38 (6), s43 (8), s44 (7) and paragraphs 4 (4) (a) and 5 (5) (a) of Schedule 3). The Act and accompanying guidance and regulations place considerable emphasis on taking account of the young person's views. However, the central premise of the Children Act is that "the child's welfare shall be the court's paramount consideration" (s1 [1]). Unlike the competent adult, the competent young person's views may be overruled in pursuit of his or her welfare.

Decisions in *Re R* & *Re W* curtail a young person's ability to refuse treatment. Furthermore, two rulings by the Court of Appeal (*Re R (A Minor) (Wardship: Medical Treatment)* and *Re W (A Minor) (Wardship: Medical Treatment)*) significantly curtail a young person's ability to refuse treatment. They concern *R*, a 15 year old young woman

refusing antipsychotic medication, and W, a 16 year old young woman with anorexia nervosa refusing transfer to another treatment centre. In both cases the Court of Appeal decided that treatment could lawfully precede with the consent of a person with parental responsibility effectively ignoring the refusal of a young person whether or not they were competent and even when they were over 16 years. In the Gillick decision Lord Scarman said: "the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed". In Re R Lord Donaldson argued that in Gillick "Lord Scarman was discussing the parent's right to determine whether or not their minor child below the age of 16 will have medical treatment...a right of determination is wider than a right of consent...I do not understand Lord Scarman to be saying that, if a child was "Gillick competent" ...the parents cease to have a right of consent as contrasted with ceasing to having a right of determination, i.e. *aveto*. In a case in which the "Gillick competent" child refuses treatment, but the parents consent, that consent enables treatment to be undertaken lawfully".

As it stands, common law allows a competent young person to consent to treatment; but does not recognize refusal if consent can be obtained from a person with parental responsibility. Many commentators consider this contradictory, even Lord Balcombe ruling in Re W admitted: "in logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment". A challenge under Article 5 of the Human Rights Act 1998 "right to liberty" seems possible. However some years ago the European Court of Human Rights upheld a mother's right to make decisions about psychiatric admission on her son's behalf under her Article 8 "right to respect of private and family life" (*Nielsen v Denmark*). The Department of Health recommend the "power to over-rule a competent child's refusal should be used very rarely" (2001 *Seeking consent: working with children*).

It would be appropriate to seek legal advice before using parental consent to treat a young person against their wishes (especially where they are competent and older). It may even be necessary to go to Court, for example the British Medical Association (2001) recommends involving the Court where restraint or detention under parental consent is contemplated. As mentioned above it would normally be inappropriate for a parent who has abused a child to override a young person's refusal. Where such a young person is not already in the care of the local authority, the High Court's authority should be sought.

### **Parents who refuse treatment for their child**

Parents have a duty under the Children and Young Persons Act 1933 5(1) to obtain essential medical assistance for a child under the age of 16 years. Occasionally the court needs to intervene in situations where parents withhold treatment. Where parent's

refusal is part of a wider process of neglect or abuse, a care order may be appropriate. This gives the local authority parental responsibility, and treatment can proceed with their consent. Alternatively if the parents' care is generally satisfactory and their objection to treatment is on the basis of religious or other firmly held beliefs, it is possible to ask the High Court to use its inherent jurisdiction to overrule the parents, or apply a Specific Issues Order of the Children Act 1989 (s8).

*Dr Mike Shaw*

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# Medical Appraisal and Revalidation Policy and Procedures

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## 1 Introduction

The Tavistock and Portman NHS Foundation Trust (the Trust) is required to have in place an approved policy and procedures to ensure that it fully meets the requirements for the introduction of revalidation of all doctors working at the Trust in 2012.

Revalidation is the process by which doctors will have to demonstrate to the General Medical Council (GMC) that they are up to date with continuing professional development (CPD), fit to practise and complying with the relevant professional standards. The medical Royal Colleges and Faculties have developed standards and defined essential specialty supporting information for the appraisal and revalidation of specialist doctors and GPs.

Appraisal is the cornerstone of revalidation. Revalidation will be based on systematic appraisal of the doctor's work on an annual basis with revalidation required every five years. Satisfactory appraisals over a five year period will enable a Responsible Officer to recommend revalidation to the GMC. All non-training grade medical staff (GPs, Consultants, SAS grades and any other non-training grade posts) are expected to go through revalidation every five years. The Deanery will be responsible for the revalidation of doctors in training.

The Royal College of Psychiatrists (2010a) has set out how psychiatrists will demonstrate that they meet the generic standards of *Good Medical Practice* (2006) and the specialist standards of *Good Psychiatric Practice* (2009). It will be through the annual appraisal process that psychiatrists will demonstrate that they are meeting these relevant standards.

This document sets out the way in which this requirement will be met by the Trust.

## 2 Purpose and objectives

The purpose of this policy and procedures is to set out the way in which the Trust will manage appraisal and revalidation recommendations for doctors working at the Trust.

The policy defines the responsibilities of key staff involved in appraisal including medical staff, managers, HR etc. The aim of the policy is to ensure that, through an effective appraisal mechanism, all medical staff are fit to practise and provide the highest standards of safe care to patients.

### Objectives of appraisal

The objectives of the appraisal scheme are to enable doctors to:

- review regularly an individual doctor's work and performance, utilising relevant and appropriate comparative performance data from the Trust, regional and national sources (if these are available in a meaningful format)
- optimise the use of skills and resources in seeking to achieve the delivery of service opportunities
- consider the doctor's contribution to the quality and improvement of services and priorities delivered locally
- set out personal and professional development needs and agree plans for these to be met
- identify the need for the working environment to be adequately resourced to enable any service objectives in the agreed job plan review to be met
- provide an opportunity for doctors to discuss and seek support for their participation in activities for the wider NHS
- utilise the annual appraisal process and associated documentation to meet the requirements for GMC revalidation
- play a significant part in wider Trust issues such as clinical governance, risk management and the process for awarding discretionary points.
-

### 3 Scope

This policy applies to all non-training grade medical staff (GPs, Consultants, SAS and all other non-training grades, and including substantive employees, employees with honorary contracts/joint contracts or temporarily employed) employed by the Trust. .

It is not directly applicable to medical trainees, whose supervision, appraisal and revalidation will be managed by the Deanery.

### 4 Definition and aims of effective appraisal

#### 4.1 Definition of Appraisal

Appraisal is defined as "a professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on his or her work and to consider how his or her effectiveness might be improved" (DoH, 2002)

Appraisal for doctors is a professional process of constructive dialogue, in which the doctor being appraised has a formal structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved. It is intended to be a positive employer-led process to give doctors feed-back on their performance, to chart their continuing progress and to identify development needs. It is a forward-looking process that enables plans to be discussed and agreed for the educational and developmental needs of each individual.

The primary aim of appraisal is not to scrutinise doctors to see if they are performing poorly but rather to help them consolidate and improve on good performance, aiming towards excellence. However, it can help to recognise at an early stage developing poor performance or ill health which may be affecting clinical practice. It is important that appraisal is seen as a two-way process, which allows consultants to feed back issues to the organisation, as well as receiving feedback themselves.

The distinction is often made between summative and formative processes in appraisal. The summative component involves an assessment of what has happened whilst the formative part of appraisal involves identifying developmental needs and looking forward. A good appraisal involves both summative and formative components. The summative assessment of what has been achieved and what standards have been reached is necessary to inform the formative and developmental stage of the appraisal process.

### 5 Roles and Responsibilities

This section defines the key staff involved in the appraisal/revalidation process.

#### 5.1 The Trust/ Chief Executive

The Trust is the designated employing authority and through the Chief Executive is responsible for:

- ensuring that a suitable system of appraisal is operating in the Trust
- nominating the responsible officer
- ensuring effective governance arrangements are in place to maintain standards of appraisal
- allocating financial and administrative resources to support appraisal and revalidation
- ensuring that appraisers are covered by Trust indemnity for their actions in this role.

#### 5.2 Responsible Officer/Medical Director

The Responsible Officer (RO) is a new statutory role which came into force on 1st January 2011 under *the Medical Profession (Responsible Officers) Regulations 2010*. The Trust has nominated the Medical Director to be the RO.

The RO is responsible for making recommendations to the GMC on revalidating doctors every five years based on the results of a doctor's annual appraisal and folder of information.

The RO is responsible for:

- Ensuring that the Trust has an up to date Medical Appraisal and Revalidation Policy and Procedures documents.
- Maintaining a list of doctors for which the RO is responsible and securely retaining records of doctors' fitness to practise evaluations including appraisals and any other investigations or assessments.
- Ensuring all doctors working in the Trust participate in annual appraisal and that appropriate action is taken to remedy identified areas of weakness in doctors' performance.
- Making recommendations to the GMC about the fitness to practise of doctors employed by the Trust, and where a doctor employed by the Trust is subject to conditions imposed by or undertakings agreed with the GMC, to monitor compliance with those conditions.
- Establishing and implementing procedures to investigate concerns about a doctor's fitness to practise raised by patients or staff of the trust or arising from another source, in line with *Maintaining High Professional Standards in the NHS*.
- Providing an annual report on Revalidation to the Board of Directors.

**Note:** Where there is justified cause for concern about a doctor's fitness to practise which cannot be managed through remediation processes, the role of the Responsible Officer is limited to drawing the case to the attention of the GMC and to ensuring that the necessary supporting information is available. Final decisions which may affect the ability of the doctor to continue in practice will remain, as at present, the sole responsibility of the GMC.

### 5.3 Appraisal and Revalidation Lead/ Associate Medical Director

The Appraisal Lead is responsible to the RO and is responsible for:

- Overseeing a network of approved medical appraisers
- Assisting the RO in meeting his responsibilities as set out above
- Providing leadership and support to appraisers
- Auditing and quality assuring the appraisal process as set out in Appendix 16

### 5.4 Appraisers

All medical appraisers in the Trust are senior medical consultants who have received formal appraisal training, and are accountable in their role of appraiser to the Appraisal Lead.

Responsibilities of the appraiser:

- To be formally trained in appraisal for revalidation.
- To ensure there is no conflict of interest between appraisee and appraiser (see Appendix 1)
- To obtain consent from the appraisee to collect information as part of the appraisal meeting.
- To agree an appraisal meeting with the appraisee normally 3 months ahead of the date and that relevant paperwork is submitted to the appraiser, at least 2 weeks before the appraisal.
- To assess the appraisee's supporting information being gathered for revalidation. The appraiser will be asked to check that the gathered supporting information is of the appropriate quality and quantity for the particular stage of the revalidation cycle that the appraisee is at. If the supporting information that is provided is insufficient to inform an evaluation of the doctors practice the appraiser in the first instance should discuss this with the appraisee. If this does not resolve the problem, the matter should be referred to the Appraisal Lead.

- To stop the appraisal process and refer the doctor to the RO if the appraisal suggests that a GP's health, conduct or performance poses a threat to patient safety.
- To ensure that any personal data recorded is accurate and is stored securely, and the appraisee is given adequate opportunity to check any information recorded.
- To have their own personal appraisal completed annually by the Appraisal Lead or Responsible Officer.
- To take part in a performance review, including feedback on performance in their role (see Section 11 below).

#### **5.4 Appraisee**

The appraisee is the doctor who is being appraised. All appraisers (as defined above) will also become appraisees when they are being appraised themselves.

Responsibilities of the appraisee:

- To provide the Trust with a secure email address which is accessed at least once a week, a valid postal address and a valid contact telephone number.
- To initiate and complete the annual appraisal in line with this policy.
- The appraisee should make contact with their allocated appraiser and arrange an appraisal date. They should then log on to the appraisal toolkit (*when this available*) and enter the details of the appraiser and appointment time. This should be completed by the end of July at the latest (3 months into appraisal year).
- To ensure there is no conflict of interest between appraisee and appraiser (see Appendix 6)
- To consent for their appraiser to view and use their pre-appraisal paperwork by arranging an appraisal meeting and submitting his/her appraisal documentation for consideration.
- To set aside adequate time to prepare the documentation and supporting information for appraisal. It is acceptable for an appraisal to take place 6 months after the last appraisal has taken place to help facilitate moving appraisals earlier in to the appraisal year.
- To send a copy of the documentation and supporting information to the appraiser at least 2 weeks before the date of appraisal.
- To inform the appraiser of any complaints or disciplinary procedures made against them.
- To contribute to the governance and future development of consultant appraisal in the Trust by completing the feedback questionnaire and returning it within 4 weeks of the appraisal.
- To ensure that the form 4 and PDP produced as a result of their appraisal is a true reflection of the appraisal interview and satisfactory for the purposes of revalidation.

#### **5.5 Medical HR Revalidation Lead**

The Medical HR Revalidation Lead will oversee the Revalidation Appraisal process in consultation with the Appraisal Lead and Responsible Officer and ensure that related procedures and practices are regularly reviewed in line with changes in legislation. The post holder will ensure that appropriate protocols, processes and records are developed and maintained to ensure that all Medical Staff undertake annual appraisal in line with National Guidance.

#### **5.6 Appraisal Facilitator**

The Appraisal Facilitator is responsible for providing administrative support to the appraisal process including:

- Maintaining the records/electronic data system and ensure that the systems in place are held securely.
- Maintaining a database of trained Appraisers
- Providing performance reports to Clinical Directorates of appraisal activity within their directorate.

## 6 The Appraisal Process

The appraisal process is set out in detail at Appendix 1.

## 7 Appraisal arrangements for clinical academics and doctors working in more than one designated body or in the private sector

### 7.1 Doctors working in more than one NHS trust

For doctors working in more than one designated body or trust, the trusts must agree on a 'lead' trust for the doctor's appraisal, which will normally be the employing trust where the doctor works most. Agreement will also include appropriate discussion prior to the appraisal between the RO and their equivalent in the other trust(s) to ensure that key issues are considered, including systems for accessing and sharing data and arrangements for action arising out of the appraisal. Feedback from the appraisal should also be given, on a confidential basis, to the other trust(s).

### 7.2 Appraisal for independent sector doctors employed by the NHS - whole practice appraisal

Doctors practising in both the NHS and independent sectors need to undertake whole practice appraisal which will take account of their work in both sectors. The appraisal will usually take place in the sector within which they do the bulk of their work. Doctors employed by the NHS and who work privately are recommended to participate in whole practice appraisal within their NHS appraisal to cover all elements of their practice. Appraisal should take place in the NHS using NHS appraisal forms together with data provided in approved forms available from the private hospitals.

For further details see BMA guidance at

[www.bma.org.uk/employmentandcontracts/doctors\\_performance/1\\_appraisal/AppraisalIM\\_PDocsNHS.jsp](http://www.bma.org.uk/employmentandcontracts/doctors_performance/1_appraisal/AppraisalIM_PDocsNHS.jsp)

### 7.3 Clinical academics

Appraisal for clinical academics should be in line with Follett Principles. The Follett Review reported in September 2001 and made a number of recommendations regarding the appraisal, disciplinary and reporting arrangements for senior clinical academic staff. In regard to appraisal, the report recommended that Universities and NHS bodies should work together to develop a jointly agreed annual appraisal and performance review process based on that for NHS consultants, to meet the needs of both partners. The process should:

- Involve a decision on whether single or joint appraisal is appropriate for every senior NHS and university staff member with academic and clinical duties.
- Ensure joint appraisal for clinical academics holding honorary consultant contracts and for NHS staff undertaking substantial roles in universities.
- Define joint appraisal as two appraisers, one from the university and one from the NHS, working with one appraisee on a single occasion.
- Require a structured input from the other partner where a single appraiser acts.
- Be based on a single set of documents and start with a joint induction for those who will be jointly appraised.

## 8 Situations when Deferral will be Permitted

A deferral request process will normally be activated in the event that a scenario arises during the appraisal year that is outside the scope of normal operating processes e.g. long-term illness, maternity leave, suspension, sabbatical etc.

A deferral request form will need to be completed by the appraisee and agreed by the appraiser (see appendix 12).

### 8.1 Illness

If the appraiser considers that an appraisee should be excluded from any aspect of the

appraisal scheme for any given year as a result of illness, they must ensure this is recorded on the database and inform the Appraisal Lead.

### **8.2 Maternity, Adoption, Paternity**

Appraisals may be prepared for or undertaken during maternity, adoption and paternity leave with the agreement of the appraisee. Exception from the appraisal in any appraisal year will be considered in the event that there is absence from practice for more than 9 months in an appraisal year, resulting in insufficient time (either before the leave or following it) for an appraisal to take place. The appraisee must inform the appraiser and the decision must be recorded on the database (see appendix 13).

### **8.3 Suspension from practice**

Suspension from practice, pending either a trust or GMC investigation is an automatic exception, unless there are six clear months for the appraisee to recover their practice between their return to work and the end of the appraisal year.

### **8.4 Sabbatical**

Appraisal can take place where there are six clear months between the time when the appraisee has returned to work and the end of the appraisal year.

## **9 Governance Arrangements for Medical Revalidation**

### **9.1 Record Keeping and Administration**

A live register will be kept by the RO's office, recording all information relating to each doctor on an annual basis. Previous records will be archived. All records will be kept in accordance with the data protection act and the register will be password protected. As a minimum, the register will include:

- Dates of previous appraisals.
- Date next appraisal is due.
- Date of return of completed appraisal forms.
- Date the appraisal actually took place.

### **9.2 Electronic appraisal toolkit**

It is expected that all appraisers and appraisees will be trained in and use an online GMC approved accredited appraisal toolkit to complete appraisal. This will provide a standard core content and electronic recording of supportive documentation. The Appraisal Lead and HR are currently researching the market for the most suitable approved appraisal toolkit to be used. This will be financed by the Trust.

### **9.3 Integration of appraisal with quality improvement, clinical governance and performance monitoring systems**

It is important that that key information such as specified complaints, SUIs and other significant events affecting patient safety, as well as outlying performance/clinical outcomes are included in the appraisal portfolio and have been discussed in the appraisal so that developmental needs are identified.

The Appraisal Lead in her role as Clinical Risk and Patient Safety Lead, and the Responsible Officer in his role as Chair of the Clinical Governance and Safety Committee, are routinely informed of all complaints, Serious Untoward Incidents and other clinical incidents, as well as clinical and performance outcomes in the Trust. The Appraisal Lead and RO will ensure that any such key information relating to an individual doctor will be discussed with the doctor concerned and communicated to the relevant appraiser to ensure that this will be included in the consultant's supporting information and discussed in the doctor's appraisal.

The Appraisal Lead will also ensure that information collated from appraisee feedback and audit of the appraisal process will be used to inform the Trust of educational needs and

organizational development activity in an annual report of the quality and outcomes of appraisal (see Section 11).

#### **9.4 Confidentiality, security and access arrangements**

Appraisal meetings will be conducted in private and the key points of the discussion and outcome will be fully documented, with copies held by the appraiser and appraisee. Both parties must complete and sign the appraisal summary document (Form 4) and PDP and send copies, in confidence, to the RO. Both the Trust and the appraisee will need to retain copies of the appraisal documentation over a five year period. All records will be held on a secure basis by the RO and access/use must comply fully with the requirements of the Data Protection Act (1998). No information from the appraisal sessions will be disclosed unless agreed with the doctor, except under exceptional circumstances where there are significant concerns about patient safety or issues that relate to fitness to practise.

No patient identifiable data is to be held in the appraisal records by either the appraisee or appraiser. If potentially identifiable information is used e.g. a complaint, it must be anonymised.

The electronic transmission of data, i.e. by email, must be safeguarded against unauthorised access. Email may only be used to transfer personal data if the transmission is encrypted such as nhs.net. Email accounts should be password controlled and care taken to ensure that login details are not shared. Electronic copies of appraisal paperwork must not be stored on shared computer drives.

### **10. Concerns and Complaints**

It is important that all complaints related to appraisal are dealt with in a timely and efficient way. Some concerns will be dealt with informally.

Appraisees may find it sufficient to raise minor concerns on their feedback questionnaire, after their appraisal interview, in the knowledge that this will be shared. Others may wish to raise issues directly with their appraiser. The Trust should ensure that appraisers report their handling of such problems to the Appraisal Lead. If the Appraisal Lead is unable to respond satisfactorily to the problem, he or she should refer the matter immediately to the RO.

If an appraisee has concerns regarding their appraisal these should be raised initially with the appraiser. If the consultant prefers not to approach his or her appraiser, or, because of the nature of the problem, considers it inappropriate to do so, the first point of contact should be the Appraisal Lead, who will attempt to resolve the problem through discussion and mediation involving others where appropriate. If the Appraisal Lead is unable to resolve the problem, he/she should refer the matter to the RO. In exceptional circumstances or when a concern cannot be resolved by these means, the RO will refer the matter to the Chief Executive.

In rare instances, where the concern or complaint is of a serious professional nature the Trust process for management of concerns raised about professional performance to protect patient safety will be followed.

### **11. Selection, Training and Support of Medical Appraisers**

Procedures for the selection, training and support of medical appraisers are detailed in Appendix 2

### **12 Monitoring Compliance with the Procedure**

The Trust will undertake a review of the following organisational quality standards of the medical appraisal process and plan to work towards achieving these.

On an annual basis the following will be undertaken and co-ordinated by the Appraisal Lead/ Associate Medical Director:

### **12.1 Appraisee feedback**

Feedback questionnaires will be given to appraisees following completion of each appraisal (see appendix 14). These will be reviewed by the Appraisal Lead and RO and the information collated and included in the annual report to the Trust Board. Feedback will be given to appraisers on their performance. The Appraisal Lead will also use feedback from PDP's and questionnaires to inform the Trust of educational need.

### **12.2 Audit of the appraisal process**

The Trust will carry out regular self-assessment audits to make sure it is meeting quality standards in line with recommendations from the Revalidation Support Team. The Appraisal Lead will facilitate review of Form 4s and PDPs against revalidation requirements and quality criteria for appraisal and collate training needs to inform provision (Appendix 15). Form 4s and PDPs will be audited and classified by appraiser. Routinely, 2 appraisals per appraiser will be examined annually to inform feedback to the appraiser and Trust and ensure appraisal provision is in line with this policy and revalidation.

The Trust will facilitate external audit of the appraisal process in line with national guidelines.

### **12.3 Exception audit of missed or incomplete appraisals**

A missed or incomplete appraisal is an important occurrence which could indicate a problem with the appraisal system or a potential issue with an individual doctor which needs to be addressed. Missed appraisals are those which were due within the appraisal year but are not performed. Incomplete appraisals are those where, for example, the appraisal discussion has not been completed or where the PDP or summary of appraisal discussion have not been signed off within 28 days of the appraisal meeting.

An exception audit (see Appendix 16) to identify the reasons for all missed or incomplete appraisals will be performed by the Appraisal Lead/Associate Medical Director at the end of each appraisal year and ensure that any recommendations and improvements are enacted within the following year.

### **12.4 Annual report**

An annual report of the quality and outcomes of appraisal will be prepared by the by the Appraisal Lead and RO (Appendix 17) and presented to the Board of Directors.

## **13 Equality Impact Statement**

The impact of this Procedure on staff and potential or prospective staff to the Trust has been fully assessed with neutral impacts identified.

## **14 References**

Department of Health (2001) *Appraisal Guidance for Consultants*

Department of Health (2006) *Good Doctors, Safer Patients*

Department of Health (2007) *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*

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## Appraisal Process

### 1. Standards underpinning the appraisal process

Appraisal should be:

- **Fair:** appraisal should be conducted fairly and consistently by competent and appropriately trained appraisers. It should be based on valid information and assessed against defined standards.
- **Supportive and developmental for doctors:** for the overwhelming majority of doctors who provide safe, effective and patient-centered care, appraisal should practice, develop skills, encourage doctors and improve the quality of professional practice.
- **Protective of patient safety:** appraisal should act as a safety net, identifying practice where development and change is needed. This should happen only in rare circumstances where clinical governance has failed to identify and address such practice.
- **Streamlined:** Appraisal systems should seek to minimise the time taken to prepare portfolios, complete documentation and participate in the appraisal.
- **Practicable:** NHS medical appraisal should support, not disrupt, the delivery of care to patients. Its implementation should take account of the pressures of the service and organizational needs, integrating with clinical governance and the complexity of the modern healthcare environment.
- **Valid and evidence based:** The ability of strengthened appraisal to meet the criteria set out above needs to be piloted and evaluated.

### 2. Phases in the Appraisal Process:

Phase	Activity
1	Preparation work and information gathering by both appraiser and appraisee. Appraisals for revalidation are made up of whole practice appraisal and therefore appraisees must provide information from all organisations that employ them.
2	Appraisal discussion <i>including</i> a review of the previous year's PDP.
3	Notification & return of papers and agreement of a new PDP going forward.
4	Review & reporting by the Responsible Officer & Clinical Directors.
5	Issue of "Statement of satisfactory completion of appraisal" signed off by both parties within 28 days of the appraisal meeting, after this stage the appraisal process is complete.

#### Phase 1: Preparation for the appraisal meeting

Preparation for appraisal should be part of a consultant's Supporting Professional Activity (SPA). It is envisaged that between 2-4 hours a month is sufficient to prepare for appraisal.

#### NHS consultant appraisal documentation

The appraisee should start by completing or updating the consultant appraisal forms. These forms will be updated by the Department of Health in line with revalidation in due course. The currently used forms are available to download from the Trust's intranet site and are as follows:

Form	Title	Details
Form 1:	Background details	This captures all personal and professional information about the appraisee including registration details, professional qualifications and work experience.
Form 2	Details of current medical activities	This captures details of current medical information and all job plan information.
Form 3:	Record of reference documentation supporting the appraisal and report on	This captures all the background evidence and information that will help to inform the appraisal discussion.

	development action in the past year	
Form 4:	Summary of appraisal discussion with agreed action and personal development plan	This provides an agreed summary of the appraisal discussion based on the documents listed in Form 3. This form should be completed by the Appraiser and agreed by the Appraisee. The form also includes a template for a personal development plan.
Form 5	Personal and organisational effectiveness	The form is for use within the job planning process and describe your effectiveness on a personal level and within the Trust.

### 3. Supporting Information

The appraisee is required to gather supporting information, referring to the standards in *Good Medical Practice* and *Good Psychiatric Practice*. This is recorded in Form 3. The information collected should be from a number of areas of a doctor's practice and should include evidence of meeting clinical standards, including audits, outcomes and case based discussion, evidence of participating in Continuing Professional Development (CPD), feedback from colleagues and patients, and evidence of reflection on care provided. In *Revalidation and Guidance for Psychiatrists (CR161)* the Royal College of Psychiatrists (2010) has produced guidance for psychiatrists as to the types of evidence that they will be expected to collect in order to meet the requirements for revalidation, and how these map on to each of the attributes and domains of the GMC standards of Good Medical Practice (see below).

An important part of the appraisal process is not only collecting the supportive information, but providing evidence that the appraisee has reflected on it, including their role, participation and involvement in the activities, and evidence that their participation has led to demonstrable outcomes and changes in practice where necessary.

#### ***GMC standards of Good Medical Practice***

The General Medical Council has grouped the standards of Good Medical Practice into four domains, each with three attributes. The standards of Good Psychiatric Practice can also be considered in these twelve headings. The four domains and twelve attributes are:

#### ***Domain 1 Knowledge, skills and performance:***

**Attribute 1** Maintain your professional performance

**Attribute 2** Apply knowledge and experience to practice

**Attribute 3** Keep clear, accurate and legible records

#### ***Domain 2 Safety and quality:***

**Attribute 4** Put into effect systems to protect patients and improve care

**Attribute 5** Respond to risks to safety

**Attribute 6** Protect patients and colleagues from any risk posed by your health

#### ***Domain 3 Communication, partnership and teamwork:***

**Attribute 7** Communicate effectively

**Attribute 8** Work constructively with colleagues and delegate effectively

**Attribute 9** Establish and maintain partnerships with patients

#### ***Domain 4 Maintaining trust:***

**Attribute 10** Show respect to patients

**Attribute 11** Treat patients and colleagues fairly and without discrimination

**Attribute 12** Act with honesty and integrity

The appraisee is expected to consider which out of the twelve attributes they wish to present supporting information for in the appraisal for each year. All twelve attributes are to be covered

in a five-year appraisal cycle for revalidation. The choice may arise from the previous year's Personal Development Plan (PDP), which will have areas of development agreed and which will link to at least one of the attributes. Some information will be presented each year, whereas other information may only be required once in a five year cycle.

The appraisee should collect information that relates to all their professional roles. Appraisal must cover the whole scope of the doctor's work including management, research and teaching, and the provision of specialist advice in not only the employing organisation but also all other areas of medical practice.

#### **4. Essential supporting information requirements**

All psychiatrists in the Trust should follow the guidance produced by the Royal College of Psychiatrists (2010) in *Revalidation and Guidance for Psychiatrists (CR161)* and the GMC's *Supporting Evidence for Appraisal and Revalidation* (2011) as to the types of supporting information that they will be expected to collect and reflect on in order to meet the requirements for revalidation (Appendix 3).

A summary of the supportive information that will be essential for revalidation and considered at annual appraisal is as follows:

- Job role
- Work Place Based Assessments – 10 case-based discussions in 5 years
- Quality improvement activities – participation in 2 audits of significant areas of practice in each 5 year-cycle, as well as participation in an audit of record keeping
- Multi-source feedback (MSF) of colleagues every 5 years
- MSF of patients every 5 years
- Significant events - review and reflection on complaints, compliments and Serious Untoward Incidents

All psychiatrists in the Trust should currently follow the guidance in *Revalidation and Guidance for Psychiatrists* on case-based discussions (Appendix 4 and 5) and audit (Appendix 6), and use the structured reflective templates for multisource feedback from colleagues (Appendix 7), multisource feedback from patients (Appendix 8), complaint report (Appendix 9), and Serious Untoward Incident audit (Appendix 10) respectively, as well as the audit *pro forma* (Appendix 11).

#### **1.3 Multisource feedback**

The GMC has stipulated that participation in patient and colleague feedback will be necessary once in the five year revalidation cycle, as part of the supporting information for revalidation. This should be based on questionnaires that meet clear and robust criteria and that are approved by the GMC. The GMC intends colleague and patient feedback to be a developmental tool to help doctors to reflect on their performance, and are not proposing to use the feedback as a screening tool, although there is evidence that patient and colleague questionnaires can help to identify outliers in particular areas of practice.

There is recognition that obtaining meaningful feedback from psychiatric patients may pose particular difficulties, and any feedback questionnaire must be devised to take these into account. Moreover, the specialist field of psychotherapy poses additional questions regarding the role of patient feedback questionnaires, for example how their use might affect the course of the patient's treatment and the therapeutic relationship.

The Appraisal Lead and RO, in consultation with the medical consultants and the Human Resources Department in the Trust, are in the process of devising and piloting appropriate multi-source feedback questionnaires for both colleagues and patients that take these issues into account and are sensitive to our patient's needs. Once completed, these questionnaires will be available for use by appraisees via the electronic appraisal toolkit.

#### **1.4 Choice of Appraiser**

The following guidelines will inform the choice of appraiser:

- All medical appraisers in the Trust must be appropriately trained in the standards for psychiatric appraisal and revalidation (see Appendix 2).
- Mechanisms must be in place to both support the appraiser and to quality assure the appraisal process.
- The majority of appraisals in each 5 year cycle should be done by a psychiatrist. It is not essential that each appraisal should be done by a psychiatrist from the same sub-specialty but appraisals should be undertaken by a colleague with a good understanding of the work being undertaken by the appraisee.
- Each appraisee should be appraised no more than four times in succession by the same appraiser, unless there are compelling indications that this would be beneficial, for example, the implementation of a complex and ongoing personal development plan.
- In order to ensure continuity appraisees should ensure that they do not frequently change their appraiser.
- The Appraisal Lead in conjunction with the RO and Clinical Directors will be responsible for allocating appraisers to appraisees.
- Appraisees should be involved in a choice about their appraiser. In circumstances where concerns are being raised about practice, agreement must be reached with the RO. If the appraisee is concerned about the choice of appraiser, this should be discussed with the RO. However, if issues are not resolved by this means, then an appraisee may request in writing to the Chief Executive, that he nominates a suitable alternative appraiser. The Chief Executive's decision on this matter will be final.
- The choice of appraiser should ensure that there are no conflicts of interest between appraiser and appraisee. The following situations should be avoided:
  - Where the appraiser and appraisee share personal or family relationships.
  - An appraiser and appraisee share close business or financial interests.
  - Reciprocal appraisal – where 2 doctors appraise each other.
  - An appraiser appraising a doctor who acts as their line manager in the same or a different organization.
  - A doctor's direct employer acting as their appraiser.
  - An appraiser receiving direct payment from an appraisee for performing the appraisal.
- The risk of collusion or complacency between appraiser and appraisee may be minimised through appraiser training, ensuring two appraisers within the revalidation cycle, periodic joint appraisal, and qualitative evaluation of appraisal outputs.
- If a conflict of interest or appearance of bias is identified between appraisee and appraiser, the RO should be informed in writing, explaining the conflict and providing as much background information as is necessary and relevant. It may be appropriate for the RO to assign another appraiser.
- If a conflict of interest or appearance of bias exists between a doctor and the RO, the Trust should be informed in writing giving as much information as possible. It is important that every attempt is made to resolve the issue using the existing mediation procedures. If, after all processes are exhausted, a satisfactory resolution is not possible the evaluation of fitness to practise may be overseen by another Responsible Officer. In such circumstances, the designated body should seek advice from the Responsible Officer's own Responsible Officer (for example the appropriate SHA Medical Director in England, or in Wales the Medical Director of NHS Wales and in Scotland, the Chief Medical Officer) and the decision should be recorded in writing.

### **1.5 Pre-meeting**

The appraisee and appraiser should make contact before the meeting to discuss the agenda and raise any particular points e.g. the first appraisal for a new consultant, specialty doctor, any significant gaps etc. The appraiser should formally invite the appraisee to the meeting, usually allowing about 2 hours for the meeting itself. The portfolio of supporting information should be delivered to the appraiser at least two weeks before the appraisal meeting.

If any third party is to be present, e.g. a patient or another appraiser as an external validator, this must be agreed with the appraisee before the meeting.

Areas that may require further thought before the appraisal meeting include: teaching activity (possible outside the Trust), research, management and private practice. The appraisee may be asked to consider obtaining third party views as part of the supporting information e.g. feedback from trainees, academic head of department, line manager, clinical director, Chief Executive etc.

The appraiser should check all supporting information provided to help avoid unnecessary distraction in the appraisal interview itself. The appraiser should come to an opinion early on about whether there is sufficient supporting information to enable the appraisal interview to go ahead as planned, whether it should be adjourned, or whether a request for further information prior to the interview itself is necessary.

## **2. Phase 2: The appraisal meeting**

### **2.1 Practicalities**

Appraisal meetings are normally about 2 hours but this will vary depending upon the individual's circumstances.

Consideration needs to be given to the location of the appraisal meeting, convenient for both appraisee and appraiser but quiet and comfortable. A table should be available for any paper documents, and seating should allow ease of reference and note taking. Access to a computer will be necessary to access the electronic portfolio.

Appraisal meetings do not have to follow a rigid format, but generally the agenda should cover the following areas:

- Introductions and clarification of the appraisal process, progress so far and any particular issues to be considered. The appraisee should lead the discussion, systematically covering the portfolio and considering each domain and attribute. Whilst appraisal is both summative and formative, the move from summative towards formative discussion would be a logical sequence.
- The appraisee should discuss the PDP from the previous year. Attention to the success or otherwise of meeting the objectives in that PDP should be noted early on. Some may remain relevant objectives for the next year. Failure to achieve objectives should not automatically be seen as a concern, unless a very clear lack of regard or effort suggests otherwise. This should then be made very clear by the appraiser at the meeting e.g. "I see you have not met your objective to undertake...My view, from what you have told me is that this represents a lower standard than acceptable and therefore this must be met in the subsequent year, or the RO will become involved."
- Career advice and support are key aspects to the formative side of the appraisal process. It would be a natural part of the discussion to consider not only the next year but career aspirations beyond that. Doctors in career grade posts in particular may benefit from an opportunity to discuss this in the appraisal meeting.
- The GMP standards for note keeping are pertinent to the appraisal discussion. The record will be kept on the individual's personal file and is potentially disclosable to the RO and others. Decisions about revalidation may be based on these records and they are therefore very important.

### **2.2. Others at appraisal meeting**

The majority of appraisals will consist of meeting with two doctors, the appraisee and the appraiser. It may be helpful to consider bringing in a third party into one or more of the appraisal discussions over a 5 year period, for example:

- A lay person to provide a patient or carer perspective on the appraisal discussion.
- A sub-specialty colleague for individuals who practise in a very specialised area.
- A representative from a different organisation for doctors that work in two or more settings.
- Another trained appraiser to quality assure the appraiser.

### 2.3. Concerns

The appraiser makes a judgement in each appraisal as to whether any concerns or issues that have come up in the appraisal are appropriately managed through the setting of objectives, as part of a personal development plan. This is the most likely outcome for most issues that arise in appraisal. The setting of such objectives is not an indicator of a poorly performing doctor but rather an understanding that there are areas in which training and practice can be strengthened.

If the appraiser identifies concerns that are not to be satisfactorily managed through agreement of a personal development plan, there are the following options:

- a. To adjourn the appraisal to reflect and seek advice from colleagues (e.g. the Appraisal Lead, the RO, the appropriate clinical lead, other medical appraisers) as to an appropriate way forward before setting another date with the appraisee.
- b. If necessary to raise issues through the Trust's clinical governance structures.
- c. If there are immediate concerns about fitness to practise, these should be discussed with the Appraisal Lead and RO, who may consider raising these with the General Medical Council.

Examples which would raise concerns about ongoing practice would include the following:

- i. Concerns about multidisciplinary working that is having an adverse impact on patient care and not responding to appropriate remediation.
- ii. Repeated failure to appropriately reflect and learn from adverse incidents and complaints.
- iii. Ongoing audits which continue to show poor standards of care attributable to the individual doctor's practice.

Known concerns should usually be handled outside the appraisal process providing the opportunity for the doctor to demonstrate appropriate action to address the issues.

Doctors who are subject to performance or disciplinary procedures should continue to have an annual appraisal. This will be used to support the individual and identify any training or development needs.

### 2.4. Outcome of meeting

A crucial aspect of appraisal is the judgement of the appraiser with regard to the quality of supporting information and performance. This is illustrated by the table below which aims to help guide the appraiser when facing one of four scenarios following an appraisal meeting.

*A matrix of relationship between quality of supporting information and associated judgement of performance*

	Good performance	Poor performance
Good quality supporting Information	a. Satisfactory appraisal	b. Satisfactory appraisal but performance concerns. Further actions needed e.g. PDP, Medical Manager, Responsible Officer, NCAS, GMC
Poor quality supporting Information	c. Unsatisfactory appraisal. Adjourn within 3 months with clear agreement about what information is required	d. Unsatisfactory appraisal. Adjourn and consult Medical Lead, Responsible Officer, NCAS, GMC.

#### a. Satisfactory appraisal.

This is the judgement that is made when good supporting information is presented and no

concerns are raised throughout the appraisal meeting. This is likely to be the majority of doctors.

**b. Satisfactory appraisal process but significant performance issues.**

This is when the doctor has provided good supporting information but the information reveals concerns about performance or patient safety issues. The PDP must reflect this and have clear e.g SMART (Specific, Measurable, Achievable, Relevant, Timed) objectives that set out how and when the performance will improve. The appraiser may refer to the consultant's line manager, the Appraisal Lead or Responsible Officer who may consider referral to the National Clinical Assessment Service (NCAS) and/or the GMC.

**c. Unsatisfactory appraisal – poor quality information.**

The psychiatrist has not provided enough supporting information to satisfy the appraiser that GMP and GPP standards have been met. There may be no performance concerns but the appraisal is adjourned for no longer than 3 months, to ensure that the required information is provided.

**d. Unsatisfactory appraisal and significant performance issues.**

The psychiatrist has not provided sufficient supporting information and there are concerns about performance. The appraisal is adjourned and the Responsible Officer should be notified, who may consider referring to NCAS or GMC may be notified. The appraiser should seek advice from the consultant's line manager/clinical lead, Appraisal Lead or RO before rescheduling a further appointment.

The appraisal meeting will end with a summary of the appraisal discussion and statement of agreed action, and the personal development plan (Form 4). There are four potential agreed statements:

- i. Presence or absence of immediate concerns about the doctor's fitness to practise. If concerns exist the statement will specify in which attribute(s) concern exists.
- ii. Whether there is sufficient supporting information recorded to demonstrate the doctor is making satisfactory progress towards revalidation
- iii. Whether there has been satisfactory progress with key elements in the previous year's Personal Development Plan.
- iv. Agreement with the Personal Development Plan that derives from the current year's appraisal discussion to demonstrate the doctor is making satisfactory progress towards revalidation and that key priorities for development have been included in the plan.

If these cannot be agreed, the appraisal is unsatisfactory and the process suggested in c and d above should be followed.

## **2.5. Content of a Professional Development Plan**

A Personal Development Plan (PDP) is the tool used to assist the appraisee in improving practice. The items in such a plan may include specific, educational or learning tasks, for example visiting another unit to learn from best practice, specific tasks linked to areas of potential concern, for example undertaking an audit in an area of clinical practice or agreement as to which aspects of appraisal need to be completed before the next appraisal cycle, for example obtaining formal feedback from users and carers.

The content of a PDP should be sufficiently challenging and ambitious to enable the doctor to improve practice but manageable within the context of the doctor's competing professional pressures.

## **2.6. Relationship of appraisal to the job planning process**

The appraisal will provide an opportunity to draw together information and data from which the job plan is shaped and reviewed. Any changes recommended in the job plan will need to be agreed at a subsequent separate meeting with the relevant clinical service manager, who should have been fully consulted on any relevant service issues as part of the appraisal preparation.

### **3. After the appraisal meeting (Phases 3-6)**

After the meeting the actions will relate to whether the appraisal was satisfactory (a or b) or unsatisfactory (c or d). A satisfactory appraisal will need to be confirmed in writing by the appraiser to the appraisee, within two weeks of the appraisal meeting, with a summary of which attributes were satisfied and what actions were agreed in the PDP. A copy of the completed appraisal (Form 4), with a PDP signed by both parties within 28 days of the appraisal interview, should be submitted to the Responsible Officer as part of the ongoing portfolio of supporting information for revalidation. The appraisee is responsible for keeping the appraisal portfolio and summary as part of revalidation supporting information. The appraisee is also responsible for submitting copies of their Form 4 and PDP to the RO's office.

In cases of unsatisfactory appraisal there is a need to establish whether simply more time is required to allow the appraisee to collect supporting information (scenario c) or should this appraisal be put on hold to allow performance management. The appraiser will notify the RO and line manager of the appraisee, as well as the appraisee, as soon as reasonably practicable. The appraiser is not expected to performance manage the appraisee – referring to the line manager helps keep the two processes separate. A doctor in scenario d is clearly in need of performance management and/or remediation and whilst appraisal should be completed in good time e.g. 3 months, it may run parallel to a performance investigation, either internal or external.

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## Selection Training and Support for Appraisers

### 1 Selection process for appraisers

The Responsible Officer/Medical Director and Appraisal Lead/Associate Medical Director will be involved in the selection process of medical appraisers in conjunction with clinical/service leads. The role of appraiser may be a stand alone role or an integral part of a broader medical management role (e.g clinical director, head of service). The core elements of the role of appraiser are described in the Job Description for Appraisers (Appendix 18)

All appraisers will be expected to meet the qualifications, experience, knowledge, expertise, skills and aptitude and associated competencies as identified by the Revalidation Support Team (Department of Health, 2010) and described in the Person Specification (Appendix 19).

The appraiser will have a probationary period of twelve months to ensure that he/she is competent and committed to the role. During this period, feedback will be obtained from appraisees and if practicable directly observed appraisal should occur.

### 2 Training and development of appraisers

#### 2.1 Initial training

All appraisers in the Trust will participate in an initial one-day training course delivered by an approved trainer. The aims of the course will be in line with the recommended training objectives for medical appraiser in the Training Appraiser Training Curriculum Framework (*Assuring the Quality of Training for Medical Appraisers 2007*) (Appendix 20) and will include:

- Understanding the purpose of appraisal and its context in other structures for improving the quality of medical practice in both the local organisation and the wider context of the NHS
- Competency in assessing portfolios of supporting information that is submitted or informs the appraisal process
- Skills to conduct an effective appraisal discussion
- Ability to produce consistently high quality appraisal documentation

#### 2.2 Support and ongoing development

All appraisers will meet regularly to discuss their work in the Appraiser Support and Development Group, led by the Appraisal Lead. The RO will also attend this group. This group will meet three to four times a year, and will provide a forum for the provision of peer support in the exchange of ideas and experience, review and development of appraisal practice and performance, mentoring specific to appraisal, identification of concerns, and identification of ongoing training needs in an anonymised and confidential environment.

The appraisers will also have access to leadership and advice on all aspects of the appraisal process via the Appraisal Lead and RO.

Because of their role within the organisation and/or their relationship to the other appraisers, the RO and Appraisal Lead will also have access to external peer support, such as the NHS London Responsible Officer Support Network.

Appraisers will also participate in regular follow-up training and support to ensure consistency and development of appraiser skills.

### **2.3 Performance review**

Participation in performance review is a requirement of working as an appraiser in the Trust. The review process of appraisers within the Trust is the responsibility of the Appraisal Lead accountable to the RO.

To maintain their skills and knowledge all appraisers will undertake no fewer than 3 appraisals annually. Where an appraiser does not achieve this minimum number the Appraisal Lead will discuss the reasons for this with the appraiser and where appropriate agree further support.

Feedback will be given to appraisers on their performance, based on the information from the feedback questionnaires from their appraisees following completion of their appraisal (see Appendix 14, and Section 9.3).

### **3 Appraiser Fitness to Practice Concerns**

The Appraisal Lead will be informed by the RO of any investigation relating to the fitness to practice of an appraiser being undertaken by the Trust. The Appraisal Lead will establish the issues from the appraiser and the case investigator. In consultation with the RO, the Appraisal Lead will determine if a temporary cessation of the appraiser role is merited. Serious concerns will result in the immediate cessation of the appraiser role. All decisions to suspend appraiser functions will be reviewed by the RO.

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## Essential supporting information requirements

Type of Information	Minimum required in 5 years	Comment
Case based discussion	10	Minimum 2 per year
Review of and reflection on complaints, compliments and serious untoward incidents	all	
Audit and other quality improvement activities	2 clinical audits 1 records audit	Complete 2 audits of significant clinical areas of practice over a 5 year cycle. Undertake at least 1 audit of record keeping in each 5 year cycle
Patient feedback survey and review	1	To be presented no later than year 3
Colleague feedback and review	1	To be presented no later than year 3
New PDP and review of previous year's PDP	5	Annually
Meeting College CPD requirements	5	Annually
Clinical governance and other information (including outcomes) produced by the organisation and doctor	5	Annually
Teaching, research, management	5	Annually if part of role



- b. have knowledge of:
  - i. human development and developmental psychopathology, and the influence of social factors and life experiences
  - ii. gender and age differences in the presentation and management of psychiatric disorders
  - iii. biological and organic factors present in many psychiatric disorders
  - iv. the impact of alcohol and substance misuse on physical and mental health
- c. be competent in undertaking a comprehensive mental state examination
- d. be competent in evaluating and documenting an assessment of clinical risk, considering harm to self, harm to others, harm from others, self-neglect and vulnerability
- e. be competent in determining the necessary physical examination and investigations required for a thorough assessment
- f. ensure that they are competent and trained, where appropriate, in the use of any assessment or rating tools used as part of the assessment.

## **2 Diagnosis**

In making the diagnosis and differential diagnosis, a psychiatrist should use a widely accepted diagnostic system.

## **3 Risk assessment**

A psychiatrist must appropriately assess situations where the level of disturbance is severe and risk of adverse events, such as injury to self or others, or harm from others, may be high, and take appropriate clinical action.

A psychiatrist must work with patients, carers and the multidisciplinary team to make management decisions that balance risks to the patient or the public with the desire to facilitate patient independence. This should involve consideration of positive therapeutic risk-taking.

## **4 Treatment plan and delivery**

A psychiatrist must ensure that treatment is planned and delivered effectively, and must:

- a. formulate a care plan that relates to the patient's goals, symptoms, diagnosis, risk, outcome of investigations and psychosocial context; this should be carried out in conjunction with, and should be agreed with, the patient, unless this is not feasible
- b. if the treatment proposed is outside existing clinical guidelines or the product licence of medication, discuss and obtain the patient's agreement, and where appropriate, the agreement of carers and family members
- c. involve detained patients in treatment decisions as much as possible, taking into account their mental health and the need to provide treatment in their best interests
- d. recognise the importance of family and carers in the care of patients, share information and seek to fully involve them in the planning and implementation of care and treatment, having discussed this with the patient and considered their views.

## **5 Expert knowledge of treatment options**

A psychiatrist must have specialist knowledge of treatment options in the clinical areas within which they are working and, more generally, knowledge of treatment options within mental health. The psychiatrist must:

- a. ensure that treatments take account of clinical guidance available from relevant bodies/the College/scientific literature, and be able to justify clinical decisions outside accepted guidance
- b. have knowledge or, when needed, seek specialist advice in the prescribing of psychotropic medication; in so doing, the psychiatrist must have an understanding of the effects of prescription

drugs, both beneficial and adverse

c. understand the range of clinical interventions available within mental health services and arrange referrals where appropriate to the needs of the patient

d. have sufficient knowledge and skills of psychiatric specialties other than their own in order to be able to provide emergency assessment, care and advice in situations where specialist cover is not immediately available.

## **6 Record keeping**

A psychiatrist must maintain a high standard of record-keeping:

a. good psychiatric practice involves keeping complete and understandable records and adhering to the following:

i. handwritten notes must be legible, dated and signed with the doctor's name and title printed

ii. electronic records must be detailed, accurate and verified

iii. a record must be kept of all assessments and significant clinical decisions

iv. the reasoning behind clinical decisions must be explained and understandable in the record and, if appropriate, an account of alternative plans considered but not implemented must be recorded

v. the record should include information shared with or received from carers, family members or other professionals

vi. notes must not be tampered with, changed or added to once they have been signed or verified, without identifying the changes, dated and signed

b. the psychiatrist should ensure that a process is in place to obtain and record in the clinical record patients' consent to share clinical information, and that this is completed for patients with whom they have direct contact and for whom they have clinical responsibility

c. if the psychiatrist has agreed to provide a report, this must be completed in a timely fashion so that the patient is not disadvantaged by delay

d. letters with details of the treatment plan should be provided to patients following a consultation.

## **7 Communication with professionals**

A psychiatrist must communicate treatment decisions, changes in treatment plans and other necessary information to all relevant professionals and agencies, as appropriate, verbally or in writing, with due regard to confidentiality.

## **8 Communication with patients**

A psychiatrist must provide information, both verbal and written, to support patients in maintaining their health. In particular, the psychiatrist must:

a. provide information in understandable terms regarding diagnosis, treatment, prognosis and the support services available; this should recognise diversity of language, literacy and verbal skills

b. if any medication is prescribed, provide information about side-effects and, where appropriate, dosage, as well as relevant information should an off-licence drug be recommended.

### Guidance for case-based discussion

- 1 The psychiatrist being assessed should either identify a case for case-based discussion or provide the assessor with a list of anonymised case records (e.g. case numbers) from which the assessor can select two. The psychiatrist being assessed should then choose one of these two for the case-based discussion. The purpose of this is to have both a random component to the selection of cases and also the opportunity for the consultant being assessed to ensure the cases chosen reflect the broad mix of their caseload.
- 2 The assessor should have the opportunity to review the case notes in advance in order to pull out the key issues that they wish to discuss in the assessment.
- 3 A non-interrupted hour should be set aside for the case-based discussion.
- 4 Case-based discussion need not be solely a one-to-one meeting but can occur in a group setting. If the latter is the case, one consultant should lead the assessment.
- 5 The assessor should lead the discussion through the key areas of clinical practice being assessed. It is not expected that each of the areas will be assessed in the same level of detail. The areas to focus on depend on the clinical case and the psychiatrist's involvement.
- 6 Following the discussion, there should be a rating of each of the eight standards being assessed on the 0–4 scale.
- 7 It is expected that the most usual rating will be that of a 2 (consistent with independent practice). Areas in which there are suggestions for development should be rated as a 1. Areas of good practice should be rated as a 3 or 4.
- 8 The main purpose of case-based discussion is developmental. It is important that colleagues give constructive feedback to each other in order to facilitate a developmental process. It is not expected that psychiatrists would be exceeding or excelling in all areas of each case that is discussed.
- 9 Each psychiatrist is required to undertake ten case-based discussions over a 5-year cycle. No more than three should be done with one individual in order to have a minimum of four assessors commenting on cases over a 5-year cycle.

Criteria and indicators of best practice in clinical audit

- 1 The topic for the audit is a priority.
- 2 The audit measures against standards.
- 3 The organisation enables the conduct of the audit.
- 4 The audit engages with clinical and non-clinical stakeholders.
- 5 Patients or their representatives are involved in the audit if appropriate.
- 6 The audit method is described in a written protocol.
- 7 The target sample should be appropriate to generate meaningful results.
- 8 The data collection process is robust.
- 9 The data are analysed and the results reported in a way that maximises the impact of the audit.
- 10 An action plan is developed to take forward any recommendations made.
- 11 The audit is a cyclical process that demonstrates that improvement has been achieved and sustained .

**Multisource feedback colleague structured reflective template**

Requirement: one every 5 years

Date of feedback:

Feedback scheme used:

Number of colleagues giving feedback:

Name and designation of person who collated and gave feedback:

Main outcomes of feedback:  
(Look at positive outcomes, as well as learning needs)

What learning might I undertake?  
(It may help to separate learning from changing your behaviour. So, rather than 'I will show more respect to nursing colleagues', it might be more productive to undertake learning that develops your understanding of the benefits of the diversity of teams. Your ideas in this section can be discussed further with your appraiser.)

Final outcome after discussion at appraisal:  
(Complete at appraisal, considering how your outcome will improve patient care)

**Multisource feedback patient structured reflective template**

Requirement: one every 5 years

Date of feedback:

Feedback scheme used:

Number of patients giving feedback:

Name and designation of person who collated and gave feedback:

Main outcomes of feedback:  
(Look at positive outcomes, as well as learning needs)

What learning might I undertake?  
(It may help to separate learning from changing your behaviour. So, rather than 'I will show more respect to nursing colleagues', it might be more productive to undertake learning that develops your understanding of the benefits of the diversity of teams. Your ideas in this section can be discussed further with your appraiser.)

Final outcome after discussion at appraisal:  
(Complete at appraisal, considering how your outcome will improve patient care)

**Complaint report structured reflective template**

Requirement: one for each complaint you have received

Date of complaint:

Key issues of complaint:

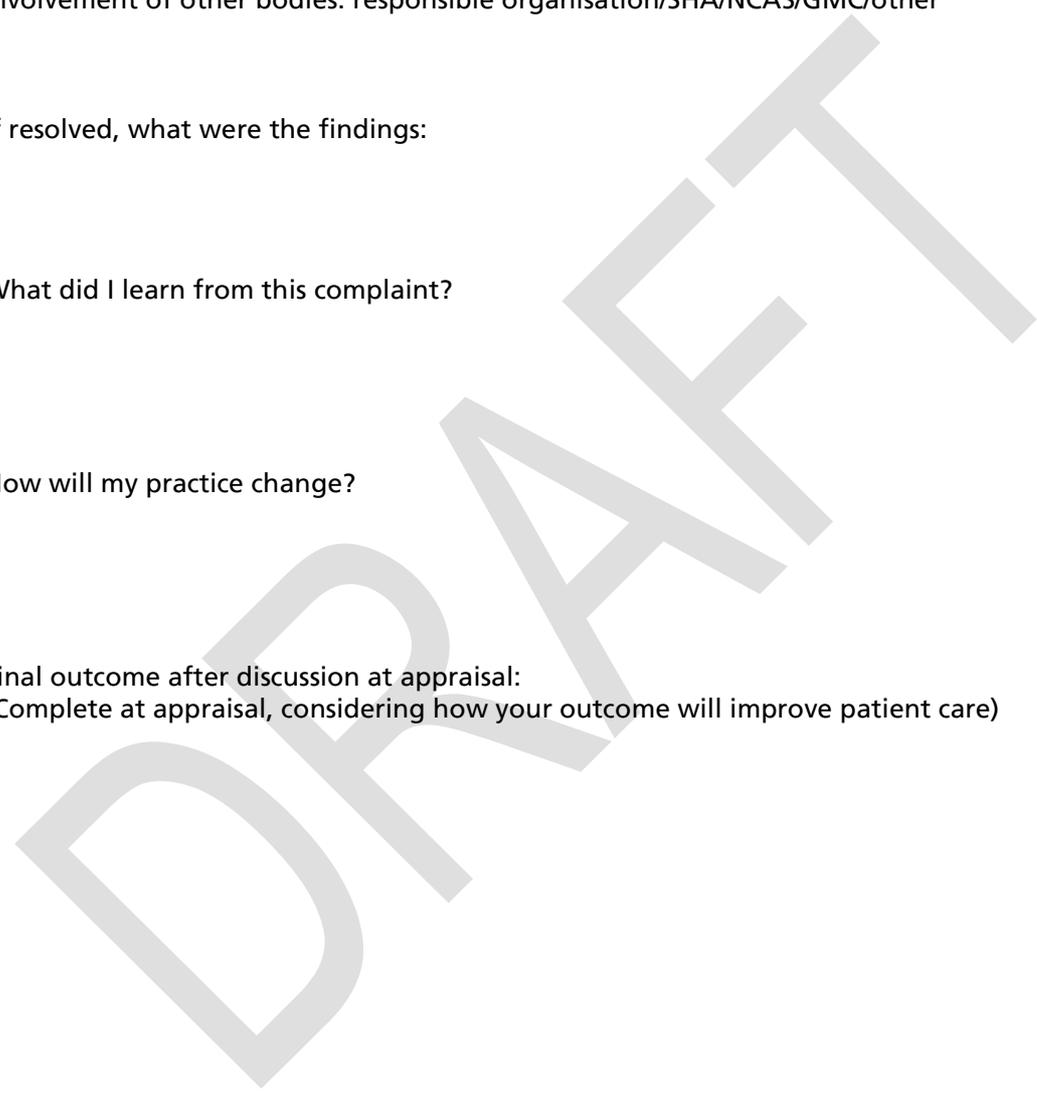
Involvement of other bodies: responsible organisation/SHA/NCAS/GMC/other

If resolved, what were the findings:

What did I learn from this complaint?

How will my practice change?

Final outcome after discussion at appraisal:  
(Complete at appraisal, considering how your outcome will improve patient care)



**Serious untoward incident audit structured reflective template**

Requirement: one annually

Date of incident:

Description of events:

What went well?

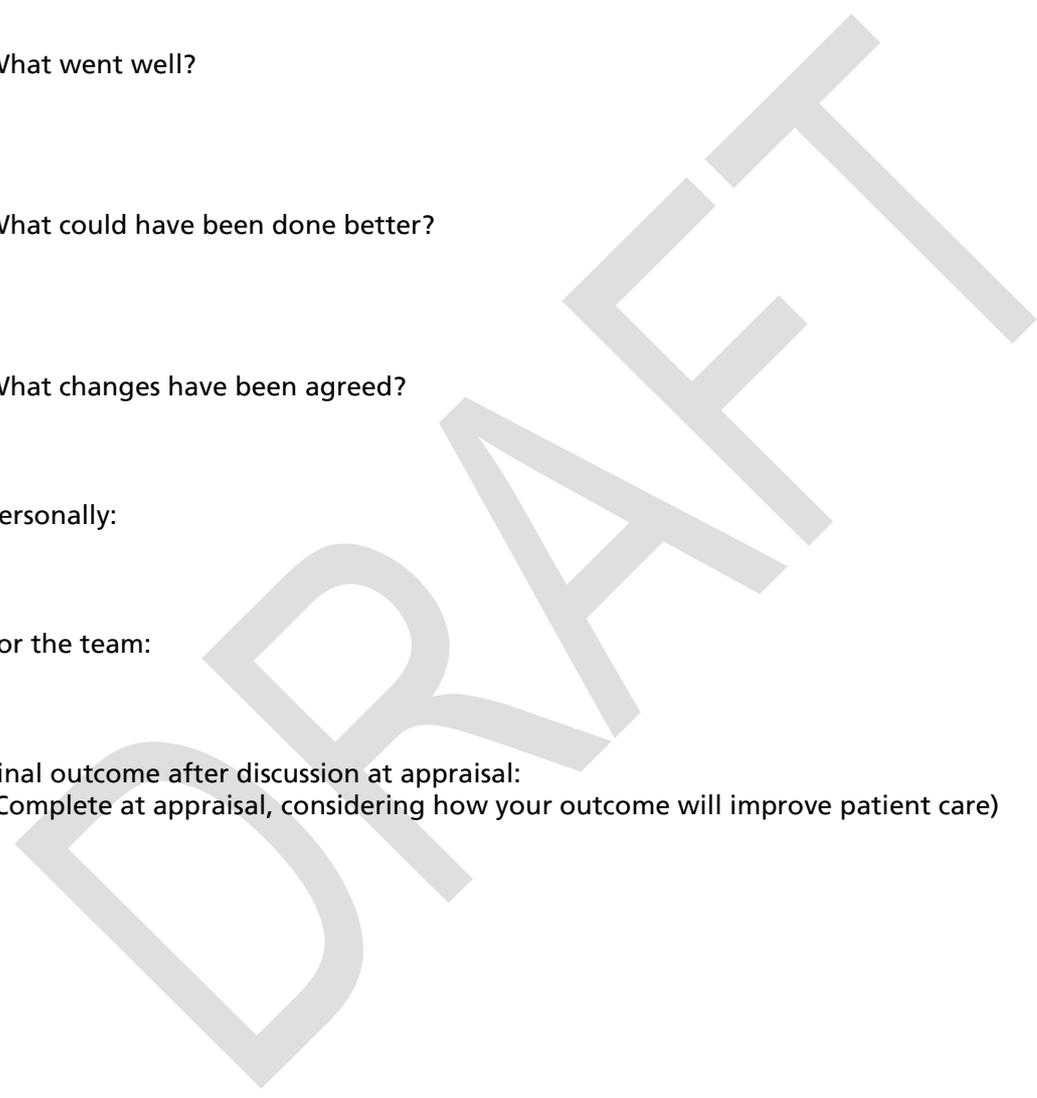
What could have been done better?

What changes have been agreed?

Personally:

For the team:

Final outcome after discussion at appraisal:  
(Complete at appraisal, considering how your outcome will improve patient care)



**Audit pro forma**

Requirement: one annually

Measurement/audit title: Date of data collection/audit:

Reason for choice of measurement/audit:

Standards set:

Audit findings:

Learning outcome and changes made:

New audit target:

Final outcome after discussion at appraisal:  
(Complete at appraisal, considering how your outcome will improve patient care)

*(Appendices 2-9 are from Royal College of Psychiatrists (2010b) Revalidation and Guidance for Psychiatrists (CR161).*



## MATERNITY LEAVE GUIDANCE

1. If maternity leave is planned after completion of at least 6 months work in an appraisal year, then an appraisal should be planned prior to leave starting.
2. The PDP and appraisal discussion should consider how the appraisee will keep up-to-date and plan for their return to work after maternity leave.
3. If after returning to work from maternity leave there is 6 months, then an appraisal should take place.
4. If after returning to work from maternity leave there is less than 6 months, then an appraisal will not be necessary, but should be planned within 6 months of return to work, even though that will be in the next appraisal year.
5. If after returning to work from maternity leave, there is less than 6 months, but more than 3 months, an appraisal can be provided if desired to help with professional development needs planning.
6. An appraisal is not necessary during maternity leave, but can be arranged by special arrangement.

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**Appendix 14**

**Appraisee Feedback Questionnaire** (see NHS Revalidation Support Team (2011) Organisational Readiness Self Assessment: End of Year Report 2010 11 v1.0)

Name of Organisation/Trust:						
Name of Appraisee		Date of Appraisal				
Name of Appraiser		Duration of appraisal meeting				
		Poor	Borderline	Average	Good	V good
The Organisation		1	2	3	4	5
The management of the appraisal system						
The access to the necessary supporting information						
Comment to help the organization improve the process						
The appraiser						
Their preparation for my appraisal						
Their skill in conducting my appraisal						
Their skill in reviewing progress against last year's PDP						
Their skill in providing challenge to help me review my practice						
Comments to help your appraiser improve their skills						
The appraisal discussion						
The new PDP reflects my main priorities for development						
The appraisal was useful for my professional development						
The appraisal was useful in preparation for revalidation						
Comments to help improve the appraisal discussion						

## Form 4 and PDP Review Tool

Source: *Sheffield GP appraisal policy*

Form 4 Criteria	Y / N	PDP Criteria	Y / N
Form 4 signed by both appraiser and appraisee (including GMC numbers)		PDP present	
Typed (legible)		Typed (legible)	
Evidence used to support statements is listed		There is a clear link between objectives in the PDP and the appraisal discussion on Form 4	
Significant absence of supporting information is noted		Learning needs reflect the needs of patients, practice, employer and GMC as well as own interests	
Reference to a review previous years Form 4 and PDP is made		Aims are converted into objectives	
Progress of PDP objectives is recorded		Objectives are SMART Especially Specific & Achievable	
Reasons for any changes to the PDP are noted and justified		Appropriate activities are stated	
Actions are agreed for the first 4 sections – not blanks “none” or “continue”		Appropriate outcomes are listed and will meet RCGP CPD credit requirements	

	COMMENT
Specificity: No blanks, vague or loose descriptions, e.g. fine / ok	
Objectivity: Relevant, factually correct, supporting information based when possible	
Freedom from bias and prejudice	
Acknowledgement of the Appraisee's achievements and developmental progress	
The appraisal discussion is challenging	
Challenging and actionable personal development plan	
<b>General Observations</b>	

## Exception audit to identify reasons for all missed or incomplete appraisals

Results of exception audit to identify reasons for all missed or incomplete appraisals		Numbers
1	<b>Appraisee factors:</b>	
	a. Absence of appraisee at the end of the appraisal year [so not possible to rearrange within year] eg maternity/sick leave	
	b. Incomplete portfolio or supporting information	
	c. PDP/summary not signed by appraisee within 28 days of the appraisal meeting	
	d. Factors relating to lack of time of appraisee	
	e. Lack of engagement of appraisee	
	f. Other appraisee factors (description)	
2	<b>Appraiser factors:</b>	
	a. Unforeseen absence of appraiser at the end of the appraisal year [so not possible to rearrange within year]	
	b. PDP/summary not signed by appraiser within 28 days of the appraisal meeting	
	c. Factors relating to lack of time of appraiser	
	d. Other appraiser factors (description)	
3	<b>Organisational Factors</b>	
	a. Administrative/management factors	
	b. Factors relating to function or failure of electronic portfolio or information system	
	c. insufficient numbers of trained appraisers	
	d. other organizational factors (description)	
4	<b>Recommendations:</b>	

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**ANNUAL APPRAISAL AND REVALIDATION BOARD REPORT PROFORMA**

The annual appraisal and revalidation board report should be produced as a stand-alone document and should be structured so that the following information is clearly available:

**1) Management of Appraisal and Revalidation**

- a) Brief description of leadership and management structure
- b) Budget/Resource Summary including SPAs/funding for appraisers and appraisal leads

**2) Activity Levels**

- a) Total number of doctors for whom the organisation has responsibility for appraisal and revalidation, reported by grade and speciality. This should include part-time and temporary appointments (including locums), those on long term leave, career breaks, suspension, etc for whom the organisation has responsibility.
- b) Subset: Number of doctors who have had a completed appraisal in year, reported by grade and speciality, including the groups above.
- c) Subset: Number of appraised doctors for whom a PDP has been agreed, reported by grade and speciality, including the groups above.
- d) Exception audit, with reasons, for all missed or incomplete appraisals and all missing PDPs.
- e) Total numbers of doctors completing revalidation cycle and total numbers of recommendations completed.
- f) Total number of doctors in remediation, performance and disciplinary procedures.

**3) Quality Assurance**

- a) Outline of processes to assure quality of the appraisal system.
- b) Outline of work done to address previously identified areas for development.
- c) Summary of annual self assessment report with areas for development in the next year.
- d) Summary of the most recent Independent External Review.

**4) Development Needs**

- a) Summary of anonymised collated development needs [with special reference to those common to a number of doctors and those affecting patient safety].
- b) Summary of constraints and progress in addressing constraints previously identified.

**5) Performance Review, Support and Development of Appraisers**

- a) Summary of training provided, including feedback on training from appraisers.
- b) Compliance with guidance on curriculum for initial training.
- c) Arrangements for support and development of appraisers.
- d) Arrangements for performance review of appraisers.

**6) Clinical Governance**

Summary of organisation development needs in the systems supporting appraisal and revalidation:

- i) Clinical information systems
- ii) Clinical risk management/patient safety systems
- iii) Clinical audit systems
- iv) Reporting investigation and management of performance concerns
- v) Complaints management systems
- vi) Continuing Professional Development systems

**7) Access, security and confidentiality**

Results of audit of compliance with access, security and confidentiality protocol and reports of investigations of breaches.

**8) Summary and actions**

- a) Summary of important issues
- b) Recommended action

## Appendix 18

**Job Description for Appraisers** (need to write according to criteria in NHS Revalidation Support Team (2011) Organisational Readiness Self Assessment: End of Year Report 2010 11 v1.0)

The role of appraiser may be a stand-alone role or an integral part of a broader medical management role (e.g. clinical director, head of service). To ensure quality and consistency the person specification of medical appraisers should include core elements relating to the role of appraiser. The following is an example.

The job description of the postholder includes the following core elements in relation to the appraiser role:	
1	Description of key accountabilities for the role which include accountability to the Responsible Officer
2	Description of role and key responsibilities of appraiser
3	Undertake pre-appraisal preparation and appraisal discussion in line with current local and national guidance and quality standards
4	Complete post appraisal documentation in line with current local and national guidance and quality standards
5	Duration of appointment as an appraiser (for example, description of arrangements for re-appointment or formal extension of contract every 3-5 years)
6	Maximum and minimum numbers of appraisal expected per year
7	Description of probationary period or provisional appointment subject to satisfactory evaluation/assessment after initial training
8	Requirement to attend initial training
9	Requirement to participate in ongoing training and support to address development needs in the role of appraiser
10	Requirement to participate in performance review in the role of appraiser
11	Requirement to participate in the management and administration of the appraisal system
12	Requirement to participate in arrangements for quality assurance of the appraisal system
13	Description of confidentiality of appraisal process and specific circumstances in which confidentiality should be breached
14	Indemnity arrangements for appraisers

**Person Specification for Appraisers** (see *NHS Revalidation Support Team (2011) Organisational Readiness Self Assessment: End of Year Report 2010 11 v1.0*)

*The role of appraiser may be a stand-alone role or an integral part of a broader medical management role (e.g. clinical director, head of service). To ensure quality and consistency the person specification of medical appraisers should include core elements relating to the role of appraiser. The following is an example.*

<b>Core elements of a person specification for medical appraiser</b>	
No distinction has been made between 'essential' and 'desirable' as the importance of each of these qualities should be determined in relation to the local context Probationary periods or provisional appointment subject to satisfactory completion of training and/or demonstration of competence should be described in the job description	
<b>Qualifications</b>	Medical degree (plus any Postgraduate qualification required) GMC License to practice Where appropriate, entry on GMC Specialist
	Completion of Appraisal Training (this may not be a requirement prior to appointment but would need to be completed before appraisals are performed)
<b>Experience</b>	Has been subject to a minimum of 3 medical appraisals, not including those in training grades. (There may be unusual situations where this is not possible for example where medical appraisal has not occurred in the past in that organisation)
	Experience of managing own time to ensure deadlines are met
	Experience of applying principles of audit education or quality improvement
<b>Knowledge</b>	of the role of appraiser of the appraisal purpose and process and its links to revalidation of educational techniques relevant to appraisal
	of responsibilities of doctors as set out in Good Medical Practice of relevant Royal College specialty standards and CPD guidance Understanding of equality and diversity, and data protection and confidentiality legislation and guidance
	of the health sector in which appraisal duties are to be performed of local and national healthcare context of Evidence Based Medicine and clinical effectiveness
	Excellent integrity, personal effectiveness and self-awareness, with an ability to adapt behaviour to meet needs of an appraisee Excellent oral communication skills – including active listening skills, the ability to summarise a discussion, ask appropriate questions, provide constructive challenge and give effective feedback
	Excellent written communication skills – including the ability to summarise a discussion clearly and accurately
<b>Expertise, Skills and Aptitudes</b>	Objective evaluation skills
	Commitment to on-going personal education and development
	Good working relationship with professional colleagues and stakeholders
	Ability to work effectively in a team
	Motivating, influencing and negotiating skills
	Adequate IT skills for the role

**Appraiser Training Curriculum Framework** (see Appendix F, NHS Clinical Governance Support Team (2007) *Assuring the Quality of Training for Medical Appraisers* [AQTMA].)

Appraiser Training Curriculum Framework  
Recommended Training Objectives for Medical Appraiser Training

Training Objective – Demonstrate an understanding of the purpose of appraisal and its context in other structures for improving the quality of medical practice in both the local organisation and the wider context of the NHS			
Performance	Conditions	Standards	Assessment
Demonstrate an understanding of the purpose of appraisal	Given the current operative GMC and DoH appraisal policies	With accuracy	Verbal demonstration
Explain the professional responsibilities of an appraiser	Given the Host organisation's, GMC and DoH policies and an Appraiser Job Description	To an appropriate level in context with delivering an appraisal	Verbal demonstration
Demonstrate an understanding of the link from appraisal to the Personal Development Plan (PDP)	Given the operative GMC and DoH appraisal policies	To the understanding of an appraisee	Verbal demonstration
Explain the difference between formative appraisal and summative assessment in the appraisal context.	Given the definitions of 'formative' appraisal and 'summative' assessment within the appraisal context	Accurately differentiate between the two	Verbal demonstration
Demonstrate an understanding of the links between appraisal and revalidation	Given the GMC revalidation policy	To the understanding of an appraisee	Verbal demonstration

## Board of Directors : November 2011

**Item :** 10b

**Title :** Appraisal for Medical Revalidation Policy

**Purpose:**

This report presents the Medical Appraisal and Revalidation Policy and Procedures.

This report has been reviewed by the following Committees:

- Management Committee, 24<sup>th</sup> November 2011

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

*(delete where not applicable)*

- Quality
- Patient / User Safety
- Risk

**For :** Approval

**From :** Dr Jessica Yakeley, Associate Medical Director

## Medical Appraisal and Revalidation Policy and Procedures

### 1. Introduction

- 1.1 Revalidation is the process by which doctors will have to demonstrate to the General Medical Council (GMC) that they are up to date with continuing professional development (CPD), fit to practise and complying with the relevant professional standards. The medical Royal Colleges and Faculties have developed standards and defined essential specialty supporting information for the appraisal and revalidation of specialist doctors and GPs.
- 1.2 Appraisal is the cornerstone of revalidation. Revalidation will be based on systematic appraisal of the doctor's work on an annual basis with revalidation required every five years. Satisfactory appraisals over a five year period will enable a Responsible Officer to recommend revalidation to the GMC. All non-training grade medical staff (GPs, Consultants, SAS grades and any other non-training grade posts) are expected to go through revalidation every five years. The Deanery will be responsible for the revalidation of doctors in training. It will be through the annual appraisal process that doctors (who are mostly psychiatrists in this trust) will demonstrate that they are meeting relevant generic and specialist standards defined by the GMC.
- 1.3 This document sets out the way in which medical appraisal for revalidation will be met by the Trust. The document incorporates the most recent guidance from the Royal College of Psychiatrists and the GMC, and covers the core content of the medical appraisal policy which we are required to put in place by the NHS Revalidation Support Team as part of this year's Organisational Readiness Self Assessment.

### 2. Summary of Writing / Review Process

- 2.1 The following people have been consulted in the writing / reviewing of this policy:
  - Dr Rob Senior, Medical Director, Tavistock and Portman NHS Foundation Trust
  - Jane Chapman, Governance and Risk Advisor, Tavistock and Portman NHS Foundation Trust
  - Caroline Taplin, Consultant, Edgecumbe Group and teacher of approved courses for medical revalidation

2.2 In writing / reviewing this Policy, the following legislation and guidance has been complied with:

- Department of Health (2001) *Appraisal Guidance for Consultants*
- Department of Health (2006) *Good Doctors, Safer Patients*
- Department of Health (2007) *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*
- Department of Health (2008) *Medical Revalidation - Principles and Next Steps: the Report of the Chief Medical Officer for England's Working Group*
- Department of Health (2010) *The Medical Profession (Responsible Officers) Regulations* TSO
- Department of Health (2010) *The Role of the Responsible Officer: Closing the Gap in Medical Regulation – Responsible Officer Guidance.*
- Follett, B. & Ellis, M.P. (2001) *A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties. A report to the Secretary of State for Education and Skills*
- General Medical Council (2006) *Good Medical Practice*. GMC ([www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp))
- General Medical Council (2009) *License to Practise*. GMC ([www.gmc-uk.org/doctors/licensing/practice.asp](http://www.gmc-uk.org/doctors/licensing/practice.asp))
- General Medical Council (2010) *Revalidation: A Statement of Intent*
- General Medical Council (2010) *Good Medical Practice Framework for Appraisal and Assessment*. GMC
- General Medical Council (2011) *Supporting Evidence for Appraisal and Revalidation*. GMC
- Mynors-Wallis, L. & Fearnley, D. (2010) *Good Practice Guidelines for Appraisal*. Royal College of Psychiatrists ([www.rcpsych.ac.uk/pdf/Good%20Practice%20Guidelines%20for%20Appraisal.pdf](http://www.rcpsych.ac.uk/pdf/Good%20Practice%20Guidelines%20for%20Appraisal.pdf))

- NHS Clinical Governance Support Team (2007) *Assuring the Quality of Training for Medical Appraisers [AQTMA]*
- NHS Revalidation Support Team (2009) *Assuring the Quality of Medical Appraisal for Revalidation [AQMAR]*.
- NHS Revalidation Support Team (2011) *Organisational Readiness Self Assessment: End of Year Report 2010 11 v1.0*
- Royal College of Psychiatrists (2009) *Good Psychiatric Practice (3rd edn) (CR154)*. Royal College of Psychiatrists.
- Royal College of Psychiatrists (2010a) *Revalidation and Guidance for Psychiatrists (CR161)*. Royal College of Psychiatrists.
- Royal College of Psychiatrists (2010b) *Good Psychiatric Practice: Continuing Professional Development (2nd edn) (CR157)*. Royal College of Psychiatrists.
- UCEA (2002) *Joint University and NHS Appraisal Scheme for Clinical Academic Staff*.

2.3 The Management Committee are satisfied with the process that was gone through in the writing / reviewing of this Policy. This Policy will be reviewed again in three years' time.

Dr Jessica Yakeley  
Associate Medical Director  
22<sup>nd</sup> November 2011

## Board of Directors : November 2011

**Item :** 12

**Title :** 2012 Annual Plan & Consultation

**Purpose:**

This paper sets out the proposed process and timetable for developing the 2012 Annual Plan. It is similar to that for 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 has been reviewed by the following Committees:

- Management Committee, 17<sup>th</sup> November

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

- Quality

**For :** Approval

**From :** Mr Simon Young, Director of Finance

## 2012 Annual Plan & Consultation

### 1. Introduction

- 1.1 The proposed outline timetable for developing the 2012 Annual Plan, including the 2012/13 Budget, is given on pages 122 and 123.
- 1.2 Work has already started in October, with the Away day for the Board and senior management on productivity and on our market strategy, which has provided early input to the thinking on both of these.
- 1.3 Monitor has not yet published the format for submitting the Plan in May 2012. Assuming that it is similar to the 2011 templates, the proposed approach is again to develop the Plan in management and Board papers and then put it into the template format at the end. The papers can be considered in part 2 of the Board if appropriate.

### 2. Key elements of the Plan

- 2.1 The key elements of the plan will be:
  - Vision, mission and values.
  - Market and environmental assessments.
  - Productivity.
  - Service development strategies. Improving access to our services. Projected changes in activity and income.
  - Quality; patient outcomes and engagement; choice.
  - Membership and governors.
  - Targets and compliance.
  - Human resources, including pay; staff numbers; recruitment and redeployment; appraisal and validation; and wellbeing.
  - Equalities.
  - Leadership and management.
  - Estates, including sustainability; and any relocation.
  - Financial projections.
- 2.2 The proposed timetable allows for these elements to be covered in separate papers and discussions before the whole plan is brought together.

2.3 Management Committee members are shown as the lead for each action, but the plans will of course need to be developed with Service Line Directors and the Associate Deans, as well as other senior managers.

2.4 The Board of Governors meetings are shown in italics.

Directors and senior management Away day on Productivity and on Market Strategy	JS SY		Tues 18 Oct
Review of the 2011 Annual Plan – progress in key areas and against key milestones	SY	MC Conf	Thurs 3 Nov Tues 8 Nov
Agree this process and timetable	SY	MC BD	Thurs 17 Nov Tues 29Nov
Report on 2011/12 financial forecast. Propose provisional efficiency targets for 2012/13.	SY	MC BD	Thurs 17 Nov Tues 29 Nov
<i>Include key elements of this process and timetable in the Finance report to the Board of Governors</i>	<i>SY</i>	<i>BG</i>	<i>Thurs 1 Dec</i>
Assessment of external factors updated. Economic strategy.	MP	MC BD	Thurs 2 Dec Tues 25 Jan
Patient services strategy	JS*	CC MC BD	Fri 16 Dec Thurs 12 Jan Tues 31 Jan
Education and Training strategy	TK/ MA*	CC MC BD	Fri 16 Dec Thurs 12 Jan Tues 31 Jan
Productivity	SY*	MC BD	Thurs 19 Jan Tues 31 Jan
Quality, patient outcomes, PPI, choice	LL*	MC BD	Thurs 19 Jan Tues 31 Jan
<i>Update and consultation on the above 4 areas, and on the Membership and Governors Strategy (also any key changes already known to be likely in other areas including Estates)</i>	<i>MP SY</i>	<i>BG</i>	<i>Thurs 2 Feb</i>

\* All these four strategies will be developed with the Trust director ,the CAMHS director and other Directors and senior managers as appropriate.

2012/13 Budget – progress, gap analysis, action plans	SY	MC	26 Jan and 16 Feb
Human Resources strategy	ST	MC BD	Thurs 9 Feb Tues 28 Feb
Research strategy	RS	MC BD	Thurs 9 Feb Tues 28 Feb
Estates strategy. Capital expenditure 3-year plan, including 2012/13 capital budget approval.	PK SY	MC BD	Thurs 15 Mar Tues 27 Mar
2012/13 Budget for approval	SY	MC BD	15 or 22 Mar Tues 27 Mar
Update and further discussion on any area as necessary. Draft financial projections for years 2 and 3	SY	MC BD	14 or 21 Apr Thurs 28 Apr
<i>Update and consultation on all areas, including financial projections</i>	<i>MP SY</i>	<i>BG</i>	<i>Thurs 3 May</i>
Final draft of Plan submission, including other supporting strategies and year 2 and 3 financial projections		MC	Thurs 17 May
Approval of Plan, including the Board statements		BD	Tues 29 May
Submission of Plan to Monitor			Thurs 31 May tbc

Note: Easter weekend is 6–9 April 2012

Mr Simon Young  
Director of Finance  
November 2011

## Board of Directors : November 2011

**Item :** 13

**Title :** Service Line Report: Camden CAMHS

### **Summary:**

This paper is written provide the Board of Directors with assurance of achievements and progress towards meeting Directorate and Trust-wide objectives of the Camden CAMHS Service Line for the period 14<sup>th</sup> November 2010 (previous updated on Camden CAMHS) and 17<sup>th</sup> November 2011.

This report has been reviewed by the following Committees:

- Management Committee, 17<sup>th</sup> November 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:**

- Quality
- Risk
- Finance

**For :** Discussion

**From :** Andy Wiener, Associate Clinical Director, CAMHS

## Service Line Report – Camden CAMHS

### Executive Summary

#### **1. Highlights and Achievements**

- 1.1 A significant shift to more formal and detailed quarterly reporting of activity and outcome measures has been put into action.
- 1.2 A big shift in the approach to young people needing admission to Tier 4 units, and a major reduction in the use of Tier 4 beds this year.
- 1.3 Following the loss of the TAMHS service the mainstream CAMHS teams are providing an agreed service into primary schools which is gradually expanding.

#### **2. Areas of Risk and/or Concern**

- 2.1 Accommodation difficulties in South Camden continue and are yet to be finally resolved although there are concrete plans.
- 2.2 Clinical activity levels in Camden remain very high and are rising. In response to increased demand. Systems of case assessment and review are being introduced and include investment in a well resourced first appointment system designed to lead to a dramatic increase in demographic and outcome data quality

## Main Report

### 3. Overview of the Service

3.1 A description of the Service was given in the report to the Board in November 2010, but this information is repeated here, in Appendix 1.

3.2 Update on issues raised in report from November 2010

3.2.1 Accommodation for South Camden Community Team has still not been finally resolved.

3.2.1.1 The accommodation in St Pancras Hospital was decided against because the St Pancras site is being closed down.

3.2.1.2 Accommodation has now been identified in a site where Ampthill GP Practice was located. After much hard work, and support from the Camden CAMHS commissioner, permission has been gained to refurbish and use the building, and plans have been drawn up. The costs are being finalised.

3.2.1.3 The Trust is making a contribution to the capital costs, and the commissioners are paying for the rent.

3.2.2 The LEAN consultancy was completed

3.2.2.1 The CAMHS management team have been able to frame recommendations from the consultancy report in a way which has enabled changes which are discussed below.

3.2.3 Tier 4 Overspend

3.2.3.1 The PCT requested significant reorganisation of services to help reduce the unprecedented level of spend on adolescent inpatient admissions. A significant proportion of the last report was dedicated to this issue.

3.2.3.2 In the meantime fewer Tier 4 admissions and a greater focus on assertive community services working for quicker discharge of young people was successful. Overall the Tier 4 budget (that had

been on course to overspend very significantly) came in under budget by approximately £250k.

3.2.3.3 Unfortunately none of these savings could be reinvested in community CAMHS and were used by the PCT to offset overspends in other areas.

3.2.3.4 The Commissioners gave notice on their contract with New Beginning inpatient unit and set up a new contract with Simmons House inpatient unit in Islington (now part of the new Whittington Community Trust). Simmons House is more accessible to Camden and the contract is for five beds rather than three. More than half the Tier 4 budget (£1m) is being used for Simmons House, leaving less money to spot purchase other beds from other providers. There is an advantage in having a significant amount of activity on inpatient one site.

3.2.3.5 It has been agreed to use some of the out-reach psychiatry capacity of the Trust's North Camden Team to provide dedicated "in-reach" psychiatry to Simmons House, to liaise between the inpatient unit and the community services to ensure the availability of robust community support packages after discharge.

3.2.3.6 The Tier 4 spend for this time last year was twice the current level. This has meant greater demands on community services (particularly nursing) and service redesign has not yet delivered the additional nursing resource to meet this need.

3.2.3.7 It is hoped that commissioners will be able to redirect money from the Tier 4 budget into community services. If this funding is not redirected there will be a need for more nurse posts which will mean fewer staff from other professional disciplines.

3.2.4 Moving towards a staff team where each member has a greater number of clinical sessions

3.2.4.1 This has been a slow process. The needs of clinical services and for training resources sometimes pull in different directions – proposals to put fractional

clinical sessions together often being counteracted by the need to make sessions for training activity.

#### 4. Activity Data

4.1 The move to Camden CAMHS being commissioned on an activity basis rather than on a block contract is not showing signs of coming into effect. However activity figures show that if Camden were operating as an activity based contract it would be (based on the prices used for other contracts) over performing financially. Using this formula Camden is predicted to over perform by 130k.

#### 5. Follow Up and DNA Statistics

5.1 These statistics cover the last year, the period 1<sup>st</sup> October 2010 to 30<sup>th</sup> September 2011, and are compared with the period 1<sup>st</sup> January 2009 to 31<sup>st</sup> December 2009 (2009 statistics in brackets).

	North Team	South Team	Other Trust Camden CAMHS	Total
Referrals accepted	<b>322</b> (294)	<b>226</b> (240)	<b>90</b> (132)	<b>678</b> (666)
Initial Appointments	<b>272</b> (231)	<b>207</b> (189)	<b>125</b> (97)	<b>604</b> (517)
Subsequent Appointments	<b>4384</b> (4288)	<b>2909</b> (2232)	<b>2277</b> (2564)	<b>9570</b> (9084)
DNAs	<b>647</b> (471)	<b>443</b> (337)	<b>241</b> (262)	<b>1331</b> (1070)
Ratio of 1 <sup>st</sup> Appts to follow-up (inc. DNA)	<b>18</b> (21)	<b>16</b> (15)	<b>20</b> (30)	
DNA rate	<b>13%</b> (9%)	<b>9%</b> (12%)	<b>10%</b> (9%)	

5.2 The activity figures show that activity has increased overall compared to 2009 both in first and follow up appointments offered.

5.3 One attempt to manage the level of activity is the introduction Consultation and Resource Clinics (CaR Clinics).

5.4 Experienced clinicians dedicate time to CaR to see first appointments. The senior clinician discusses the referred difficulties with the family and agrees what services should be provided. The works is supported by a small multi-disciplinary meeting and also aims to ensure that required data is collected for files and outcome monitoring.

- 5.5 The activity level management strategy includes reviewing open cases to ensure that an agreed treatment plan is in place.

## 6. Financial Situation

- 6.1 The Camden contract does not fully cover staff costs and overheads. There is a deficit of 20% after taking into account £234k agreed through the national training contract.
- 6.2 High banded senior staff add to the cost of clinical services, but their expertise and experience is required in relation to their teaching and supervision, and for the specific service supervision and management of funded clinical trainees in teams.
- 6.3 Funding of the Camden CAMHS contract has not been reduced, but there has been no additional funding for salary increments or inflationary uplift. This is, effectively a 4% reduction in real terms.
- 6.4 The impact of the productivity programme – discussed in other reports -has reduced costs by approximately 4% through voluntary redundancy and retirement. Some staff have been lost (0.8 last year and 0.8 this year) and lower banded staff have been employed.

## 7. Clinical Quality

- 7.1 **Quarterly Reporting:** A new system of monitoring activity has been introduced by the Camden Commissioners, from October 2011, which has brought about a step change in the amount of data that we provide to the commissioners.
- 7.2 Each team developed a service specification with outcome targets (measuring outcome) and output targets (the number of new cases and open cases).
- 7.3 Each team produce a quarterly Patient Level Report, detailing on an (anonymised) case by case basis demographic details, appointment data and outcome measurement. They also provide a quarterly Quality Report covering areas such as the challenges facing them, what has been done to address the challenges, staffing issues, user feedback (CHI ESQ) and case vignettes. The teams rose to this challenge in the October round of reporting. The next round of reporting is due in January 2012.
- 7.4 The biggest single issue was missing data, particularly outcome data. Team leaders have worked hard with staff to identify reasons, which

indicate issues at all points in the system. These issues are being addressed one by one.

- 7.5 Dormant (inactive) cases and cases open for many years are now a focus for team leaders and their staff who are reviewing these cases and closing as many as possible.
- 7.6 Problems have been identified and are being tackled one by one. The commissioners are pleased with the new reporting system now in operation.
- 7.7 Some services are not on RIO but there are plans to have an administrator enter their data onto RIO (IEYS, BSS and YOS). Other services which use different data systems are either going to report manually to the commissioners (MOSAIC) or transfer the data automatically to the data warehouse (MALT).
- 7.8 A quarterly output report, records the activity of the teams against targets set in the service specifications, and a CRB report allows the commissioners to monitor the compliance with the protocol for staff to have CRB checks done every three years.

## **8. Complaints, Compliments and Patient Feedback**

- 8.1 One complaint logged in July 2010 continued until August 2011 and was reported to the Board of Directors. There have been only two further complaints. The first from a father requiring access to file notes on sessions which his wife attended without him, which was dismissed by the ombudsmen. The other came from a mother who felt that incorrect information had been passed to Social Services. An offer to reassess her son resolved the matter.

## **9. Patient Safety Incidents**

- 9.1 Following a problem about admitting an adolescent, which was reported in the last Camden CAMHS report, a recommendation was made for a protocol to be drawn up by the commissioners between different trusts to manage such occurrences. The Trust is not in a position to move this task forward (as it is a commissioning task). The problem remains unresolved at the time of writing.
- 9.2 Other clinical incidents and patient safety incidents have been reported separately and addressed appropriately.

**10. Seeking feedback from users (Patient & Public Involvement), including patient satisfaction surveys etc.**

10.1 As noted above the CHI Experience of Service Questionnaire is being integrated into day to day clinical practice and is reported on in the Quality Reports

**11. Other activities**

11.1 Agreement was made with the commissioners in Spring 2011 to develop a CAMHS service in primary schools. Mainstream CAMHS teams would make a "core offer" to each primary school for half a day a fortnight in term-time. An "enhanced offer" for half a day a week would require a payment by the school of £6k extra per year to the Trust. Alternatively schools could opt for a link clinician or could decline the offer altogether.

11.2 Victoria Blincow has been appointed to take a lead role in the CAMHS service to primary schools with lead staff in North and South Camden CAMHS teams. Three schools are taking up the enhanced offer, nine the core offer, and 23 the "link offer". Six have declined any offer.

Andy Wiener  
Associate Clinical Director  
20<sup>th</sup> November 2011

## Appendix I

### Description of Camden CAMHS

Camden CAMHS is a group of clinical teams and outreach clinicians which serve the 0-18 year old population of Camden, approximately 40,000 children. Via the outreach work they do the clinical teams receive referrals directly from the different agencies. They also receive referrals via a central system called Camden Joint Intake, which processes most of the GP referrals.

There are two generic community teams, one in the South of the Borough, based at St Pancras Hospital and Crowndale Health Centre, and one in the North, based in the Child and Family Department at the Tavistock Clinic. These teams are employed and managed by the Trust. Staff are drawn from the full range of clinical disciplines. Each community team provide outreach services in Secondary Schools and in Primary Care, as well as home visits when required. The objective is to provide an integrated service between the school, primary care and specialist services so that specialist services can be accessed speedily, in community settings, and with the minimum of bureaucracy. Referrals come directly to the community teams from education and primary care and from Camden Joint Intake.

The Refugee Team is a small specialist team based at the Child and Family Department which takes cases from Camden and further afield. The team consists of a small team of three WTE. There are strong community links with the Somali and Congolese communities in Camden.

There is also Child Protection and Looked After Children Team called Camden Multi Agency Liaison Team (MALT) which is staffed by Trust employees and Local Authority employees, and is jointly managed by the Trust and the Local Authority, with health taking the lead role. This team work with children subject to Child Protection Plans or who are Looked After in Care. Some of these children are subject to Care Proceedings. Referrals come directly to the team from Social Workers and from Camden Joint Intake.

Beyond this there is a Disability CAMHS Team called MOSAIC CAMHS which is managed by the Local Authority and PCT, but where the Trust employ the staff.

Camden CAMHS clinicians employed by the Trust are also present in the Integrated Early Years Service in Children's Centres around the borough, the Youth Offending Service, Pupil Referral Units, all the Special Schools in Camden, and Primary Schools (TOPS). Clinicians in these services pick up referrals directly from the multi-agency teams they work with.

Beyond Camden CAMHS, but of great significance to the overall service the population receive, are CAMHS teams at the Royal Free Hospital and at UCLH (provided by the Royal Free Acute Trust and Islington PCT respectively). There are also third sector services in Camden such as the Anna Freud Centre, the Brandon Centre (young person's counselling) and Families in Focus (Parenting).

This complex multi provider network is coordinated by a Single Point of Entry Service, called Camden Joint Intake. It is clinically led and receives referrals from General Practitioners and a wide constituency of other professions and also self-referrals. The referrals are passed on, as appropriate to the Camden CAMHS teams and also the Royal Free Hospital CAMHS, the Brandon Centre (a young person's Counselling Service) and the Anna Freud Centre. Families in Focus and UCLH are currently outside this system.

Although the Camden CAMHS Service covers the age range of 0-18, some referrals go to the Adolescent Department in the Tavistock, particularly patients who are in the transition to adulthood.

## Board of Directors :November2011

**Item : 14**

**Title : Education and Training Report**

### **Purpose:**

The purpose of this report is to provide the following information:

- Introduction & broad overview
- Financial and recruitment position
- Student feedback
- Update on e-learning

This report has been reviewed by the following Committees:

- Management Committee, 17<sup>th</sup> November 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:**

- Finance
- Quality
- Risk

**For : Discussion**

**From :** Trudy Klauber, Dean

## Education and Training Report

### 1. Introduction

- 1.1 The national economic slow down, and NHS organisational and commissioning changes are both challenging for education and training services in the Trust.
- 1.2 Simultaneously, it is important to note that directors, service line managers, Associate Deans, Heads of Discipline and organising tutors have responded with their usual energy to the challenges. All are eager to work with the Commercial Directorate and its new integrated business development and marketing plan. Indeed course marketing and web materials are all under development and will be discussed at the Training Executive at the end of November 2011, well ahead of previous years.
- 1.3 The most urgent priority for business development, and planning for growth is e-learning where work with the E-learning unit continues at a fast pace.
- 1.4 NHS Health Education Commissioning plans are developing quickly. NHS London now expects to have only three local skills networks across London. It is promoting a pan-London (London Health Education) commissioning group because of London's unique position vis-à-vis national and local training provision, and Health Education England now has its first CEO, Christine Outram.
- 1.5 Our National Contract is to be renewed for a further two and a half years. NHS London has understood our concern about negotiating a renewal in a newly established and preoccupied commissioning structure. Its performance management is likely to be more rigorous and demanding in future, but the renewal is cause for relief and could be seen as a demonstration of confidence in our brand and our reputation for high quality effective provision.
- 1.6 Recruitment levels are slightly down on 2010/11 (see [Section 2](#) below).
- 1.7 London Continuing Professional and Personal Development (LCPPD) will not be funded after 2012/13, for which elaborate software has been developed by NHS London, in preparation, we think, for providers Trusts (like ours) and HEIs to enable purchaser trusts in London to find and purchase our products in future using their own CPD funds. We believe we shall need to market extensively and intensively in order to compensate for the loss of NHS London

funding of around £230k per annum, including over £60k for Trust staff (Band 5 and above).

- 1.8 We are working with Essex on specific support and collaboration on e-learning and credit rating CPD related to their validated programmes.
- 1.9 The Trust and UEL have established a Strategic Partnership Board with agreed terms of reference and a plan for discussing strategy and for reviewing current course provision, led by Professor Andrew Cooper.
- 1.10 UEL has also established its own Health and Social Care Commission with NHS London. The Dean has a seat on the commission which is reviewing the opportunities created by the Health and Social Care Bill for business development, as well as looking at risks to core activities. The first meeting reviewed each school's activity in health, education and social care and also invited Dr David Fish of UCL Partners to come and discuss possible opportunities and developments. UEL and the Trust are both involved in the North and East London and Essex HIEC and UEL is very interested in UCL Partners. David Fish presented a picture of a fully collaborative and enabling organisation of peers seeking to avoid competition by developing real partnerships.
- 1.11 A revitalised relationship with Middlesex is linked with the Adult Department plan to create a Nursing degree in Mental Health Practice, and SAMHS is looking at the collaborative development of training courses in elderly care and dementia care – where Middlesex have funding sources and the Trust can offer distinctive expertise and recognised quality in teaching.
- 1.12 Reorganisation of courses into clusters in CAMHS and SAMHS is under way. We have received expressions of interest for nine of the eleven training cluster lead roles and expect to be ready to start in January 2012.
- 1.13 The new Dean and Director of Education and Training, Malcolm Allen is becoming actively involved in handover with the Dean, meeting other key colleagues and attending strategic meetings.

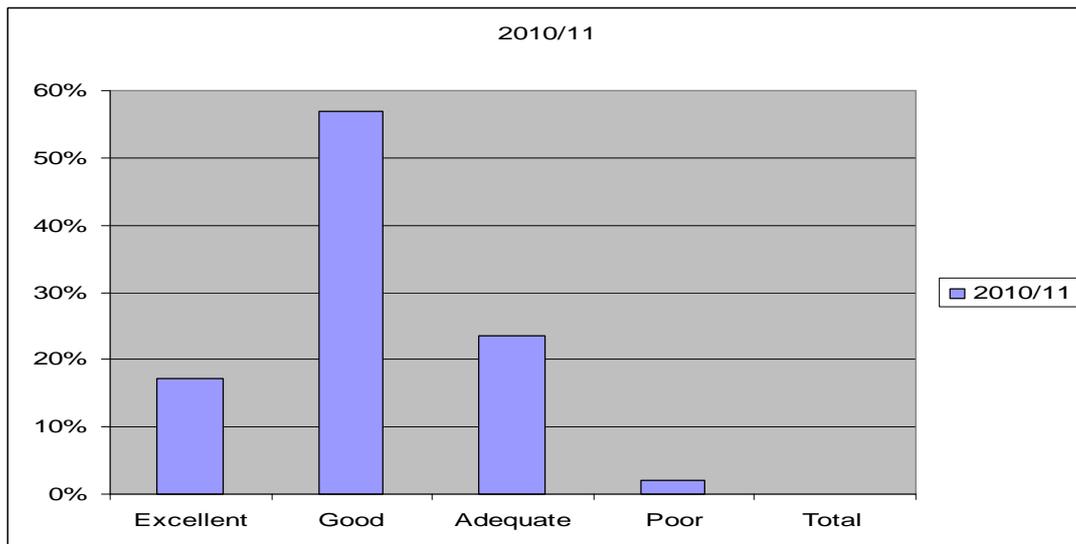
## **2. Financial position and student recruitment**

- 2.1 **Appendix 1** shows the full financial plan set against forecast for academic year and for financial year with variance. The overall income is forecast at £14,897,866.

- 2.2 The National contract is reduced by the NHS efficiency saving imposed by NHS London and there is a slight decrease in commissions for the child psychotherapy contract. Other contracts are very similar to the previous year, including Specialist Medical funding.
- 2.3 Fee income, as we expected is lower than the previous year but might be slightly less than -£84k once we have a picture on remaining “progressing students”
- 2.4 CPD courses are currently forecast at a £26k variance but this is likely to change positively during the second half of the financial year.
- 2.5 **Appendix 2** gives a picture of student recruitment and notes the good performance of some major courses and the unexpected lower recruitment on D10, *Consultation and the Organisation*, which did exceptionally well in the previous two years.
- 2.6 The Income summary by service lines is shown in **Appendix 3**. Taking SAMHS as a whole, the total for these income streams is £1,016,565, and for CAMHS, £1,724,306. The total £2,740,872 differs very slightly from the forecast on **Appendix 1** which is £2,737,319. While CAMHS forecast is higher, making comparisons between two service lines in education and training seems more helpful and useful for the future, while retaining the possibility of looking at the four SAMHS lines separately as well. CAMHS has done exceptionally well with three major successful conferences between September and November.
- 2.7 Tuition fee increases are under discussions for the coming academic year and thereafter. All M level courses will need to increase by at least £225 per student to cover the gradual removal of HEFCE funding, and then to increase to cover rising costs of delivery, by at least 3-5%. We raised some course fees by 10% but most by 5% for the present academic year.
- 2.8 There will be an expectation that tuition fees for postgraduate courses will rise.
- 2.9 We are currently benchmarking against a range of “similar” programmes and consulting with tutors about the strength or fragility of each of their market.
- 2.10 Marketing is already further ahead than in any previous year (see Introduction).

### 3. Student Feedback (now incorporated into an Education and Training Report)

- 3.1 In Academic Year 2010/11, 644 out of a total of 1067 students responded across all centres; a response rate of 60% compared with 52% in 2009/10. Responses from Associate Centres rose most, in line with the action plan for the year. The selected responses below are taken from the Tavistock Centre student responses which looked separately at M level and D level courses.
- 3.2 In most cases we continue to receive a high proportion of positive feedback and small fluctuations are not statistically significant. See **Appendix 4**. Good quality teaching, relevance for the workplace and meeting learning needs all speak to *employability* by which many courses and programmes are judged currently. Quality and promptness of feedback are issues which are of concern to the Trust, and also to our University partners. We are grappling with the need to maintain feedback quality, which takes hard pressed clinician teachers time to produce. An attempt to set a deadline of up to six weeks for completion of the process will eventually be lowered to four weeks if possible so that students are more able to put together their submitted work and the feedback to assist their development over time.
- 3.3 We have included some of our first feedback on professional doctorates, which will be the benchmark for comparison in the next year. The Trust's results generally compare favourably or very favourably with the national Postgraduate Research survey (PRES). There are fewer opportunities for some professional doctorate students to come together and support each other, and individual experiences and use of supervision and tutors is very variable. The Trust Research degree sub-committee is looking closely at the feedback as is the Quality Committee, where action plans are developed through an annual review and enhancement process which lays a strong emphasis on response to student feedback.
- 3.4 It is of interest that we asked the D level students about the Trust's website. It will be interesting to note whether changes currently in progress increase the Excellent rating in the coming academic year. We are all aware there is room for improvement in functionality and getting somewhere with fewer clicks. Key pages on Education and Training are currently being rewritten alongside marketing content



#### 4. E-learning Unit Update

- 4.1 The Unit was not able to appoint a project manager. An appointment has now been made and the new project manager will begin within a month. The unit now has a full time administrator.
- 4.2 An e-learning steering group chaired by the Dean includes the Trust Director, both Associate Deans, Assistant Commercial Director and Assistant Director of Education and Training has now met twice to authorise key strategic decisions, on priorities with clear dates for update or delivery. These include building unit capacity and building staff capability, making decisions on e- and distance-CPD and which modules of courses can be turned into distance learning packages. The plan is that different work streams shown in **Appendix 5** will have products ready in six to nine months' time.
- 4.3 We have a highly experienced video consultant who is already working to produce video material - both filming and editing. We have in place a system for producing highest quality material in significant quantities and have and are training Trust staff to operate cameras as well as using the Lecture theatre and Studios.
- 4.4 From a standing start the Steering group needs some staff resources from Service Lines, and needs to launch its ideas and current tool box so that staff understand how to turn ideas into products. Plans are advanced for a major launch in week beginning 16<sup>th</sup> January 2012 to involve all course tutors and other Trust staff.
- 4.5 Initial income targets may be very optimistic for web based video supervision and teaching, and a target of £30k has been retained.

- 4.6 The new Unit Development Manager and Administrator will transform the pace of project development and free the Unit Head to work with service lines and creative and committed “subject expert” staff.
- 4.7 Partnerships are now developing with current university partners while we retain optimism for work with our very large and prestigious new partner.

## 5. And finally...

- 5.1 This is my last report as Dean. In writing it I have naturally looked back over seven and a half year’s work in Education and Training Services and with the Management Committee and fellow Directors.
- 5.2 It has been the most fascinating time and I have learnt so much that I now feel I understand the nature and scope of the task of the Dean. I am very grateful indeed for the thoughtfulness, concern and friendship of the Management Committee, who have each individually been such exceptional colleagues.
- 5.3 I shall miss the work and some of the challenges and can only hope that the expansion and development in Training during my tenure will continue, perhaps faster, and, I very much hope the e-learning project enables us to reach further and to experiment with new ways of working. I also sincerely hope that we do not lose the heart of our training enterprise – which fundamentally changes and supports the capacity of dedicated public sector staff in making a difference in the lives of their clients, patients or students. They remind us all of the necessity of “looking after the basics”, to quote Matthew Patrick, as well as growing developing and changing to meet new needs and circumstances. In this work I have confidence in the new Dean and know that he has excellent colleagues in the Management Committee, on the Board and in the two dedicated Associate Deans and the Assistant Director, to whom I owe so much.

Trudy Klauber  
Dean  
18<sup>th</sup> November 2011

Appendix I

**Training fees and other academic income**

	AY 10/11	AY10/11	AY10/11	AY11/12	FY11/12	FY11/12	FY11/12
	<u>Plan</u>	<u>Forecast</u>	<u>Actual</u>	<u>Forecast</u>	<u>Plan</u>	<u>Forecast</u>	<u>Variance</u>
<i>Now in Contract Income</i>							
Training Skills Escalator					133,608	129,600	-4,008
Child Psychotherapy tuition	397,264	405,381	404,959		374,925	403,967	29,042
LCPPDb/f ( AY contract)					62,272	62,272	0
NHSLLCPPD	220,000	266,231	266,231	233,802	250,930	247,314	-3,615
					821,735	843,153	21,419
<b><u>Other Training and Academic Income</u></b>							
Fee Income							
Tuition Fees	2,356,683	2,281,127	2,298,426	2,298,174	2,382,643	2,298,321	-84,322
Partner Centres	61,295	70,429	82,630	48,330	68,971	68,338	-633
Commissioned Income	394,584	366,799	347,383	403,248	356,933	370,660	13,727
					2,808,548	2,737,319	-71,228
HEFCE	583,681	744,046	800,434	610,395	682,676	689,578	6,902
CPD Courses					352,921	326,529	-26,392
Research funding					0	10,500	10,500
E-learning					30,000	30,000	0
Conferences					102,800	174,053	71,253
CWDC Income ( Ed Psych Tr.)					103,770	103,770	0
					<b>4,902,449</b>	<b>4,914,902</b>	<b>12,453</b>
<b>Other Contract Income</b>							
Training Contract						7,383,980	
Child Psychotherapy						1,804,355	
Madel						794,629	
<b>TOTAL</b>						<b>14,897,866</b>	

## Appendix II

### Student and Income Summary

1. Recruitment for 2011/12 is broadly in line with the position forecast in July 2011. Courses in TCS and the Adolescent Department are down mainly because of 2 courses, D10 – *Consultation and the Organisation*, and M33 *Psychotherapeutic Approaches to work with Adolescents*. The latter recruits from a low paid workforce often reliant on local authority funding or release; the former was a course which recruited exceptionally well in the previous two years, when public sector managers and senior professionals were seeking to gain new skills and to be adaptable to a changing labour market as efficiencies and productivity plans became more clear.
2. Some courses have done exceptionally well in a difficult market – these include CAMHSM7, *Psychoanalytic Observational Studies*, (50+ Year 1 students), CAMHSD24, *Foundation Year in CAMHS Practitioner Training* (40+ students), ADULT DIRECTORATE D12 *Introduction to Counselling and Psychotherapy* (29) and D58 *Foundations of Psychoanalytic Psychotherapy* (25).
3. The recruitment picture for this year bears out our plan to develop e-learning products within the current academic year.

Service Lines	Student numbers						
	Actual		Target based on 10/11 students enrolled at Jan 2011		Actual enrolled as at 16/11/11		Progressing students not yet enrolled
By academic year	AY10/11		AY11/12		AY11/12		AY11/12
	Year 1	Total	Year 1	Total	Year 1	Total	
TCS	27	73	28	78	15	66	4
Adolescent	73	171	73	174	48	154	1
Adult	113	194	104	165	116	210	0
CAMHS& Children's Workforce	272	613	273	648	269	631	18
Portman	19	19	19	19	8	8	0
Not yet allocated to service line							
<b>Total students enrolled</b>	<b>504</b>	<b>1070</b>	<b>497</b>	<b>1084</b>	<b>456</b>	<b>1069</b>	<b>23</b>
FTE fee paying							

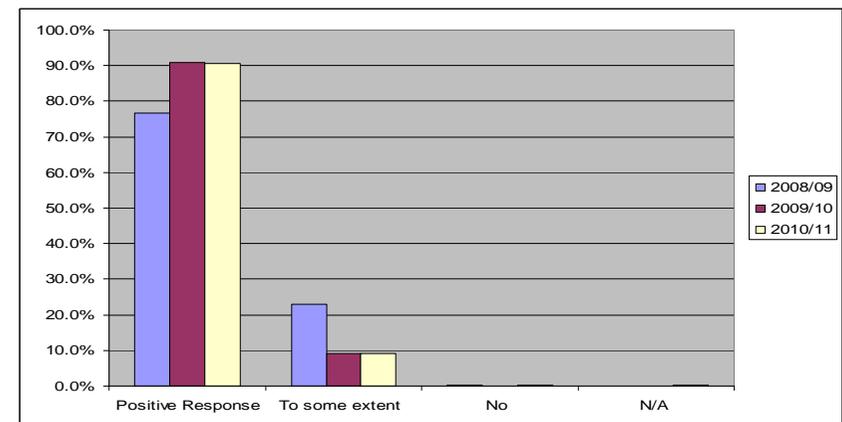
Appendix III

Education & Training Income Summary by Service Lines 2011/12																
Service Lines	Income Summary															
	Fee Income (incl. Associate Centres)			Commissioned Income			HEFCE			LCPPD (NHSL)			CPD		Conferences	
	Actual	Target	Forecast as at 31 OCT 2011	Actual	Target	Forecast	Actual	Target	Forecast	Actual	Target-reallocated to service lines based on actual commissions	Forecast	Target	Forecast	Target	Forecast
By academic year	AY10/11	AY11/12	AY11/12	AY10/11	AY11/12	AY11/12	AY10/11	AY11/12	AY11/12	AY10/11	AY11/12	AY11/12	FY11/12	FY11/12	FY11/12	FY11/12
	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£	£
TCS	165,984	221,800	159,991	0	0	0	41,174	33,720	36,923	43,666	10,823	55,490	36,921	34,540	0	0
Adolescent	406,157	405,679	343,954	0	0	0	85,323	63,600	69,300	18,848	16,487	37,458	100,000	93,428	20,000	16,885
Adult	420,213	470,517	461,630	26,100	25,534	24,790	55,830	71,464	114,720	107,520	157,818	64,338	50,000	45,300	22,800	8,642
CAMHS& Children's Workforce	1,382,302	1,423,072	1,375,649	321,283	363,458	363,458	618,108	470,055	389,453	44,931	43,903	35,055	140,000	130,183	60,000	148,526
Portman	6,400	7,260	5,280	0	0	15,000		0	0	6,777	10,969	4,883	36,000	23,078	0	0
Not yet allocated to service line				0	0	0				44,489	0	36,578				
	<b>2,381,056</b>	<b>2,528,328</b>	<b>2,346,504</b>	<b>347,383</b>	<b>388,991</b>	<b>403,248</b>	<b>800,434</b>	<b>638,840</b>	<b>610,395</b>	<b>266,231</b>	<b>240,000</b>	<b>233,802</b>	<b>362,921</b>	<b>326,529</b>	<b>102,800</b>	<b>174,053</b>

## Appendix IV

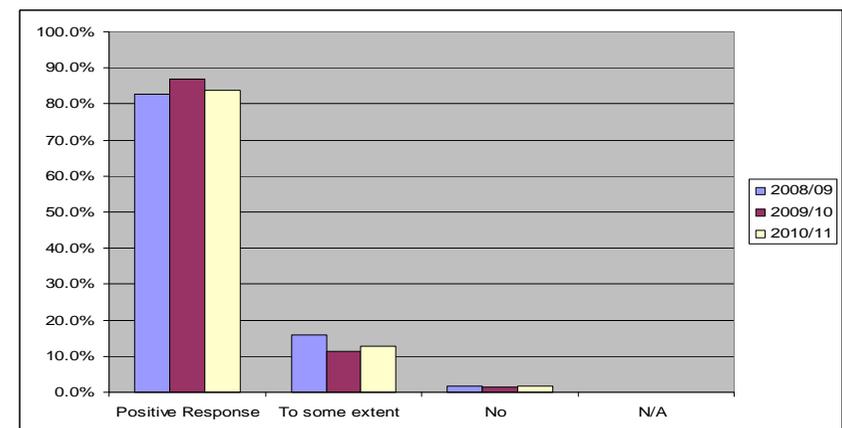
### M level: Does the course meet your learning needs?

	Definitely	To a large extent	To some extent	No	N/A	Total
2008/09	426	n/a	128	2	n/a	556
2009/10	298	255	55	0	n/a	608
2010/11	315	284	60	1	1	661



### M level: Is the course relevant to your work?

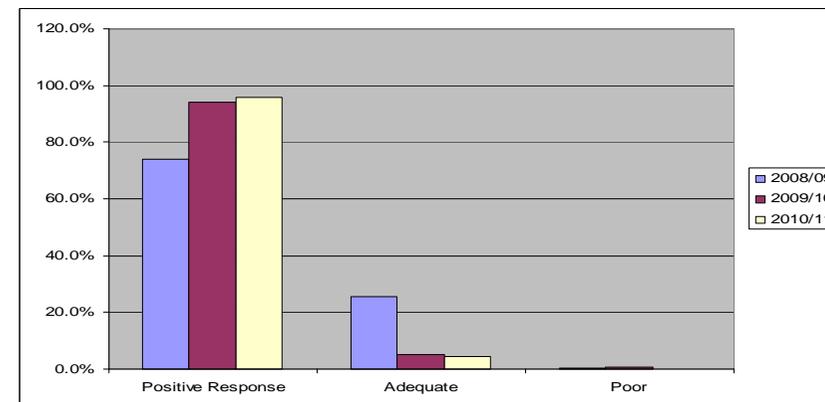
	Definitely	To a large extent	To some extent	No	N/A	Total
2008/09	459	n/a	88	9	n/a	556
2009/10	369	149	68	9	n/a	595
2010/11	347	207	85	12	10	661



**M level: How would you rate the quality of teaching on the course?\***

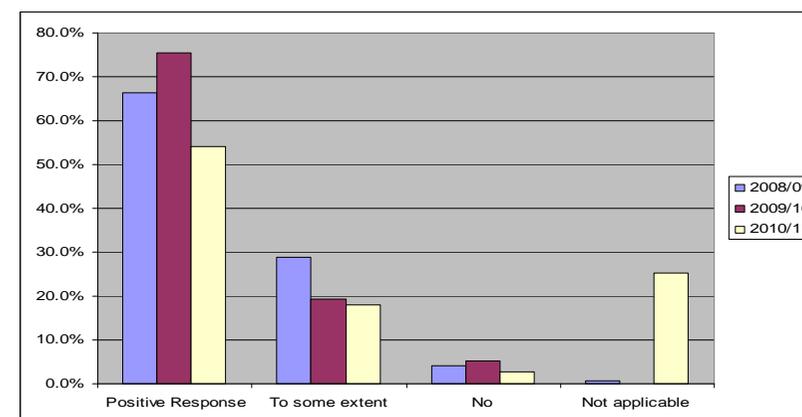
	Excellent	Good	Adequate	Poor	Total
<b>2008/09</b>	406	n/a	141	2	549
<b>2009/10</b>	301	<b>235</b>	30	4	570
<b>2010/11</b>	322	295*	28	0	645

\*This is an extremely high positive rating with above 50% rating "excellent" this year.



**M level: Are you satisfied with the quality of the feedback you receive on assessed course work?**

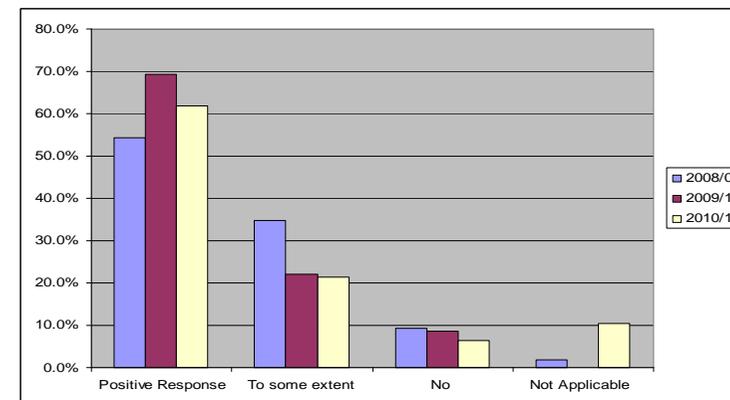
	Definitely	To a large extent	To some extent	No	Not Applicable	Total
<b>2008/09</b>	227	n/a	139	16	177	559
<b>2009/10</b>	132	141	74	22	0	369
<b>2010/11</b>	123	139	76	17	37	392



### M level: Are you satisfied with the promptness of feedback on assessed course work leading to your award? (re-phrased)

2009/10 "Are you satisfied with the promptness of feedback on assessed course work leading to your award? If you have not yet submitted any assessed work please indicate 'not applicable' below"

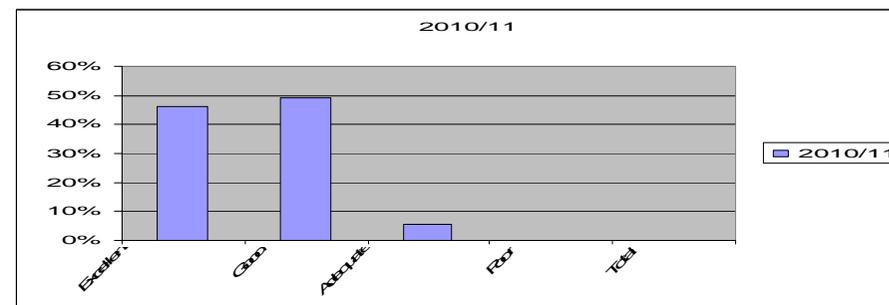
	Definitely	To a large extent	To some extent	No	Not Applicable	Total
2008/09	211	n/a	135	36	7	389
2009/10	132	119	80	31	0	362
2010/11	111	136	85	25	42	399



### Postgraduate Research Degree Student Feedback 2010-11

D Level: How would you rate the quality of teaching?

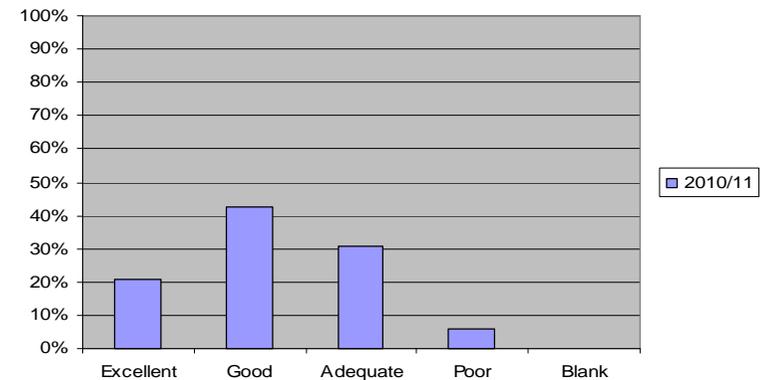
	Excellent	Good	Adequate	Poor	Total
2010/11	64	68	8	0	140



**D Level: Are you satisfied with the academic supervision you receive?**

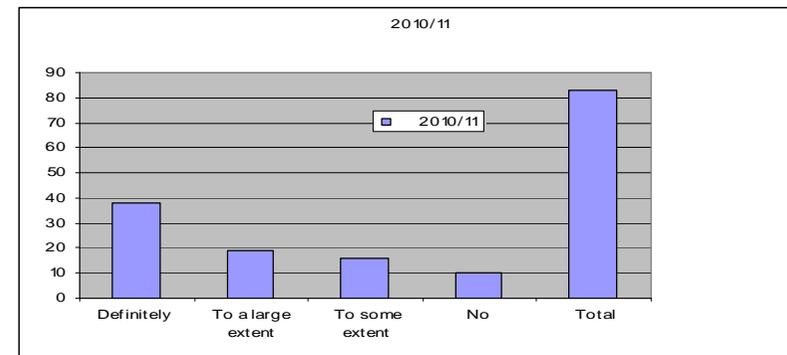
	Definitely	To a large extent	To some extent	No	Total
2010/11	61	43	28	1	133

There is more anxiety about doing professional doctorates and our staff are developing their skills as a group with new staff working closely with the very experienced small core group of doctoral supervisors. Staff training is already in place as well as apprenticeship learning through co-supervision.



**D Level: Do you feel that you have been given adequate research supervision on the course?**

	Definitely	To a large extent	To some extent	No	Total
2010/11	38	19	16	10	83



## Project Plan Identification, Marketing and Production of Courses (not delivery)

