

Board of Directors

Agenda and papers
of a meeting to be held

2.30pm – 4.30pm
Thursday 28th April 2011

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

Board of Directors
2.30pm – 4.30pm, Thursday 28th April 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**
 - a. Clinical Quality, Safety, & Governance Quarter Three Report** *(Report attached)*
Dr Rob Senior, Medical Director *For assurance* p.8

Reports & Finance

- 5. Chair and Non-Executive Directors' Report** *For noting*
- 6. Chief Executive's Report** *(Report attached)*
Dr Matthew Patrick, Chief Executive *For discussion* p.12
- 7. Finance & Performance Report**
 - a. Finance & Performance Report** *(Report attached)*
Mr Simon Young, Director of Finance *For noting* p.16
 - b. Quarter 4 Governance Declaration** *(Report attached)*
Ms Pat Key, Director of Corporate Governance & Facilities *For approval* p.24
Mr Simon Young, Director of Finance
 - c. Operational Risk Register** *(Report attached)*
Ms Pat Key, Director of Corporate Governance & Facilities *For noting* p.29

Corporate Governance

- 8. Annual Report & Accounts 2010/11** *(Report attached)*
Miss Louise Carney, Trust Secretary *For noting* p.40

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|---|---|-------------|
| 9. Clinical Quality, Safety, & Governance Committee Terms of Reference
<i>Dr Rob Senior, Medical Director</i> | <i>(ToR attached)
For approval</i> | <i>p.43</i> |
| 10. Corporate Governance Report
<i>Miss Louise Carney, Trust Secretary</i> | <i>(Report attached)
For noting</i> | <i>p.52</i> |
| 11. Annual Information Governance Compliance Report
<i>Mr Simon Young, Director of Finance</i> | <i>(Report attached)
For noting</i> | <i>p.57</i> |

Quality & Development

12. Quality Report

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|---|---|--------------|
| a. Quality Report
<i>Ms Louise Lyon, Trust Director
Ms Justine McCarthy-Woods, Quality Standards & Report Lead</i> | <i>(Report attached)
For approval</i> | <i>p.65</i> |
| b. Data Assurance Overview
<i>Ms Louise Lyon, Trust Director
Ms Justine McCarthy-Woods, Quality Standards & Report Lead</i> | <i>(Report attached)
For approval</i> | <i>p.122</i> |

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| 10. Academic Health Science Centres and Health Innovation and Education Clusters Updates
<i>Dr Matthew Patrick, Chief Executive</i> | <i>For discussion</i> |
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Conclusion

11. Any other business

12. Notice of future meetings

Thursday 5th May 2011 : Board of Governors
Tuesday 24th May 2011 : Board of Directors
Thursday 2nd June 2011 : Ex. Board of Directors (*Time TBC*)
Tuesday 14th June 2011 : Directors' Conference (*Board Review*)
Tuesday 28th June 2011 : Board of Directors
Tuesday 26th July 2011: Board of Directors
Monday 12th September 2011: Directors' Conference (*Topic TBC*)
Thursday 15th September 2011: Board of Governors
Tuesday 27th September 2011: Board of Directors
Tuesday 25th October 2011: Board of Directors
Tuesday 8th November 2011: Directors' Conference (*Plan Review*)
Tuesday 29th November 2011: Board of Directors

Thursday 1st December 2011: Board of Governors
Tuesday 31st January 2012 : Board of Directors
Thursday 2nd February 2012 : Board of Governors
Tuesday 28th February 2012 : Board of Directors
Tuesday 27th March 2012 : Board of Directors
Tuesday 24th April 2012 : Board of Directors
Thursday 3rd May 2012 : Board of Governors
Tuesday 29th May 2012 : Board of Directors
Tuesday 26th June 2012 : Board of Directors
Tuesday 31st July 2012 : Board of Directors
Thursday 13th September 2012 : Board of Governors
Tuesday 25th September 2012 : Board of Directors
Tuesday 30th October 2012 : Board of Directors
Tuesday 27th November 2012 : Board of Directors
Thursday 6th December 2012 : Board of Governors

Meetings of the Board of Directors are from 2.30pm until 5.30pm, and are held in the Board Room. Meetings of the Board of Governors are from 2pm until 5pm, and are held in the Lecture Theatre. Directors' Conferences are from 12.30pm until 5pm.

Board of Directors Part I

Meeting Minutes, 2.30pm – 4.30pm, Tuesday 29th March 2011

Present:			
Ms Angela Greatley Trust Chair	Mr Martin Bostock Snr Independent Director	Ms Lis Jones Nurse Director	Mr Altaf Kara Non-Executive Director
Ms Trudy Klauber Dean	Ms Louise Lyon Trust Director	Ms Joyce Moseley Non-Executive Director	Dr Matthew Patrick Chief Executive
Dr Ian McPherson Non-Executive Director	Dr Rob Senior Medical Director	Mr Richard Strang Deputy Trust Chair	Mr Simon Young Director of Finance
In Attendance:			
Miss Louise Carney Trust Secretary (minutes)	Ms Justine McCarthy- Woods Quality Standards & Report Lead (items 11a and 12)		
In Attendance:			
Ms Pat Key Director of Corporate Governance & Facilities (item 7c)			

Actions

AP	Item	Action to be taken	Resp	By
1	3	Miss Carney to amend minutes	LC	Immed
2	5	Ms Klauber to prepare report on workforce development, education, and training	TK	
3	6	Dr Patrick to prepare paper on marketing and business development	MP	May 11
4	7a	Miss Carney to clarify toilet refurbishment in Capital Budget	LC	Immed
5	8	Miss Carney to investigate insurance policies for Directors	LC	May 11
6	8	Miss Carney to update Board of Directors on Governors' and Directors' responsibilities as appropriate	LC	Cont
7	9	Dr Senior to review and revise CQSG Quarter Three Report	RSe	Immed
8	11a	Comments on Data Quality Policy to be sent to Ms McCarthy-Woods	BD	Immed

Actions Agenda item

Future Agendas

1. Trust Chair's Opening Remarks

Ms Greatley welcomed everyone to the meeting.

2. Apologies for Absence

As above.

3. Minutes of the Previous Meeting

AP1 The minutes were approved subject to a minor typographical amendment.

4. Matters Arising

All Action Points had been completed.

Outstanding Action 1 had been completed and the correct version was included in this month's report. Outstanding Actions 2, 3, and 4 had been completed.

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

Angela Greatley, Trust Chair

Ms Greatley contributed to the discussions under "*Chief Executive's Report*" (item 6).

Mr Richard Strang, Non-Executive Director

Mr Strang had attended a King's Fund seminar on commissioning in London. Mr Strang noted that there had been considerable enthusiasm for GP commissioning.

Ms Klauber tabled a diagram on workforce development, education, and training. Although it was unclear at this stage how many skills networks there would be, Ms Klauber highlighted the importance of ensuring the Trust is not left out of any developments. The consultation finishes on 31st March. Ms Klauber to report following publication of the Government's response to the consultation.

AP2

6. Chief Executive's Report

Mr Strang queried the signing of the contract with the Big White Wall. Dr Patrick noted that the documents were being drawn up and would soon be signed. Mr Strang queried when revenue could be drawn from – the date of signing the contract, or the date from when work commenced. Mr Young confirmed it was from when work commenced. Dr Patrick confirmed that the contract encompassed all revenue except that specifically related to technical development.

AP3

Dr Patrick reported that a paper on marketing and business development would be presented to the Board of Directors.

Ms Greatley noted that London mental health Chairs and Chief Executives were working together on the disparity between acute trusts and mental health trusts. Ms Greatley suggested that mental health trusts ought to be lobbying at ministerial level, rather than through Strategic Health Authorities.

7. Finance & Performance Report

7a. Finance & Performance Report

Mr Young highlighted that at previous meetings, the Board had discussed

the possibility of using some of the 2010/11 surplus for allowances for expected redundancy costs. International Financial Reporting Standards are strict, and as the Trust has not yet made any definite decisions, the Trust is unable to allocate these costs for 2010/11. The current projected figures do not indicate any problems with possible funding for redundancies, which would appear as an additional unusual expense in the 2011/12 accounts.

Mr Strang queried CQUINS. Ms Lyon explained that there were two areas that had not been achieved – adult waiting times; and data levels in CAMHS. Mr Strang pushed for a prudent estimate for next year's CQUINS. Ms Lyon explained that commissioners set targets, but that the Trust had been as prudent as possible in the Annual Plan. Mr Bostock noted that figures had improved significantly. Mr Young noted that both finances and services had improved.

7b. Budget 2011/12

Mr Young explained that there were a number of external factors that had affected the 2011/12 budget: national efficiency targets, which had placed just over £1m cost pressure on the Trust; a three percent cut in the value of the national training contract; a reduction in the purchasing of adult services; and the loss of some short-term contracts.

The Trust was aiming for a surplus of £150k, and was also increasing its contingency reserve. It was not anticipated that this would prevent the Trust from funding service developments.

Mr Young noted that the Trust had announced a voluntary redundancy scheme. The Trust's Financial Risk Rating would not be affected by this, as the costs fall into the category of restructuring costs. The FRR is based on the cumulative performance of the Trust over the year. However, as restructuring will take place in Quarters Three and Four, the Trust must be mindful of its cash balance in Quarters One and Two.

Mr Strang suggested that the Big White Wall would be a high-margin business, and queried what would happen to the surplus. Mr Young noted that it would be declared, but that the Trust would need to carefully manage its dependence on this.

Mr Strang queried how the FRR would be monitored in Quarter One. Mr Young noted that the Month Two results would be closely considered. Projected figures for Quarter One are relatively small, but that the Trust could consider releasing deferred income.

Approval of the Budget was deferred until after a discussion of commercially sensitive matters had taken place in Part 2. Following this discussion, the Budget was approved.

7a. Capital Budget 2011/12

Mr Young highlighted that the projected expenditure for Years 2 and 3 had been included for information, and not for approval.

AP4

Mr Strang queried why toilet refurbishment for the same floors appeared more than once. Mr Young suggested that different toilets were being refurbished at different times. Miss Carney to clarify.

The Capital Budget for 2011/12 was approved.

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

AP5

Mr Strang queried the need for Directors' indemnity insurance in light of the proposed changes. Miss Carney noted that Directors' were probably already covered by the Trust's existing insurance policies, but would investigate further.

Mr Strang suggested the Trust be proactive in making any necessary constitutional or governance changes, and in developing Governor training.

The Board queried paragraph 4.1 and whether this was feasible. Ms Greatley suggested that this probably meant authorisation from half of members present at a meeting, rather than half of all members of the foundation trust.

AP6

Miss Carney to update the Board of Directors as more information becomes available.

9. Clinical Quality, Safety, & Governance Committee Quarter Three Report

AP7

Dr Senior noted that the report was very long, and would need refining in future Board reports.

Mr Strang noted that paragraph 1.1 referred to "substantial" assurance, whilst paragraph 4.1 referred to "adequate" assurance. Dr Senior to review and revise.

The Board queried whether the report needed to be approved. Dr Senior suggested that the Board needed to confirm that they accepted the report as adequate assurance. The Board confirmed that they did.

Mr Kara queried whether it was conceivable that items could be RAG rated green because progress was good, but outcomes amber or red. Dr Senior explained that the RAG rating in the report was unmitigated.

Mr Strang noted that the frequency of "inadequate data" in the action column raised wider concerns about data completeness throughout the Trust.

10. Annual Schedule of the Board of Directors 2011/12

Further to the proposed schedule, Miss Carney suggested that the Annual Safeguarding Arrangements Report be reviewed by the Clinical Quality, Safety, & Governance Committee, rather than the Board of Directors, and that the review of Committee Terms of Reference be moved to May when the Committees are due to submit their Annual Reports, with the exception of the Audit Committee, which reports in September. These amendments were approved.

Mr Young noted that Service Line Reports would have a different format, as agreed with the Internal Auditors.

The schedule was approved.

11. Trust Policies

11a. Data Quality Policy

Ms McCarthy-Woods noted that the Policy linked to the Quality Report (see item 12).

Mr Strang suggested that the Policy read more like a mission statement than a policy, and did not cover implementation. Ms Klauber suggested that the Policy distinguish which areas each Director was responsible for.

AP8 The Policy was agreed in principle. Comments to be sent to Ms McCarthy-Woods.

12. Quality Report

Ms McCarthy-Woods noted that the Report contained data for Quarters One and Two only. The comments that appeared on the Report were from the Trust's External Auditor KPMG, and the Trust's Governance and Risk Advisor. The Board noted that it was difficult to comment on an incomplete document. Ms McCarthy-Woods explained that the Report would return with data from Quarters Three and Four.

Ms McCarthy-Woods explained that the Board of Directors were responsible for signing-off the Quality Report, which would be presented at the May 2011 Board of Directors meeting.

Dr McPherson asked Ms McCarthy-Woods to highlight any areas of concern. Ms McCarthy-Woods noted that outcome monitoring data for Quarters Three and Four may be of some concern.

Ms Moseley queried who the Report was aimed at. Ms Greatley noted that although the document was public, its audience was not the general public, and that the way in which the Report must be written was very prescribed.

Ms Lyon noted that Governors had been consulted on the Report in February 2011. Ms Lyon highlighted that the Trust's intention was to include patient and user comments.

Mr Strang noted that the Audit Committee had questioned KPMG on the Report and reported that KPMG had seemed positive over the direction of travel of the document.

13. Academic Health Science Centre and Health Innovation and Education Cluster Updates

Dr Patrick noted that a great deal of work was being carried out with the Anna Freud Centre and with UCL Partners. This was starting to prove fruitful in terms of research funding.

14. Any Other Business

Miss Carney reminded all Board members to submit their annual Declaration of Interests before month-end.

15. Notice of Future Meetings

Noted.

Outstanding Action Part 1

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date
1	Feb-11	5. Trust Chair's and Non-Executive Directors' Reports	Ms Greatley to forward any briefings on the changing role of Non-Executive Directors and Governors	Angela Greatley	As appropriate
2	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
3	Jan-11	7a. Finance & Performance Report	Ms Lyon to report back on structure of consultancy work	Louise Lyon	
4	Jan-11	4. Matters Arising	Dr Senior and Ms Lyon to give further consideration to cavassing GP's knowledge of mental health	Rob Senior / Louise Lyon	

Board of Directors : April 2011

Item : 4a

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

Summary:

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

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

Positive themes include:

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

Areas being addressed include developing systems for:

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

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

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

This report focuses on the following areas:

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

For : Approval

From : Medical Director

Clinical Quality, Safety, and Governance Committee Quarter 3 Report

1. Introduction

- 1.1 The report is based on the work of the Workstream Leads and is validated by the Management Committee before scrutiny at the CQSG. The CQSG was satisfied that reports from the work stream leads provided adequate assurance and accepted where further assurance was required, that adequate action plans were in place, though in some cases proposed action would not result in short term change.

2. Findings

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

3. Conclusion

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

4. Recommendations

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

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

Board of Directors : April 2011

Item : 6

Title : Chief Executive Report

Summary :

The report covers the following items:

1. Introduction
2. Productivity
3. NHS Reforms
4. UCL Partners
5. And Finally...

This report focuses on the following areas:

(delete where not applicable)

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

For : Noting

From : Chief Executive

Chief Executive Report

1. Introduction

- 1.1 I wanted to begin this month's report by letting the Board of Directors know that Trudy Klauber, Dean and Director of Academic Services, has announced that she is standing down from role. Trudy has always planned to step down mid-way through her second term of office, and she and I have been discussing the timing of this for some while. Trudy has been in role now for seven years.
- 1.2 The plan is that recruitment of a successor will begin after Easter, with a new appointment in post by the end of August at the latest. Trudy will then work with her successor to ensure a smooth and stable transition.
- 1.3 In the meantime, Trudy will continue with her role, which is of particular importance when the NHS and university sectors are experiencing so much change and instability.
- 1.4 After the end of the year, Trudy intends to remain working in the Trust, returning to her original clinical and training role alongside Trust-wide roles.
- 1.5 In another senior staff change, Marcus Evans, Head of the Nursing Discipline, has been appointed as interim lead for the Adult Directorate. This will initially be for a period of three to four months to enable Marcus to work with Louise Lyon, Trust Director, and the Directors of the Adolescent Directorate and the Portman Clinic in reviewing how best to organise these services.

2. Productivity

- 2.1 As highlighted in my last report to the Board of Directors, the budget for next year requires that we identify a further £500k of cost reductions / savings in the current financial year.
- 2.2 Work is already underway on a program to identify these savings, while ensuring that all of our services are organised in such a way that they can be delivered with a slightly smaller staff group. I believe that there will also be opportunities to genuinely improve the way in which we deliver some services across the Trust.
- 2.3 The Programme Board is being chaired by Simon Young, Director of Finance, and comprises Louise Lyon, Trust Director, Rita Harris, CAMHS Director, and Susan Thomas, Human Resources Director, in

addition. These latter three will be leading work streams focused on specialist and adult services; CAMHS; and central directorates and services respectively. The former two work streams will be looking at training and education, clinical services, consultancy and research within those areas.

- 2.4 Alongside this work I am organising a series of Trust-wide staff meetings. The first two of these will be held in May, with later dates in June / July. These meetings will not only provide an opportunity for us to discuss the work underway, but importantly an opportunity for sharing the strategy and planning incorporated into the Annual Plan, ensuring that all staff are familiar with our direction of travel as an organisation. While much of this planning originates locally within directorates, it is not always the case that everyone is familiar with the contents of such plans.
- 2.5 The voluntary redundancy and early retirement scheme made available to staff last month has now closed to expressions of interest. While some firm applications have already been received, a number of staff are still waiting for their quotes. To ensure that all applications are dealt with equitably, none will be considered until after Easter.

3. NHS Reforms

- 3.1 The Prime Minister has announced a break in the progress of the Health Bill through Parliament, allowing for a 'listening exercise' to be undertaken. The expressed aim is to gather suggestions and opinions as to how the Bill can be improved. It has been made clear, however, that no change is not an option, and that there should be no halt in the implementation of many of the Bill's major objectives, including the development of GP consortia, the establishment of an NHS Board, and the dissolution of Primary Care Trust's and Strategic Health Authorities (although the timetable for the latter has been put back slightly).
- 3.2 The Government is establishing an NHS Future Forum, which will review the Bill in response to expressed concerns. The membership will comprise for the main part senior NHS clinicians, with charity, third sector, patient and managerial representation. The Forum will report to the Prime Minister and Deputy Prime Minister along with Health Secretary, Andrew Lansley.
- 3.3 In the meantime, the Royal College of Nursing, at its annual conference, passed a vote of no confidence in Andrew Lansley. The RCN has expressed very significant concern about planned reforms from the outset.

4. UCL Partners

- 4.1 On 4th April, I joined the first meeting of a group convened under the mental health theme of UCL Partners. This multi-disciplinary group is chaired by Professor Fonagy, the theme Director, and will be looking at the development of a values-based approach to mental health and wellbeing. This work builds on the work of Michael Porter in the United States, and will look not only at individual benefit but family, group and community benefit, from the perspectives of those most directly affected by mental health difficulties as opposed to clinicians and professionals. I think that as a Trust we have a good deal to contribute on these matters.
- 4.2 This work will run alongside a group being co-chaired by Professor Alessandra Lemma (of the Tavistock and Portman), looking at the outcomes and mechanisms of change associated with psychological therapies (broadly defined).

5. And Finally...

- 5.1 On 8th April, two important events were held at the Trust. The first was a national conference on the development of payment by results for Child and Adolescent Mental Health. The conference was organised and chaired by Simon Young, who chaired the London project board for this work before it became a national project. Over 100 people attended.
- 5.2 Alongside this, the Trust held a learning day with the British Red Cross. The Trust has recently agreed a Memorandum of Understanding with the Red Cross and will be offering some of our trainees and staff the option of placements with Red Cross refugee services. The project, led on our side by Sarah Davidson, Philip Stokoe and Jo Stublely, is an exciting one that offers benefit to the refugees with whom the Red Cross is in such close contact, as well as to both organisations and their staff. For us, as a specialist mental health trust, such partnerships are essential if our contribution is to be made available to those most in need in places and in ways that facilitated access.

Dr Matthew Patrick
Chief Executive Officer
April 2011

Board of Directors : April 2011

Item : 7a

Title : Finance & Performance Report

Summary :

At the end of the financial year a surplus of £145k is reported compared to the planned surplus of £150k. There has been a decrease in the surplus in month of £202k. This is mainly due to reduced income as a result of low performance on contracts and deferrals in addition to increased expenditure which has been offset by a reduction in the annual leave accrual and the recalculation of the dividend.

The cash balance increased to £4,712k at 31 March, due to income being received in advance for April. Cash is expected to decrease during 2011/12 but to remain ahead of the 2010 Plan, subject to achievement of planned income and expenditure.

The draft accounts will be completed and submitted by 5pm on 21 April. After audit, they are due to be presented to the Board of Directors for approval on 2 June.

This report will have been reviewed by the Management Committee on 21 April.

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 : Director of Finance

Finance & Performance Report

1. **External Assessments**

1.1 **Monitor**

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

2. **Finance**

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

2.1.1 At the end of the financial year, income is £925k below budget and expenditure £815k below budget. The dividend is also £113k below budget, as the Trust's net relevant assets are lower, due mainly to the high balance with the Government Banking Service, which is excluded from the calculation. The Trust's surplus is £145k, which is £5k below the annual target of £150k.

2.1.2 The material variances to both income and expenditure in the month of March are:

Income

The £226k under achievement in month is due to the following:

- £67k underperformance on cost and volume contracts
- £117k deferred PCT income, to fund projects and activity in 2011/12
- £63k Monroe underperformance
- £90k adverse movement on Training Income due to an LCPPD deferral and a provision for a HEFCE reduction
- Offset by a £55k overachievement on departmental consultancy

Expenditure

The £242k under spend in month includes:

- £108k reduction in the 2010/11 annual leave accrual due to a reduction in average staff leave carried forward
- £386k release of budgeted reserves and contingency
- GIDS £51k over budget due to additional Endocrinology clinics and study
- £40k Staff termination costs
- There were also investments in non pay across the organisation

2.1.3 For the year, the income shortfall of £925k includes £358k for Consultancy, with TCS under target by £137k and departmental

consultancy under by £221k. There is also a shortfall in Clinical, but Training is in surplus (see sections 3 and 4 below).

2.1.4 Research income is below budget by £184k and the income target for 2011/12 has been reduced to reflect this.

2.1.5 In the under-spend of £815k for the year, the main factors were the unallocated contingency reserve; a reduction in the annual leave accrual of £108k; and vacancies in Child & Family £25k, Portman £151k and Adolescent £55k. These under-spends have been offset by an over spend in TCS of £105k (as reported previously) due to delayed 2009/10 payments for associate consultants and termination costs.

2.2 Cash Flow

2.2.1 Cash was £4,712k at 31 March, compared to the plan of £1,524k and the recent forecast of £3,005k. The main reason for exceeding the forecast was £1.1m of unexpected payments in advance from two PCTs.

2.2.2 The cash projections for 2011/12 were updated for the November report. With the higher opening balance now expected, cash balances will reduce but are still projected to remain satisfactory throughout the year, subject to achieving the productivity improvements needed to deliver a small surplus in 2011/12.

2.2.3 Next month's report will include the final detailed cash flow report for 2010/11 and the cash projections for the next 24 months, revised for the Annual Plan.

2.2.4 The Trust's liquidity, using Monitor's formula and including the £2m financing facility, remains satisfactory.

3. Training

3.1 Training income achieved £139k above budget in total, mainly due to university income over-performing by £247k.

3.2 CPD income is also overachieving cumulatively. These gains have been offset by a shortfall of £83k on Conferences.

4. Patient Services

4.1 Activity and Income

4.1.1 Total contract income for the year is £105k below budget. The CQUIN shortfall has been successfully reduced to £10k; but the base value of one contract was £33k below budget; and adverse variances on cost and volume activity, offset however by an additional £34k cost & volume increase for GIDU. The main factor at the end of the year has been that £150k income has been deferred to next year.

4.1.2 Named patient agreements (NPAs) actual income was £22k below budget, which is spread across the service lines.

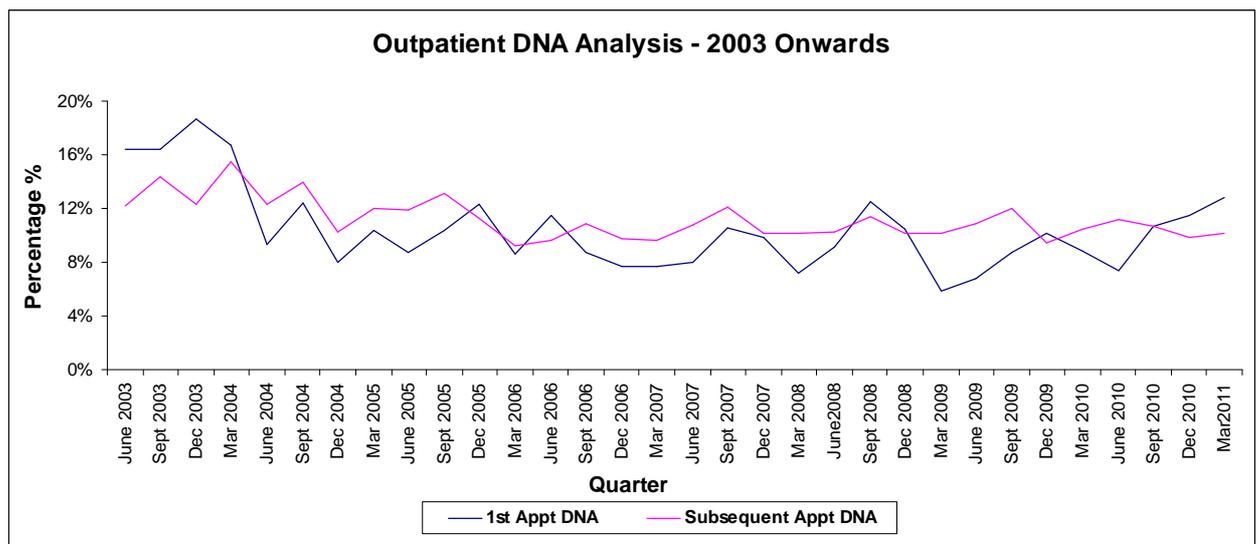
- 4.1.3 Court report income is £19k below budget. The majority of the under-performance was from Portman which has been offset by C&F over performance.
- 4.1.4 Monroe income is £171k below budget. March income was lower than expected and this has also been reduced by £19k to allow for the late distribution of invoices for prior months' income.
- 4.1.5 Day Unit over performed by £81k cumulatively, due to high pupil numbers earlier in the year.
- 4.1.6 Project income is £190k below budget for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.
- 4.2 **Clinical performance** (provided by the Service Development Directorate)
- 4.2.1 There were a total of 33 waits of 11+ weeks for first attended appointments across the Trust services during Quarter Four. Of these, 16 patients were in GIDS, and they waited an average of 16 weeks. This was largely due to increased demand on the service; staff levels were increased during the year, but there were making further increases, using the additional funding available.
- 4.2.2 Of the 17 remaining patients who waited 11+ weeks for their first attended appointment, 14 were in generic services:
- 6 long waits were due to external causes – e.g. lack of sufficient information in referral, difficulty contacting patient due to changes of address, liaison with local professionals/patient choice or difficulty in engaging patient
 - 1 due to lack of clinical resources
 - 2 requiring specialist clinician
 - 1 NPA applications
 - 2 administrative errors
 - 1 cancelled due to clinician illness
 - 1 cause unknown
- 2 were in the LCDS (1 NPA / and 1 delayed by an external factor) and 1 in the Portman (an NPA).
- 4.2.3 Five of these patients waited 20+ weeks for their first attended appointment:
- Portman: 1 (NPA)
 - Adult Department: 2 (Both patients needed to wait for specialist clinician to be available)
 - LCDS: 1 (delayed due to lengthy liaison with local services)
 - SCCT: 1 (lack of referral information followed by holiday)

period)

4.2.4 In the Quarter ended 31 March, 12.8% of patients due to have their first appointment did not attend (DNA), higher than in recent quarters. For the much larger number of subsequent appointments, the DNA percentage was 10.1%. Both these figures are within the range achieved previously, as shown in the graph below.

4.2.5 Low DNA rates can be seen as an indication of patients' satisfaction with their care. High DNA rates can be seen as inefficient use of resources for patient benefit. We have been reporting DNAs as a quality indicator for several years. Our results are similar to or better than other mental health trusts, but we continue to investigate variations between services, and to take action to reduce the rates where possible.

4.2.6 For these reasons, it has been agreed that our processes for collecting and monitoring DNA rates will be included in the audit work for this year's Quality Report. The proposal to choose this indicator for audit was agreed by the Board of Governors.



5. **Consultancy**

5.1 TCS income was £59k in March, below budget by £18k. The cumulative income of £593k is £137k behind budget.

5.2 Departmental consultancy is £221k below budget. This is offset by higher income in other areas in the same departments; and/or by savings.

Simon Young
Director of Finance
19th April 2011

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

APPENDIX A

		Mar-11			CUMULATIVE		
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S
INCOME							
1	CLINICAL	1,198	1,045	(153)	14,669	14,297	(372)
2	TRAINING	1,276	1,186	(90)	16,065	16,204	139
3	CONSULTANCY	149	187	37	1,615	1,256	(358)
4	RESEARCH	28	(25)	(53)	331	148	(184)
5	OTHER	53	85	32	613	463	(149)
TOTAL INCOME		2,704	2,478	(226)	33,293	32,367	(925)
OPERATING EXPENDITURE (EXCL. DEPRECIATION)							
6	CLINICAL DIRECTORATES	1,492	1,680	(188)	18,122	18,047	75
7	OTHER TRAINING COSTS	483	489	(6)	6,575	6,256	319
8	OTHER CONSULTANCY COSTS	53	69	(16)	630	738	(108)
9	CENTRAL FUNCTIONS	538	472	66	6,494	6,347	147
10	TOTAL RESERVES	386	0	386	386	0	386
TOTAL EXPENDITURE		2,952	2,710	242	32,207	31,388	819
EBITDA		(247)	(232)	16	1,085	979	(106)
ADD:-							
12	BANK INTEREST RECEIVED	2	3	(1)	20	15	5
LESS:-							
11	DEPRECIATION	42	44	(2)	509	512	(3)
13	FINANCE COSTS	0	4	(4)	0	4	(4)
14	DIVIDEND	37	(76)	113	446	333	113
RETAINED SURPLUS		(325)	(202)	122	150	145	(6)
EBITDA AS % OF INCOME		-9.2%	-9.4%		3.3%	3.0%	

	Mar-11			CUMULATIVE		
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S
INCOME						
NHS LONDON TRAINING CONTRACT	623	623	0	7,479	7,480	1
TRAINING FEES & OTHER ACA INC	405	338	(68)	5,616	5,795	179
POSTGRADUATE MED & DENT'L EDUC	6	7	1	70	28	(42)
JUNIOR MEDICAL STAFF	86	72	(14)	1,037	1,071	34
CHILD PSYCHOTHERAPY TRAINEES	155	146	(9)	1,863	1,829	(34)
R&D	28	(25)	(53)	331	148	(184)
CLINICAL INCOME	997	901	(95)	12,288	11,984	(304)
DAY UNIT	84	102	17	1,014	1,095	81
MONROE	68	5	(63)	780	609	(171)
FDAC	28	31	3	332	373	41
TCS INCOME	77	59	(18)	730	593	(137)
DEPT CONSULTANCY INCOME	73	127	55	885	664	(221)
COURT REPORT INCOME	21	7	(15)	255	236	(19)
EXCELLENCE AWARDS	10	10	(0)	118	116	(2)
OTHER INCOME	43	75	32	495	347	(148)
TOTAL INCOME	2,704	2,478	(226)	33,293	32,367	(925)
EXPENDITURE						
EDUCATION & TRAINING	301	323	(22)	4,395	4,297	98
PORTMAN CLINIC	135	150	(15)	1,620	1,471	149
ADULT DEPT	258	312	(54)	3,112	3,107	5
MEDNET	18	13	5	221	229	(8)
ADOLESCENT DEPT	129	144	(15)	1,581	1,572	9
C & F CENTRAL	736	785	(49)	9,004	8,913	91
MONROE & FDAC	82	91	(10)	979	1,020	(41)
DAY UNIT	64	69	(5)	768	792	(23)
SPECIALIST SERVICES	62	119	(57)	732	871	(138)
COURT REPORT EXPENDITURE	9	(2)	11	105	72	33
TRUST BOARD & GOVERNORS	10	7	3	115	102	12
CHIEF EXECUTIVE OFFICE	26	11	15	308	303	5
PERFORMANCE & INFORMATICS	79	66	13	930	877	53
FINANCE & ICT	91	91	0	1,093	1,147	(55)
CENTRAL SERVICES DEPT	181	206	(25)	2,197	2,365	(168)
HUMAN RESOURCES	56	49	7	709	641	69
CLINICAL GOVERNANCE	31	36	(5)	374	367	7
TRUST DIRECTOR	28	52	(24)	348	345	3
PPI	15	25	(10)	166	166	0
SWP & R+D & PERU	31	13	18	375	239	136
R+D PROJECTS	0	0	0	0	(0)	0
PGMDE	9	0	9	109	69	40
NHS LONDON FUNDED CP TRAINEES	155	153	2	1,863	1,718	145
TAVISTOCK SESSIONAL CP TRAINEES	9	7	2	111	86	25
FLEXIBLE TRAINEE DOCTORS	8	5	3	97	87	11
TCS	49	68	(19)	587	693	(105)
DEPARTMENTAL CONSULTANCY	4	1	2	43	46	(3)
DEPRECIATION	42	44	(2)	509	512	(3)
PROJECTS CONTRIBUTION	(10)	26	(36)	(121)	(98)	(23)
IFRS HOLIDAY PAY PROV ADJ	0	(108)	108	0	(108)	108
CENTRAL RESERVES	386	0	386	386	0	386
TOTAL EXPENDITURE	2,994	2,754	240	32,716	31,900	816
OPERATING SURPLUS/(DEFICIT)	(290)	(280)	10	576	463	(114)
INTEREST RECEIVABLE	2	3	1	20	15	(5)
UNWINDING OF DISCOUNT ON PROVISION	0	4	4	0	4	4
DIVIDEND ON PDC	(37)	76	113	(446)	(333)	113
SURPLUS/(DEFICIT)	(325)	(203)	118	150	145	(6)

Board of Directors : April 2011

Item : 7b

Title : 2010/11 Monitor's Quarter 4 Governance Declaration

Summary:

The Trust continues to meet all of the targets and indicators set out in the 2010/11 Compliance Framework, with one exception which is set out in the attachment to this report. Action plans are in place to ensure that this remains the case.

The overall score remains at 0.5, which should again result in a Green rating for governance. The Board of Directors is asked to approve the following declaration:

For one or more targets the Board cannot make Declaration 1* and has provided relevant details on worksheet "Targets and Indicators" in this return. The Board confirms that all other healthcare targets and indicators have been met over the period (after the application of thresholds) and that sufficient plans are in place to ensure that all known targets and national core standards that will come into force will also be met.

Details of any elections held (including turnout rates) and any changes in the Board or Board of Governors are included on worksheet "Board Changes and Elections" in this return.

* The wording of Declaration 1 is that all healthcare targets and indicators have been met and that sufficient plans are in place to ensure that they will continue to be met.

This report has been reviewed by the following Committees:

- Management Committee, 7th April 2011

This report focuses on the following areas:

- Risk

For : Approval

From : Director of Corporate Governance and Facilities,
Director of Finance & SIRO

2010/11 Monitor's Quarter 4 Governance Declaration

1. Declaration of performance against healthcare targets and indicators

- 1.1 The Monitor template for our quarterly return sets out a list of targets and indicators, in line with the Compliance Framework 2010/11 document. The 7 targets and indicators which apply to this Trust are given in the table below. Our assessment of our result for quarter 4 is unchanged from Quarter Three.
- 1.2 As previously reported, one target is not currently being met, leading to a score of 0.5. All other targets and indicators are being met and plans are sufficient to ensure that they continue to be met. Further details are given below. The Trust should therefore continue to receive a green Governance Rating.

Target / Indicator	Weighting	Quarter 4 result	
Data completeness: 99% completeness on all 7 identifiers	0.5	Not met in full	0.5
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	0.5	Achieved	
Moderate CQC concerns regarding the safety of healthcare provision	1.0	No	
Major CQC concerns regarding the safety of healthcare provision	2.0	No	
Failure to rectify a compliance or restrictive condition(s) by the date set by CQC within the condition(s) (or as subsequently amended with the CQC's agreement)	4.0	No	
Registration conditions imposed by Care Quality Commission		No conditions	
Restrictive registration conditions imposed by Care Quality Commission		No conditions	
		Total score	0.5
		Indicative rating	

2. Care Quality Commission registration

- 2.1 The Trust was registered by the CQC on 1 April 2010 with no restrictions. Actions continue throughout the year to ensure that this status is retained, assurance is considered by the CQSG Committee.
- 2.2 The Trust remains compliant with the CQC registration requirements.

3. Self certification against compliance with requirements regarding access to healthcare for people with a learning disability

- 3.1 The self certification was reviewed and approved by the Board of Directors in April 2010.

4. Data Completeness

- 4.1 As reported previously, we do not achieve 99% completeness on marital status, one of the seven data identifiers specified in the 2010/11 Compliance Framework. We are at or near 99% on all the other six: recent work by the Informatics department has remedied a problem on validity for a small number of codes.
- 4.2 The 2011/12 Compliance Framework has recently been published by Monitor. 99% completeness is still required, but for only six of the seven data items previously listed; marital status has been dropped. The Trust is implementing an action plan to ensure that we consistently achieve 99% for the remaining six items, to support the declaration to be submitted in May with the Annual Plan.

Board of Directors : April 2011

Item : 7c

Title : Operational Risk Register Full Year Review

Summary:

The Board of Directors has requested to review the full Operational Risk Register on an annual basis. The Risk Register is reviewed on a quarterly basis via the Clinical Quality, Safety and Governance Committee (CQSG).

The CQSG reviewed all operational risks scoring 9 or more on the Risk Register at its last meeting on 22nd February 2011. In February 2011, the CQSG confirmed that it accepted all the risks and were assured that the action plans set out on the register were appropriate to mitigate / reduce risks scoring more than 9.

Risks with a score below 9 are managed at Directorate level and these are reviewed on a quarterly basis with the support of the Governance and Risk Adviser.

At April 2011, the Trust has identified the following risks as scoring 9 or more on the risk matrix.

Deficit in 2011/12 if productivity savings of £120 (Camden CAMHS) and £500 (across the Trust) are not achieved	16
Interruption to Trust system and/or email	16
Trust is not meeting its KPI for mandatory training or induction attendance which poses a risk to a declaration of compliance with CQC regulation and will have effect on NHSLA compliance	12
Failure to ensure patients fully aware of treatment plans (risk arising from recent complaint)	9

Failure to follow Trust procedures for informing parents when making a child protection concern (risk arising from recent complaint)	9
Breach of confidential information resulting in harm to patient and/or investigation by IG Commissioner	9
RIO Implementation a) increased administrative time and stress as a result of implementation	9
Risk to MONITOR and CQC rating as a result of failing to publish a Quality Report of sufficient standard which could have a knock on effect on our income and business development	9
Other budget items, including additional income, not achieved, leading to a shortfall of more than £300k (excluding the productivity savings).	9

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance for the identification and management of operational risks, 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:

- Risk

For : Accepting for Assurance

From : Director of Corporate Governance and Facilities

Principal Risk	Controls	Assurances of Controls	Gaps	C	L	R	Actions/Treatment Plans	Tolerated with plan?	Lead	Target Date	Review /Change
Deficit in 2011/12 if productivity savings of £120(Camden cams) and £500 (across the Trust) are not achieved	Target date of 8 July agreed by BD. Productivity programme board set up, to report fully to BD in May and July. 3 teams also set up, for CAMHS, SAMHS and central.	PP Board on 14 April has received reports from each project on initial work and action plans. Progress of voluntary redundancy scheme also being monitored.	No definite savings plans at this early stage Voluntary redundancy scheme may be delayed and/or not produce enough applicants	4	4	16	PP Board will be meeting at least twice per month. Service line and central directors have all been asked for initial plans by early May. Action being taken to obtain VR quotes promptly for all who have expressed interest. Management to make first decisions late May.	Yes	Director of Finance		new risk April 2011
Interruption to Trust system and/or email	back up and restore plans are in place	audit of our procedures recommend improvements, only some of which have so far been implemented	Recent email failure took too long to resolve showing that procedures are not adequate	4	4	16	Action plan for email to be presented to MC on 5.5.11. Full review of all recovery processes by end May 2011	Yes	Director of Finance	28/02/2014	2011 following serious incident
	real-time evidence review process in place (PA) which allows updated RAG status of achievement level	PA reports									
Trust is not meeting its KPI for mandatory training or induction attendance which poses a risk to a declaration of compliance with CQC regulation and will have effect on NHSLA compliance	HR follow up all non attendance at induction and offer second date, if not attended then matter escalated to Director	no formal assurance of this system currently in place	Detailed action plan required to be agreed and monitored	3	4	12	Action plan to address shortfall to be presented to CQSG June 2011	Yes	Director of HR	03/09/2013	induction and mandatory training criterion
	introduction of sanctions for failure to complete mandatory training	none as new process, requires monitoring in practice									
	separate induction letter issued at appointment	internal HR check of process									
	Use of OLM/ESR to identify staff due to attend INSET	quarterly data report to Corporate Governance and Risk Work stream									
Failure to ensure patients fully aware of treatment plans (risk arising from recent complaint)	case review and supervision arrangements	case notes and meeting notes	full action plan not developed following complaint	3	3	9	action plan in development following receipt of expert report	Yes	Director of Nursing CAMHS Director	01/06/2011	new risk added April 2011

Principal Risk	Controls	Assurances of Controls	Gaps	C	L	R	Actions/Treatment Plans	Tolerated with plan?	Lead	Target Date	Review /Change
Failure to follow Trust procedures fro informing parents when making a child protection concern (risk arising from recent complaint)	child protection training	training records and case review records	full action plan not developed following complaint	3	3	9	action plan in development following receipt of expert report	Yes	Director of Nursing CAMHS Director	01/06/2011	new risk added April 2011
Breach of confidential information resulting in harm to patient and/or investigation by IG Commissioner	Attendance at induction which includes training on confidentiality.	Attendance at induction and inset records held by HR.	need to complete updating of all relevant policies and procedures	3	3	9	Promote revised policies and procedures when available, continue IG training	Yes	Medical Director		wording changed to include IG Commissioner
	Availability of Caldicott Guardian and IG Lead for advice.	Feedback from Caldicott Guardian									
	Confidentiality Policy.	Staff sign for policy issued on employment.									
	Incident reporting and investigation.	RMC review of incidents, Board and external review of SUI reports									
	information governance e-learning assessment	% pass rate of IG toolkit on line learning currently at 95%									
RIO Implementation a) increased administrative time and stress as a result of implementation	Regular meetings with & feedback from administrative staff to identify issues and resolutions & to provide support	Minutes of steering group, related emails	Carers solution not finalised and team clinic structure requires revision	3	3	9	Carers solution to agreed by end May Team structure to be implemented on Rio by end June	Yes	Director of Service Development	05/05/2012	controls updated post go live
	Responsive informatics support in place	Feedback from administrative staff at RiO steering group.									
	The need for clinicians to provide timely and accurate information for administrative staff emphasised e.g. meetings in adult department & at CAMHS Management Group	Date of meeting with adult department, minutes of CAMHS MG									
	Weekly steering group and risk/issues/clarification log with action plans.	Minutes of steering group and risk/issues log									

Principal Risk	Controls	Assurances of Controls	Gaps	C	L	R	Actions/Treatment Plans	Tolerated with plan?	Lead	Target Date	Review /Change
Risk to MONITOR and CQC rating as a result of failing to publish a Quality Report of sufficient standard which could have a knock on effect on our income and business development	development of method to verify data quality being implemented	validation report signed by Data owner/Director	Data Quality Policy and Procedure in draft form	3	3	9	complete Data Quality Policy Provide Board with opportunity to review draft Quality Report prior to sign off in May.	Yes	Trust Clinical Director	31/03/2013	method added to controls
	receive feedback from KPMG (external auditors) on policy and draft report	feedback from KPMG									
Other budget items, including additional income, not achieved, leading to a shortfall of more than £300k (excluding the productivity savings).	All budgets agreed with Directors. Monthly monitoring of actual and variance	Monthly report to MC and Board	Smaller items could lack resources or be overlooked. Productivity programme will take most management attention.	3	3	9	All budget-holders and Management Accounts required to review all budgets at risk each month.	Yes	Director of Finance		new risk April 2011
A patient causes physical and or mental harm to another patient/member of staff or visitor whilst on site.	Ongoing risk assessment during contact with trust.	Follow up and learning from incidents when they occur.	No formal de-escalation training for clinical staff Inadequate facilities for 'stressed' patients in reception area.	4	2	8	Following successful pilot of conflict resolution training in adolescent and C and F second pilot to be run for adult and Portman		Lead Adult Services	30/12/2010	
	Pre acceptance procedure.	Records audit to confirm risk assessment.									
	Support arrangements in place (on call clinician and 3333 emergency support number).										
A patient causes physical and or mental harm to another patient/member of staff/ family member/public whilst off site.	Direct referral review appointments available on request post discharge.	Self referral rate show this is available.	Failure to hit regular communication targets for letters to GPs.	4	2	8	2010-11 records audit to report in May 2011 will include review of GP letters		Lead Adult Services		action plan updated
	Information exchanged with referrer and other relevant agencies after assessment, during therapy and after discharge.	Records audit to show completeness and incident/complaints monitoring for external feedback									
	Ongoing risk assessment and risk management during contact with our services.	Records audit considers complexity of risk assessment documentation shortfalls are fed back for action .									

Principal Risk	Controls	Assurances of Controls	Gaps	C	L	R	Actions/Treatment Plans	Tolerated with plan?	Lead	Target Date	Review /Change
Harm to a child who absconds from Day Unit.	Audible alarms on all secure exits, fire exit and front door.	Alarm test schedules.	The ground floor windows and garden are used as another escape route.	4	2	8	To consider risk of absconding when reviewing potential new premises.		CAMHS Director		no change.
	Children closely monitored by staff at all times.	Record of monitoring.									
	Contingency Procedure to be activated if child absconds to minimise risk (includes early involvement of police), a and incident reporting.	Detailed review on each occasion that a child absconds to learn lessons.									
	Individual Risk Assessment for the children re absconding.	Recorded risk assessments and plans for each child.									
No new site identified for Day Unit and children remain at risk of harm due to the design and layout of the current building	lessons learned from incidents and local changes made to mitigate future risk	incident report to RMC	Existing building not purpose built and difficult to ensure safety	4	2	8	Actively negotiate with Camden re plan to co-locate sites so that service can be moved to purpose built premises Consider alternative options for site including new build in place of temporary structure to relocate the DU service		Director of Corp Gov and Fac		no change.
	staff meetings held to discuss daily events and plan best work arrangements	log book of meetings held by department									
Staff at risk of harm from patients/strangers due to location and layout of entrance to FDAC unit on CORAM site	Director of CGF met with CEO CORAM to confirm that new entrance will be installed as part of site rebuild	none, as no agreed date for rebuild	no agreed timetable for new entrance due to delays created by other tenants in the building	4	2	8	Tolerated		Director of Corp Gov and Fac	31/07/2011	no change.
	Lone worker policy promoted and staff issued with personal alarms	incident reporting									
Inability to account for full assessment/ treatment received by a patient due to incomplete written case record	Annual case note audit.	Results of case note audit and action planning reported to CG committee.	Trust wide case note audit does not review specialist services	2	3	6	Process for reviewing case note standards to be reviewed in 2011-12 to encourage local systems to be established to support annual case note audit	Yes	Medical Director		no change will update with new case note audit report
	Local case note audit.	Results of case note audit and action planning reported to CG committee.									
	Promotion of good practice via team leaders and via supervision.	appraisal									
	Trust wide agreed standards for written case notes	Case note standards available via intranet.									

Principal Risk	Controls	Assurances of Controls	Gaps	C	L	R	Actions/Treatment Plans	Tolerated with plan?	Lead	Target Date	Review /Change
Risk to a near 18 self harming/harming others due to break down in services for a 'near 18' yr old	Trust does not have controls relating to adolescents requiring inpatient admission as it does not hold beds	Incident report sent to Commissioners to stimulate review of this issue	No agreed protocol for the emergency admission of near 18's	3	2	6	To continue to seek ways of influencing commissioning decisions around this issue		Adol Director		no change
Failure to comply with Child protection training requirements for clinical staff resulting in impact on CQC assessment	internal audit Aug 2010, SIT audit 2010	audit reports and agreed action plans		3	2	6	Training programme to continue Action plans from recent audit to be agreed and monitored		Medical Director		no change.
	Level 1 training needs met via INSET and local training.	Records held by HR.									
	Training plan in progress for Level 3 training for C and F.	Invitations and attendance records held by HR.									
Incident of physical and/or psychological harm to clinical staff due to violence or aggression by patient	Clinical on call rota for immediate senior support.	Incident report following need to use 'on call ' support		3	2	6	Continue to make MAYBO training available on demand to high risk areas, monitor all incidents		Medical Director		no change.
	Day Unit specialist training (Team Teach) and detailed review of every incident involving violence and aggression by pupils	training records and case review records									
	Emergency number 3333 for access to support for Tavy/Portman	Incident reports are followed up when 3333 used in these circumstances.									
	Ongoing clinical risk assessment of patients to anticipate problems and take appropriate action.	Records audit to show compliance.									
Incident of harm to an outreach worker caused by a patient	focused localised lone worker risk assessments for high risk teams undertaken and local arrangements	completed assessments and local action plans		3	2	6	To keep risk assessments under review and continue to raise profile at Mandatory training		Medical Director		Apr 2011 likelihood reduced
	Incident reporting and investigation	Incident reviews and action plans reviewed by CG and H and S committee									
	Lone worker procedure promoted at induction and INSET, this promotes requirement for case by case risk assessment	Induction and INSET programmes. Completed risk assessments.									
	Personal alarm system provides for 'high risk' staff, together with training	Use of alarms monitored by H and S Manager and reported to RMC									

Principal Risk	Controls	Assurances of Controls	Gaps	C	L	R	Actions/Treatment Plans	Tolerated with plan?	Lead	Target Date	Review /Change
Under reporting of verbal/physical violence results in loss opportunity to reduce future risk.	analysis of incidents received and review at RMC	RMC minutes	Low levels of reporting of incidents of verbal abuse.	3	2	6	Continue to promote the importance of incident reporting.		All Directors		no change
	Promotion of incident reporting at induction and INSET.	Review and feedback from incident reports received.									
Child causes member of staff physical or psychological harm in the Day Unit.	Daily planning and behaviour review meetings.	Written behaviour management plans for each child.		2	3	6	To explore staffing structure and provision with view to creating capacity for a response team in major 'outburst' scenarios to reduce risk to staff and other pupils.		CAMHS Director		no change
	Incident reporting.	Incident analysis and review.									
	Pre intake assessment to plan and provide for child's behaviour management needs.	Written pre intake plans and risk assessments.									
	Regular teaching and updates for all staff in contact with children.	Team teach records.									
	Team Teach approach to children's behaviour which provides staff with strategies and techniques to avoid danger.	Team teach records.									
Trust is at risk of failing to meet inspection standards of external regulators e.g. CQC, NHLSA and Monitor in repose to Trust policies, due to the fact a large number are out of date, and some may be redundant but they are still listed for staff to use on the trust intranet.	Systematic process for ensuring authors are notified when policy/procedure is due for review	policy, data base and email audit trail	some polices still out of date require work by policy authors	3	2	6	Continue to work on reducing the now small number of out of date policies reduced		All Directors		April 2011 likelihood reduced to 2

Principal Risk	Controls	Assurances of Controls	Gaps	C	L	R	Actions/Treatment Plans	Tolerated with plan?	Lead	Target Date	Review /Change
Increased number of children in day unit results in increased number of avoidable violent incidents	Daily planning and behaviour review meetings.	Written behaviour management plans for each child.	Non apparent, but situation is monitored on a daily basis	2	3	6			CAMHS Director		no change
	Incident reporting.	Incident analysis and review.									
	Pre intake assessment to plan and provide for child's behaviour management needs.	Written pre intake plans and risk assessments.									
	Regular teaching and updates for all staff in contact with children.	Team teach records.									
	Team Teach approach to children's behaviour which provides staff with strategies and techniques to avoid danger.	Team teach records.									
Risk to lone worker as a result of failure to follow lone worker procedure	Simplified procedure and risk assessment tool approved and implemented	evidence of completed risk assessments and local action taken to mitigate /reduce risks	Revised procedure not fully implemented, risk assessments of vulnerable staff not completed	3	2	6	To promote risk assessments and local support arrangements to reduce risk		Jane Chapman		Risk added Dec 2010
Failure to meet the requirements of BWW			shortage of skilled staff to support the BWW contract	2	3	6	Recruit to vacant post, review CD support for Adolescent Directorate		Jane Chapman		new risk added April 2011
Risk of patient self harming on site.	'Early day' timing of appointment for 'at risk patient' timing of appointments for 'at risk' patients.	Audit of appointment times	none identified	2	2	4			Richard Graham		Reviewed Jan 2010 no change
	Risk assessment during clinical sessions.	Records audit include assessment of completion of risk assessment during contact with Trust, next report due March 2010									

Principal Risk	Controls	Assurances of Controls	Gaps	C	L	R	Actions/Treatment Plans	Tolerated with plan?	Lead	Target Date	Review /Change
Patients seen by D57/58 students at risk of lack of on site clinical supervision of their care due to training structure.	Clinical unit now in place with clinical lead to oversee management of patients seen by D58 trainees	Monitoring by Clinical Director (new unit established Mar 2010, needs a period do monitoring to test effectiveness)	none identified	4	1	4			Lead Adult Services	30/09/2010	action plan fully achieved, likelihood risk now
	Each trainee is supported by an supervisor and mentor.	Local records of supervision arrangements, shown in records and via mentoring/appraisals.									
Risk of food poisoning or other environmental hazard from on site kitchen	Contracted service with detailed risk arrangements in contract.	Contract records held by Facilities Directorate.	none identified	4	1	4	Tolerated low risk with satisfactory ongoing monitoring.		Director of Corp Gov and Fac		reviewed Jan 2010 no change
	Regular internal and external inspections, certificates in place.	External inspection reports (Camden Council)									
Investigation by Information Commissioner due to lack of robust DPA polices and procedures.	Incident reporting if breach.	Review of breaches via incident reporting and investigation.	Out of date confidentiality policy. Lack of 'experts' around Trust to advice staff on DPA, FOI and IG issues.	4	1	4	Reach 95% completion of IG module by March 2011 (achieved) Complete and reissue confidentiality policy		Director of Finance		Likelihood reduced to 1 at Jan 2011,
	Promotion of DPA policy and procedures via Induction and INSET.	Attendance records at mandatory training.									
	work towards IG toolkit	evidence held on PA in support of IG toolkit self assessment									
Breach of confidentiality of Portman patient resulting in media interest.	All Portman records on Portman site.	Record audit.		4	1	4	To keep issue on review and respond to any incidents that occur in year.		Portman Clin Director		2009 no change (tolerated risk).
	All requests for access referred to Clinical Director and discussed with Caldicott Guardian.	Feedback from CD and Caldicott Guardian if problems arise.									
Portman patient harms a member of non clinical staff whilst on site.	More than one clinician in building when patients seen out of hours.	Work schedules to show presence of more than one clinician.		4	1	4	To keep issue on review and respond to any incidents that occur in year.		Portman Clin Director		reviewed July 2009 no change (tolerated risk).
	People in reception area at all times when patients in building.	Written guidelines for reception staff operational.									
	Staff aware of escalation arrangements.	Incident reports.									
Monroe service not adequately housed by September 2010 resulting in loss of business	Monroe staff consulted re service needs and timetable for work agreed	regular project meetings timetabled and minute	no current gaps	2	2	4	Tolerated		Director of Corp Gov and Fac	31/07/2011	no change

Principal Risk	Controls	Assurances of Controls	Gaps	C	L	R	Actions/Treatment Plans	Tolerated with plan?	Lead	Target Date	Review /Change
RiO, post go live risk b) drop in data quality which could significantly impact on income in 2010/11 and following year if not resolved quickly	As above and regular reports on number of uncoded appointments circulated. Uncoded appointments have significantly decreased due to action taken by admin staff.	As above and Emails of reports	no current gaps	4	1	4	Informatics to continue to support administrators to maintain high level of entry on RiO		Director of Service Development	05/05/2012	risk score reduced April 2011
	Reminders sent to all users re. linking records so that family attendance can be accurately captured for contract reporting purposes (this triggers an additional financial charge to PCTS)	Email guidance									
Risk to patient who requires rapid transfer to acute care due to self harming or other medical emergency.	Agreed operational procedure in place and tested.	Incident review of each transfer to check procedure.	No current gaps identified (procedure complete and implemented).	3	1	3			Medical Director		Updated risk reduced May 2009.
	On call clinical support for staff who need advice re a patient.	On call rota.									
	Trained first aiders on site to support emergency if required.	First aider list.									
Risk of losing patient record due to complex service reconfiguration that is taking place in CAMHS.	Promotion of safe record keeping practices in directorate.	Team meeting minutes.	Local case note management procedure implemented No data loss incidents reported.	3	1	3			CAMHS Director		2008 no change.
	Safe storage available on satellite sites.	Site inspections.									
Failure to meet income target for day unit	Feedback sought form referrers (questionnaires) (to influence marketing).	Use of feedback in future promotion.	Continued efforts to secure further SLA's.	3	1	3	Continued efforts will be made with commissioners to maintain income levels.		CAMHS Director		view of current waiting list risk of not meeting target
	Further SLAS's in discussion.	Contract development.									
	Pupil target for 2009-10 met.	Pupil numbers against target.									
	SLA's in place with guaranteed funding.	Income monitoring via Finance.									
Risk that case note audit may give a falsely high impression of standards of record keeping at Portman's due to small sample size of closed files	Case note audit.	Audit done by team from outside the Portman, results presented to CG Committee and Board of Directors	None	3	1	3	Sample from open and closed cases at all future audits		Portman Clin Director		no change

Principal Risk	Controls	Assurances of Controls	Gaps	C	L	R	Actions/Treatment Plans	Tolerated with plan?	Lead	Target Date	Review /Change
No formal system to monitor supervision arrangements of all clinical staff which is in breach of CQC Outcome 14 and NHSLA requirements	updated procedure has an agreed process of gathering and recording supervisors, master list to be held in clinical governance, data collection Sept-Oct 2010	status report to CQSG (quarterly during data collection and then annually)	none	3	1	3			Assoc Med Director	31/03/2011	no change
Trust fails to meet its CRC targets due to delay in replacing the boilers	replacement project in progress (April 2011)	regular project meetings timetabled and minute	no current gaps	3	1	3	Tolerated.		Director of Corp Gov and Fac	31/07/2011	no change
Failure to meet IG toolkit requirements by March 2011 resulting in a negative report to CQC and Monitor which could impact on ability of trust to secure future business,			none	3	1	3	Board to receive IG Toolkit performance report for approval		Director of Finance	28/02/2014	risk green at April 2011
Deliberate self harm by a child whilst in the Day Unit	Close supervision of each child at all times whilst in the Day unit.	Daily log.	No specific gaps identified, Signs of 'self harm' is part of ongoing observation of each child.	2	1	2			CAMHS Director		no change
	Individual risk assessment pre admission and throughout time in unit.	Patient records.									
	Staff alert to potential risk of self harm so can intervene.	Daily log.									

Board of Directors : April 2011

Item : 8

Title : Annual Report & Accounts 2010/11

Summary:

This report outlines the timetable for the submission of the Annual Report and Accounts for 2010/11.

This report focuses on the following areas:

- Risk
- Finance

For : Noting

From : Trust Secretary

Annual Report & Accounts 2010/11

1. Introduction

1.1 The Annual Reporting Manual was published by Monitor on 31st March 2011. It outlines what Foundation Trusts are required to include in their Annual Report.

2. Reporting Deadlines

2.1 The deadlines for the Annual Report are as follows:

Deadline	What is required?	Where should it be sent?
Thursday 21 st April*	<ul style="list-style-type: none"> • Draft Accounts • Draft FT consolidated schedules 	Monitor External Auditor
Tuesday 26 th April	<ul style="list-style-type: none"> • Draft Quality Report 	External Auditor
Tuesday 3 rd May	<ul style="list-style-type: none"> • Draft Report 	External Auditor
Thursday 2 nd June	<ul style="list-style-type: none"> • Final Accounts • Final Report 	Board of Directors
Thursday 7 June*	<ul style="list-style-type: none"> • Audited Accounts • Audited FTCs • Copy of signed audit opinion on accounts • Copy of Auditors report on FTCs • Copy of Auditor's ISA • Original signed SIC • Original signed CEO & FD certificate 	Monitor

* Submission dates required by Monitor – these dates are mandatory and cannot be negotiated

Deadline	What is required?	Where should it be sent?
	on FTCs	
Thursday 30 th June*	<ul style="list-style-type: none"> Full Report & Accounts 	Department of Health
Wednesday 20 th July*	<ul style="list-style-type: none"> Full Report & Accounts laid before Parliament 	Monitor

2.2 The extraordinary meeting to sign off the Accounts and Report will be held on Thursday 2nd June, from 10am until 11.30am.

3. Report Contents

3.1 The requirements for the Report for 2010/11 remain largely unchanged. The requirements to include sustainability reporting and equalities reporting are optional for foundation trusts, but the Trust is anticipating including these at present.

3.2 This year, FTs may produce an “annual governance statement” with enhanced reporting on quality governance, in place of the Statement on Internal Control. This will be a requirement for 2011/12. A decision on whether the Trust will produce an Annual Governance Statement or a Statement on Internal Control has yet to be taken.

4. Preparing the Annual Report

4.1 Jonathan McKee, Governance Manager, will be leading on the Annual Report this year.

5. Updating the Board of Directors

5.1 The Board will be appraised on progress to-date with the Report, but will not see the Report in its entirety before the extraordinary Board meeting on Thursday 2nd June.

Louise Carney
 Trust Secretary
 4th April 2011

Board of Directors : April 2011

Item : 9

Title : Proposed changes to the terms of reference to the Clinical Quality, Safety, and Governance Committee

Summary:

Information governance has become a significant work area in the Trust and its inclusion under Corporate Governance and Risk work stream has made that area difficult to manage. It is proposed to make this a separate work stream.

This report has been reviewed by the following Committees:

- Management Committee, March

The final version is attached.

This proposal is of relevance to the following areas:

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

For : Approval

From : CQSG Chair

Clinical Quality, Safety and Governance Committee

Terms of Reference, v3

Ratified by:	Board of Directors
Date ratified:	28th September 2010 April 2011
Name of originator/author:	Rob Senior, Committee Chair
Name of responsible individual:	Clinical Quality, Safety & Governance Committee Chair
Date issued:	April 2011
Review date:	March 2015

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Clinical Quality, Safety and Governance Committee Terms of Reference

1. Constitution

- 1.1 The Board of Directors hereby resolves to establish a Committee to advise and support the Executive Directors who lead on clinical and corporate governance, clinical quality and safety and to provide assurance to the Board of Directors that clinical quality, safety, and governance are being managed to high standards. The Committee shall be known as the Clinical Quality, Safety and Governance Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

2. Membership

- 2.1 Membership of the Committee shall be as follows:

- 2.1.1 Medical Director (Committee Chair)
- 2.1.2 Two Non-Executive Directors (one to be Deputy Committee Chair)
- 2.1.3 Up to two Governors
- 2.1.4 Chief Executive
- 2.1.5 Trust Director
- 2.1.6 CAMHS Director

3. Attendance

- 3.1 The following staff shall be in attendance:

- 3.1.1 Director of Corporate Governance and Facilities
- 3.1.2 Director of Service Development and Strategy
- 3.1.3 Governance and Risk Lead (advisory role)
- 3.1.4 Associate Medical Director (Safety, and Revalidation)
- 3.1.5 Association Medical Director (Clinical Outcome, and Clinical Audit)

3.1.6 Quality Reports Lead

3.1.7 Patient and Public Involvement Lead

3.1.8 Senior Information Risk Owner (for information governance, as required)

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3.1.8.1.9 Governance ~~Project~~ Manager (Committee Secretary)

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4. Quorum

- 4.1 This shall be at least one third of members, to include at least one Non-Executive Director.
- 4.2 Each member will be expected to attend at least 75% of meetings in any year.

5. Frequency of meetings

- 5.1 The Committee will meet four times per year.

6. Agenda & Papers

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

7. Minutes of the Meeting

- 7.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.
- 7.2 Approved minutes will be forwarded to the Audit Committee for noting and the Board of Directors for discussion as required.

8. Authority

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

9. Duties

- 9.1 The Committee's primary duty is monitoring implementation of strategic priorities (related to sections 9.2 – 9.6, below), providing assurance of compliance with regulatory requirements, and providing assurance that the Trust is providing best patient safety, governance and quality improvement practice. Where assurance of quality is not sufficient, or where unmitigated risk are identified, the Committee shall seek assurance that plans are in place to effect improvements. The Committee shall seek assurance for the following:

9.2 Corporate Governance and Risk

- 9.2.1 prospective submissions to the following organisations are fit for purpose:

9.2.1.1 Care Quality Commission (including evidence in support of continued compliance with standards pending an inspection)

9.2.1.2 NHS Litigation Authority

9.2.1.3 Monitor

- 9.2.2 non-clinical risks are being identified and managed

9.2.3 the Assurance Framework provides board level information that will contribute to a risk-enabled board culture

9.2.4

9.2.4.2.3 external information governance submissions are accurate

9.2.4.2.4 HR submissions of compliance with mandatory regulations are fit for purpose

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9.2.69.2.5 Estates submissions of compliance with mandatory regulations are fit for purpose

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9.3 Clinical outcomes

9.3.1 that adequacy of outcome measures reflect corporate planning and the needs of external assessors and commissioners

9.3.2 that there are improvements in outcome monitoring over the long term

9.3.3 that National Institution for Health & Clinical Excellence (NICE) and National Service Framework (NSF) guidance is implemented where appropriate

9.3.4 that responses to external consultations are submitted when relevant to the work of the Trust

9.4 Clinical Audit

9.3.59.4.1 that monitoring of the outcomes of clinical audit results in improvements where indicated

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9.3.69.4.2 that the annual audit programme complements relevant organisational priorities

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9.3.79.4.3 that audits and reviews are commissioned as requires and the results lead to improvements in patient care

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9.3.89.4.4 that the implementation of outcomes of the recommendations of audits lead to improvements in patient care

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9.49.5 Patient safety and clinical risk

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9.4.19.5.1 that review reports on patient safety, clinical incidents, clinical complaints and clinical claims result in improvements to patient care

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9.4.29.5.2 that safeguarding arrangements for children and adults are effective

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9.4.39.5.3 that clinical risks are adequately assessed and reviewed

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9.4.49.5.4 that the Trust responds in an appropriate and timely fashion to all relevant clinical safety alerts

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<u>9.4.59.5.5</u> that clinicians' revalidation records are accurate	← Formatted: Bullets and Numbering
<u>9.4.69.5.6</u> to review, on behalf of the Board of Directors the Trust's compliance with the Health Act 2006 on reducing Healthcare Associated Infections (HCAIs)	← Formatted: Bullets and Numbering
<u>9.59.6</u> Quality Reports	← Formatted: Bullets and Numbering
<u>9.5.19.6.1</u> that quality accounts are reviewed and inform business planning	← Formatted: Bullets and Numbering
<u>9.5.29.6.2</u> that the arrangements to deliver Commissioning for Quality and Innovation (CQUIN) result in improvements in patient care	← Formatted: Bullets and Numbering
<u>9.5.39.6.3</u> that data quality improves over the long term	← Formatted: Bullets and Numbering
<u>9.5.49.6.4</u> that non-financial SLM reporting results in improvements in patient care	← Formatted: Bullets and Numbering
<u>9.69.7</u> Patient and public involvement	← Formatted: Bullets and Numbering
<u>9.6.19.7.1</u> that consistent good quality information is made available to patients about treatment options available at the Trust to support patients giving informed consent	← Formatted: Bullets and Numbering ← Formatted: Bullets and Numbering ← Formatted: Bullets and Numbering ← Formatted: Font: Bold
<u>9.6.29.7.2</u> that action plans based on the findings reports on patient feedback and other PPI work result in improved care	← Formatted: Bullets and Numbering ← Formatted: Justified, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1 cm + Tab after: 2.5 cm + Indent at: 2.5 cm
<u>9.6.39.7.3</u> that public members views influence strategic planning.	← Formatted: Bullets and Numbering
<u>9.8</u> Information Governance	← Formatted: Justified, Indent: First line: 0 cm
<u>9.8.1</u> that IG across all areas of the Trust is well managed	← Formatted: Justified, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1 cm + Tab after: 2.5 cm + Indent at: 2.5 cm
<u>9.8.2</u> that assurance to the CQSG that regulatory and other external requirements in relation to IG are being provided, and that the Trust adheres to its approved process for responding to IG risk issues that arise in practice	← Formatted: Bullets and Numbering ← Formatted: Justified, Indent: First line: 0 cm
<u>9.8.3</u> that the Trust maintains an effective IG strategy and associated procedures that are fit for purpose	← Formatted: Justified ← Formatted: Bullets and Numbering
<u>9.8.4</u> that information security matters are effectively managed	← Formatted: Justified, Indent: Left: 1 cm, No bullets or numbering ← Formatted: Justified ← Formatted: Bullets and Numbering
	← Formatted: Justified, No bullets or numbering

9.8.5 that information assets are managed in accordance with the respective procedures

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9.8.6 that all requests for information made under the Freedom of Information Act were responded to by the statutory deadline and that any trends are explored

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9.8.7 that a comprehensive IG training programme has been delivered by the Governance Manager.

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10. Liaison

10.1 The Committee will work with the Audit Committee to provide assurance that the process for managing risk is sufficient to meet the requirements of the regulatory bodies.

11. Other Matters

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

12. Sources of Information

12.1 The Committee will receive reports from the following ~~working stream leads~~:

12.1.1 Corporate Governance and Risk Lead

~~12.1.3~~ 12.1.2 Clinical Outcomes Lead

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~~12.1.3~~

~~12.1.4~~

~~12.1.5~~ 12.1.3 Clinical Audit Lead

~~12.1.6~~ 12.1.4 Patient Safety and Clinical Risk Lead

~~12.1.7~~ 12.1.5 Quality Reports Lead

~~12.1.8~~ 12.1.6 Patient Experience and Public Involvement Lead

12.1.7 Information Governance Lead (biannually)

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~~Internal and External audit~~

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12.2 The Committee may also commission reports as required.

13. Reporting

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

13.2 A quarterly Clinical Quality, Safety and Governance Report will be presented to the Board of Directors.

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

14. Support

14.1 The Committee will be supported by a Secretary from the Director of Corporate Governance and Facilities' team.

Board of Directors : April 2011

Item : 10

Title : Corporate Governance Report

Summary:

This report covers the following items:

- Monitor Updates
- Care Quality Commission Updates
- Health & Social Care Bill Update

This report focuses on the following areas:

- Quality
- Risk

For : Noting

From : Trust Secretary

Corporate Governance Report

1. Monitor Updates

1.1 Monitor's review of foundation trusts

1.1.1 Monitor have published *NHS foundation trusts: review of nine months to 31 December 2010*. There were 132 foundation trusts at the end of Quarter Three in 2010/11. Monitor's report is based on the data submitted by FTs on a quarterly basis.

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

Table 1: NHS Foundation Trust Statistics at 31 December 2010¹

Type of FTs		
Total	132	
Acute	76	58%
Mental Health	40	30%
Specialist	16	12%
FTs by Strategic Health Authority ²		
North West	28	74%
South West	16	62%
Yorkshire & The Humber	16	73%
London	15	39%
East of England	14	54%
West Midlands	12	44%
North East	10	91%
South Central	7	47%
South East Coast	8	47%
East Midlands	6	46%
Governance Risk Ratings		
Green	75	57%
Amber-Green	32	24%
Amber-Red	15	11%
Red	10	8%
Financial Risk Ratings		
5 (lowest risk)	17	13%
4	54	41%
3	51	39%
2	7	5%
1	3	2%
FTs in significant breach of terms of authorisation		
Total	9	7%
Combined actual net surplus Q3		
Total	£330m	
EBITDA margin		
Total	6.9%	

¹ As at April 2011, there were 137 Foundation Trusts

² Percentages are of foundation trusts out of potential foundation trusts in each Health Authority

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

1.1.4 To date, around 43% of all potential Foundation Trusts are still to achieve FT status.

1.1.5 Monitor's document can be found at <http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/reports-nhs-foundation-trusts/nhs-foundation-trusts-quarterly--28>

2. Care Quality Commission Updates

2.1 In Quarter Three, the CQC registered 12 foundation trusts with conditions. Of these, two still have conditions in place. Both trusts are currently in significant breach of their terms of authorisation.

2.2 Whilst the number of trusts registered with conditions has continued to decrease, the number of foundation trusts with CQC concerns has increased from six at Q2 to 16 at Q3 (15 with moderate concerns, one with major concerns). This has been attributed to the CQC undertaking detailed reviews, including site inspections, following the completion of the registration process and oversight of resulting conditions.

3. Health & Social Care Bill Update

3.1 The Bill has now completed its Committee stage. The two-month "pause", announced by Andrew Lansley, Secretary of State for Health, on Monday 4th April has delayed the passage of the Bill, which will be revived in mid-June, when it will progress to the Report stage on the floor of the House (date to be announced).

3.2 During the pause, the former Chairman of the Royal College of GPs, Prof. Steve Field, will head the NHS Future Forum, which will hold a series of "listening exercises" over the next two months. During these events, the Forum will meet with the public and those working in the NHS to explain the reforms and ascertain whether improvements can be made to the Bill.

3.3 The engagement exercise will focus on four areas:

- Choice and competition;
- Patient involvement and public accountability

- Clinical advice and leadership
 - Education and training
- 3.4 The Forum will report back on its initial findings around the end of May.
- 3.5 Some alterations to the Bill have already been confirmed. These include:
- arrangements to ensure that private health companies are not able to “cherry-pick” simple cases; and
 - amendments that will remove the ability for providers to compete on price.
- 3.6 It has also been confirmed that the April 2013 target for GPs taking on budget commissioning will not be considered an absolute deadline. Instead, the Deputy Prime Minister has suggested that consortia not ready to take on budget commissioning will be granted more time and extra transitional support from a national board led by the NHS Chief Executive, Sir David Nicholson.

4. Further NHS Updates

- 4.1 Sir David Nicholson, NHS Chief Executive, wrote to Chairs and Chief Executive’s of all NHS Trusts, Foundation Trusts, Primary Care Trust and Strategic Health Authorities on 13th April, highlighting the financial pressures under which the NHS finds itself, and also noting the following:
- GP consortia now cover 88% of the population
 - 90% of Local Authorities, together with GP consortia pathfinders and other partners have signed up to be early implementers of Health and Wellbeing Boards
 - All remaining NHS Trusts have agreed plans with local commissioners for achieving FT status
 - PCT clusters are now established across the country with senior appointments either completed or being finalised. All clusters will be fully established by 1st June 2011, and NHS London is working with clusters and SHAs to develop a shared operating model for clusters by June

- Because of the pause in the legislative process and subject to the results of the listening exercise and the passage of the Bill, all of the statutory changes which were due to take place in April 2012 will now take place no earlier than July 2012. That includes:
 - The abolition of Strategic Health Authorities;
 - The assumption of its full statutory powers by the NHS Commissioning Boards;
 - The assumption of their full powers by the NHS Trust Development Authority, Health Education England, and Public Health England;
 - The first phase of taking on its new powers by Monitor; and
 - The establishment of HealthWatch England and other changes to Arm's Length Bodies

Louise Carney
Trust Secretary
18th April 2011

Board of Directors : April 2011

Item : 11

Title : Annual Information Governance Compliance Report

Summary:

The Department of Health sets high IG standards for all NHS organisations. Failure to adhere to these standards risks disconnection from national services (e.g. networks). Compliance with standards is accepted by regulators as evidence in respect of their information governance standards, in lieu of a separate additional assessment. Satisfactory compliance was found for 2010/11 and measures to enhance performance have been agreed for 2011/12.

This report has been reviewed by the following Committees:

- Management Committee, 7th April 2011

This report focuses on the following areas:

- Quality
- Risk

For : Noting

From : Senior Information Risk Owner

Annual Information Governance Compliance Report

1. Introduction

- 1.1 This has been a challenging year for IG; not only has the assessment changed, but the way it was undertaken changed too. In addition, the context changed as part of internal and external developments in governance.
- 1.2 The Trust has not been alone in finding the new approach a challenge. This is in addition to generating compliance evidence where it did not exist for existing and new standards. The challenge will be to maintain the progress in delivering these standards at least minimal level in order to improve, and also to ensure that systems of delivery and accountability are in place for the future.

2. Findings

2.1 Systems

- 2.1.1 Systems that succeeded with previous cycles of assessment were found not to be fit for purpose for IG8. Whilst a challenge, this created an opportunity to start to build links to other work areas, and this was successfully completed with risk and governance, whilst other areas are in need of substantial development in order to achieve a steady state.

2.2 Evidence

- 2.2.1 It was agreed that due to the internal and external factors that affected work in 2010/11, that gathering evidence would be limited to key requirements. It is assumed by Monitor that having achieved FT status, FTs will already be up to standard in many areas, the key requirements being the rest (about half). The Trust met the minimum standards for all key requirements. This report's findings are limited to those key areas unless stated otherwise; the results can be found in appendix one, though it is useful to reflect on outcomes and themes elaborating as follows:

2.2.1.1 **Policy**

Though much improved by the end of 2010/11, policy management needed development; finalising technical policies (that is, IT related policies) proved particularly difficult.

2.2.1.2 **Training**

Though IG training has been part of mandatory training for some time, the way in which it was delivered changed significantly in 2010/11. At first the Trust recognised this as a significant risk, but after benefiting from some investment the Trust is now amongst the best in the country in achieving this very demanding target ahead of the deadline. Collaborative working with HR colleagues has ensured that this training is now fully integrated with other training requirements and reporting systems have been aligned to show progress through the CQSG.

2.2.1.3 **Staffing**

A change in staffing structure and skill mix enabled the key work areas to be delivered. The aim for 2011/12 is to embed these arrangements so that the team can be more proactive and supportive of other work areas.

2.2.1.4 **Information assets**

Some preliminary work had been undertaken some years ago to identify and log information assets; however, an update was indicated and undertaken. The Trust established a new procedure complementing the new IG Policy, and IA owners have received training and undertaken risk assessments. The first risk assessment addressed business continuity, an area of development for the Trust, and a good example of mutually supportive aims being achieved where previously neither would have been completed.

A comprehensive programme supporting IA owners is ongoing in order to ensure that the Trust remains compliant on every element. A plan to ensure that no assets went undetected and/or unrecorded was put in place; consequently additional assets were found.

2.2.1.5 **Use of personal information for non-clinical purposes**

This is a complex issue for the Trust. A balance has to be struck between the need to protect confidentiality, and the need for the taxpayer, and other interested parties obtain, through regulatory bodies, the assurance that the Trust is well

governed and can show it is providing quality services and value for money. The Internal Auditor agrees with the Trust's position that these standards should be interpreted sensitively and expediently; new guidelines were issued.

2.3 Nature of evidence

- 2.3.1 In the spirit of the guidance received from the DH to internal auditors, the approach taken has been to understand the whole picture, and provided that satisfactory compliance was found to be probable, an example was used rather than a vast suite of evidence in every case. Where this approach was adopted, the most sensitive examples were used, e.g. data maps of data patient and financial flows were mapped as a priority for inclusion in 2010/12; other information assets (e.g. research) will be used as examples for 2011/12.

2.4 Internal Audit Report

- 2.4.1 An audit was undertaken in February 2011 and found that little evidence existed to provide assurance at that time. The auditor took the view that the Trust was working towards achieving the standards required and would probably do so by the deadline, except in the case of some IT related areas where such an assertion could not be made. The overall score was weak amber, but this was a score given for plans rather than outcomes. Given the challenges, this was a good score for the Trust and the subsequent outcome confirms this.

2.5 Indications for 2011/12

- 2.5.1 The way in which CQSG system has delivered good governance in line the principles agreed by the MC last April has yielded benefits for planning and collaborative working. However, IG is an area of concern as highlighted by Internal Audit. The interim solution for 2010/11 has generated some positive outcomes (e.g. excellent results in mandatory training, and a very well received approach to risk management for information assets); however, there remains a need to develop a cohesive systems that can support existing areas of development and creativity that is sustainable and integrates with Trust systems and structures. The Management Committee considered that the best way forward would be to:

- 2.5.1.1 To develop delivery of the Trust's Clinical Quality, Safety and Governance agenda by firmly establishing IG systems and staff
- 2.5.1.2 Better integrate IG activity and create capacity for creativity in other work areas
- 2.5.1.3 Add an IG work stream for the CQSG, otherwise the CGR work stream will become overloaded. The new IG group would become the IG work stream lead's group, the SIRO would become the work stream lead and the IG manager's role would be to facilitate.

2.6 Evidence not collected

- 2.6.1 Evidence for non-key requirements has not been collected on this occasion.

3. Conclusion

- 3.1 The Management Committee considered the findings of an interim report, and was content for the SIRO to review and approve the assurance statement.
- 3.2 On 31 March, the SIRO reviewed the evidence and confirmed that this showed that the Trust complied with all the 23 key requirements at the minimum Level Two or above. He therefore approved the assurance statement to be submitted.

Jonathan McKee
Information Governance Manager
1st April 2011

Appendix 1

Information Governance Report by Key Requirement

Key			
IG8-101: There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda			
IG 09/10 Scores	Level 3	IG Current Score	Level 3
IG8-110: Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations			
IG 09/10 Scores	Level 3	IG Current Score	Level 2
IG8-111: Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation			
IG 09/10 Scores	Level 3	IG Current Score	Level 2
IG8-112: Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained			
IG 09/10 Scores	Level 2	IG Current Score	Level 3
IG8-200: The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs			
IG 09/10 Scores	Not Rated	IG Current Score	Level 2
IG8-201: Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users			
IG 09/10 Scores	Level 3	IG Current Score	Level 2
IG8-202: Consent is appropriately sought before personal information is used in ways that do not directly contribute to the delivery of care services and objections to the disclosure of confidential personal information are appropriately respected			
IG 09/10 Scores	Level 3	IG Current Score	Level 2
IG8-203: Individuals are informed about the proposed uses of their personal information			
IG 09/10 Scores	Level 3	IG Current Score	Level 2
IG8-209: All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines			
IG 09/10 Scores	Not Rated	IG Current Score	Level 2
IG8-210: All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements			

IG 09/10 Scores **Level 2** IG Current Score **Level 2**

IG8-300: The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation’s assessed needs

IG 09/10 Scores **Not Rated** IG Current Score **Level 2**

IG8-301: A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed

IG 09/10 Scores **Level 3** IG Current Score **Level 2**

IG8-302: There are documented information security incident / event reporting and management procedures that are accessible to all staff

IG 09/10 Scores **Level 3** IG Current Score **Level 3**

IG8-303: There are established business processes and procedures that satisfy the organisation’s obligations as a Registration Authority

IG 09/10 Scores **Not Rated** IG Current Score **Level 2**

IG8-304: Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use

IG 09/10 Scores **Not Rated** IG Current Score **Level 2**

IG8-305: Operating and application information systems (under the organisation’s control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems

IG 09/10 Scores **Level 3** IG Current Score **Level 2**

IG8-307: An effectively supported Senior Information Risk Owner takes ownership of the organisation’s information risk policy and information risk management strategy

IG 09/10 Scores **Level 2** IG Current Score **Level 2**

IG8-308: All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers

IG 09/10 Scores **Level 3** IG Current Score **Level 2**

IG8-313: Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely

IG 09/10 Scores **Level 2** IG Current Score **Level 2**

IG8-314: Policy and procedures ensure that mobile computing and teleworking are secure

IG8-323: All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures

IG 09/10 Scores	Not Rated	IG Current Score	Level 2
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IG8-401: There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements

IG 09/10 Scores	Level 3	IG Current Score	Level 2
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Board of Directors : April 2011

Item : 12a

Title : Quality Report

Summary:

Directors' Responsibilities in Respect of Quality Report

The Board of Directors is asked to approve the Quality Report. Directors should satisfy themselves that the Report meets the criteria.

Please note that the additions to the Draft Quality Report for Quarters One and Two are in blue font.

This report has been reviewed by the following Committees:

- Management Committee, 21st April 2011

This report focuses on the following areas:

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

For : Noting

From : Trust Director

Statement of Directors' Responsibilities in Respect of the Quality Report

1. Introduction

- 1.1 The Board of Directors is asked to self-declare that they have received reasonable assurance that the Trust has met the requirements for the preparation of the quality report.

"The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trust Boards of Directors on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Boards should put in place to support the data quality for the preparation of the Quality Report."¹

- 1.2 It is important to note, that the following instructions in Monitor's Annual Reporting Manual (AReM) were not issued by until 31st March 2011, which means that this is the first opportunity to provide this information to the Board of Directors.
- 1.3 The reporting guidance required for preparing the Quality Report is included as an attachment (Appendix A), which incorporates the relevant pages (pp 94-95, 101-107) from the AReM.

2. In preparing the Quality Report, Directors are required to take steps to satisfy themselves that²:

- 2.1 *"The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11".*

2.1.1 The Draft Quality Report contains Parts 1, 2 and 3, as required. It includes all the mandatory sections, with the section on Quality Initiatives included by the Trust.

- 2.2 *The content of the quality report is not inconsistent with internal and external sources of information including:*

- Board minutes and papers for the period April 2010 to June 2011

¹ Monitor, *NHS Foundation Trust Annual Reporting Manual 2010-11*, March 2011, p.106

² Requirements are taken from Monitor's Annual Reporting Manual, cited above.

- Papers relating to Quality reported to the Board over the period April 2010 to June 2011
- Feedback from the commissioners dated XX/XX/20XX (tba)
- Feedback from governors dated XX/XX/20XX
- Feedback from LINKs dated XX/XX/20XX (tba)
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX;
- The [latest] national patient survey XX/XX/20XX (Not applicable - The Trust's Patient Survey replaces this)
- The [latest] national staff survey XX/XX/20XX
- The Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX
- CQC quality and risk profiles dated XX/XX/20XX

2.3 *The Quality Report presents a balanced picture of the NHS Foundation trust's performance over the period covered.*

2.3.1 As we have pointed out in the Draft Quality Report, where there are areas where performance or practice is below a standard of quality we consider acceptable, we have put action plans in place to address this.

2.4 *The performance information in the Quality Report is reliable and accurate*

2.4.1 The derived evidence for the Draft Quality Report is to the best of our knowledge no different from the information provided in other reports. In addition, we have utilised a data validation process, where the data included in the Report has been signed off by the relevant Director responsible for the data.

2.5 *There are proper internal controls over the collection and the reporting of measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice*

2.5.1 Data validation forms, which form part of the Framework for Data Quality and Reporting have been completed for each data entry in the Draft Quality Report, and signed off by the

relevant Director. These forms outline the systems for recording the data; process for obtaining the data; data validation processes, where relevant; assurances over data quality; gaps/risks in data assurance, and action plans to address risks and/or provide assurance, where required. The information from these forms (specimen form, Appendix 3) is summarised in the Data Assurance Overview document (Appendix 4), which provides an overview for the assurance over data, gaps and risks in data assurance and a data quality confidence rating. The Data Assurance Form has been reviewed and discussed at the Management Committee. The Trust has fully implemented its assurance process via the CQSG, which has been in operation since July 2010. We consider therefore that there are proper controls in place, which are subject to review and which work effectively in practice.

2.6 the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance.

2.6.1 To the best of our knowledge the data underpinning the measures of performance is robust and reliable, and conforms to data quality standards and meets the requirements for reporting. For example, for patient safety incidents (which are reported to the NPSA), complaints received, monitoring of adult safeguard alerts, waiting times, DNA rates and other quality indicators. However, in those areas where the data is seen to fall below an acceptable standard, action plans are in place to address this. For example, reporting on local induction was identified as non-compliant with Trust procedure and an action plan has been put in place to increase reporting.

2.7 Directors will be required to approve the Quality Report on behalf of the Chief Executive and Chairman, in order that the Chief Executive and Chairman can 'sign off' the Quality Report on May 30 2011, as follows:

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive

Louise Lyon
Trust Director

and

Justine McCarthy-Woods
Quality Standards and Reports Lead

April 2011

Draft Quality Report 2010-11



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Introduction

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

Core Purpose

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

- Providing relevant and effective patient services for children and families, young people and adults, ensuring that those who need our services can access them easily
- Providing education and training aimed at building an effective and sustainable NHS and Social Care workforce and at improving public understanding of mental health

- Undertaking research and consultancy aimed at improving knowledge and practice and supporting innovation
- Working actively with stakeholders to advance the quality of mental health and mental health care, and to advance awareness of the personal, social and economic benefits associated with psychological therapies

DRAFT

Part 1: Statement from the Chief Executive



The Trust is proud of its record for the provision of high quality mental health services. In previous years the Healthcare Commission awarded the Trust the highest rating of excellent for the quality of our clinical services. Under the Care Quality Commission regulation the Trust has achieved registration without conditions. [In March 2011, the Trust achieved NHSLA Level 2 Risk Assessment. This is a significant achievement for the Trust as it is the first time it has been assessed at this level.](#) We have valued the opportunity provided by the Quality Report to work closely with patients, the public, our staff, the Board of Governors, the Board of Directors, our commissioners and other

stakeholders in our efforts to ensure that we continue to provide the highest quality services and innovative ways of improving mental well-being.

Building on our achievements from last year, where we introduced a quality programme which was strongly supported by senior management and the Board of Directors and locally owned in each clinical service line, this year we have implemented an integrated system of Clinical Quality, Safety and Governance (CQSG). The CQSG Committee includes the following work streams: *Patient Safety and Clinical Risk; Corporate Governance and Risk; Clinical Outcomes and Clinical Audit; Patient and Public Involvement* and the *Quality* work streams. The CQSG Committee, which is clinically focused and clinically led, meets quarterly and provides assurance to the Board of Directors and ensures that the work streams deliver on their objectives. Each service line within the Trust continues to produce an annual report to the Board of Directors which includes financial, performance, clinical quality, and staffing data.

The majority of the national indicators proposed for mental health do not apply to our Trust because we provide specialist out-patient services and few indicators have yet been developed which apply either to CAMHS or adult psychological therapies. However, we are committed to finding ways of evaluating and demonstrating the quality of the services we offer whenever possible through the use of national measures, which allow us to benchmark our services. [The implementation of our new electronic Patient Administration System \(PAS\), RiO, has also enabled us to improve our data](#)

collection. In addition, this year through the use of the CQUINs (Commissioning for Quality and Innovation) Framework, in conjunction with our commissioners we have agreed indicators (goals) aimed at encouraging innovative practice and improving the quality of services we provide.

Over the past year we have made significant progress on the five areas we identified as priorities. Overall we have increased return rates within our Outcome Monitoring Programme; our redesigned website has been launched and the initial feedback has been very positive from patients and students, and we are awaiting the results of our survey in April; we maintain a rolling programme of refurbishments; we are involved in on-going consultation with patients, carers, Governors and our Non-Executive Directors on the quality of our services through the Patient Public Involvement (PPI) Committee, and we have provided additional training to support staff.

We continue to work to improve outcome monitoring return rates across all clinical services and this year have piloted a number of new outcome measures for use with specific patient groups. We are pleased that over 65% of respondents to our annual survey rated the care they received as "good", "very good", or "excellent". We continue to explore ways of improving the communication with our patients and facilitating engagement in services, through the use of telephone surveys and text messaging.

We believe that well-trained, well-supported staff are essential to delivering high quality services. In the past year we have added a number of courses to our Staff Training Prospectus, including workload management and stress awareness. In addition, the findings from the 2010 National NHS Staff Survey indicate that the Trust is rated very highly by the staff.

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

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

I confirm that I have read this draft quality report which has been prepared on my behalf. I have ensured that, whenever possible, the report contains data that has been verified and/or previously published in the form of reports to the Board of Directors and confirm that to the best of my knowledge the information contained in this report is accurate.

Dr Matthew Patrick, Chief Executive

[Insert date]

DRAFT

1.1 Quality Initiatives

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

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

- Established an integrated approach to providing assurance to the Board of Directors on Quality, Safety and Patient and Public Involvement with the establishment of the Clinical Quality, Safety and Governance Committee (CQSG), with work streams reporting on quality and safety issues spanning the Trusts services
- Developed a data validation process to support reported data items in this report, to provide assurance to the Board of Directors on the quality of data. [The establishment of a Framework for Data Quality and Procedures has been a key area of development for improving data validation and the assurances over the data quality during the course of the year. A Data Validation Form has been developed for use with each data entry in the Quality Report. This Form specifies the Lead responsible for providing evidence and assurance, concerning the accuracy and the completeness of data as appropriate, along with identifying gaps, risks and an action plan as required, with the Lead responsible for signing off this form. This data is summarised in a Data Assurance Overview document, which is presented to the Board of Directors](#)
- Undertaken a series of stakeholder consultations involving patient and public representatives, a Non-Executive Director, and to which Governors have been invited. These meetings have focused on patient experience and both the process of providing information to patients on the psychological therapies offered by the Trust, and facilitating patients making informed decisions about their treatment
- Established a Clinical Quality Forum [open to clinical and administrative staff](#), to identify and share examples of good clinical practice across the Trust and for the purpose of identifying key factors contributing to effective clinical practice, especially in complex cases

- Appointed a Quality Standards and Reports Lead, who leads the Quality work stream reporting to the CQSG Committee and is a member of the Trust Patient and Public Involvement (PPI) Committee and Pan-London PPI Mental Health Forum. Her role has also involved liaising with staff and relevant stakeholders including commissioners to agree the quality priorities for next year and the Quality indicators for the CQUINs (Commission for Quality and Innovation) scheme for 2011/12
- Appointed a staff member with specific responsibility for promoting and developing Trust and Governor links with the Trust's Members and improving patient experience
- Participated as a key member of the Pan-London Patient and Public Mental Health Forum, which represents ten mental health trusts across London. The PPI Mental Health Forum, which meets regularly, has a remit to ensure that the involvement of service users, carers and the wider community forms an integral part of mental health services in London, and to share good practice

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

2.1 Priorities for Improvement

2.1.2 Progress against 2010/11 Quality Priorities

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

Clinical Outcome Monitoring

Outcome Monitoring (OM) in “talking therapies” is used as a way of evaluating the effectiveness of the therapeutic intervention. For some patients, their engagement with a service may consist of their attending relatively few appointments, limited to the assessment phase, whereas for other patients, they will progress to the treatment phase and complete a course of therapy. Typically, the patient is asked to complete a pre-assessment questionnaire. The therapist may also complete a questionnaire during the assessment phase. At the end of the assessment, the patient will be required to complete a post-assessment questionnaire, as will the therapist. The patient is also requested to complete a questionnaire at the end of treatment. It is recognised by mental health trusts that it is difficult to continue to engage patients in the process of completing and returning questionnaires, especially as the patient moves towards the end of treatment. The lower rate of returns reported by the Trust at treatment end are similar to other trusts offering talking therapies.

Although the implementation of RiO in November 2010 has led to an overall improvement in our data collection, RiO was not designed to include a tracking function for use with outcome monitoring, specifically to indicate when the OM questionnaires have been sent to and received back from patients, which our previous Patient Administration System, Care Notes, enabled us to do. As a consequence, gathering the OM data for Quarters Three and Four has required an extensive cross-checking process for every patient in each service. Because of the time taken to collect the OM data, this has not left us with sufficient time to properly interrogate the data for inclusion in this Report, nor to ensure that we have captured all of the required OM data. Therefore, for the purpose of this Draft Quality Report we have made the decision to focus our reporting on the Quarters One and Two OM data.

However, being able to demonstrate clinical effectiveness for our psychotherapeutic interventions is a priority for the Trust. As part of this process we need to be able to provide adequate assurances over the data we report. In order to take this forward, we have developed an action plan to improve OM. This includes making improvements to the Trust Data Warehouse; recruiting new staff to support OM; linking OM to each patient's file; and other strategies.

Priority 1.1: CAMHS (Children and Adolescent Mental Health Service) Outcome Monitoring Programme

Clinical Outcome Monitoring	
1.1 CAMHS (Child and Adolescent Mental Health Service) Outcome Monitoring Programme:	
Targets for 2010/11	Progress
1.1.1. To increase the return rates for CAMHS to 60% and above.	1.1.1. This has been achieved for the SDQ and C-GAS for the combined data for Q1 and Q2, 2010/11.
1.1.2. To implement the CORC (CAMHS Outcome Research Consortium) expanded protocol across all CAMHS services within the directorate for every new patient referred.	1.1.2. The expanded CORC protocol has been implemented.
1.1.3. To pilot the new outcome measures within the Learning and Complex Disabilities Service (LCDS), the Under Fives Service and the Fostering and Adoption Service.	1.1.3. LCDS are participating in a national programme to develop the CORE-LD (Clinical Outcomes for Routine Evaluation - Learning Disabilities). The Under 5's and Fostering and Adoption pilots are in progress.
1.1.4. To improve data collection in CAMHS across an agreed range of domains.	1.1.4. This had been achieved for all of the CAMHS services and teams by Q3 2010/11.

1.1.1 Following on from the achievements last year, the CORC (CAMHS Outcome Research Consortium) protocol has now been implemented across CAMHS, requiring services and teams to utilise the SDQ (Strengths and Difficulties Questionnaire), C-GAS (Children's Global Assessment Scale), which provides a global rating of functioning covering a range of situations, e.g. school, home environment etc. and is completed by clinicians, and the GBM (Goal-Based Measure) as part of the routine CAMHS Outcome Monitoring Programme. This is in addition to the CHI-ESQ (Experience of Service Questionnaire), which is used to gather information about patient's experience. An improvement in the patient return rates has been achieved for the SDQ and the C-GAS/PIR-GAS compared to previous years. This increase in return

rates (see Table 1 below) has been particularly noticeable for the pre-assessment phase (with an increase to 65.3%) for young people and parents / carers where, rather than posting the pre-assessment SDQ forms, they are now handed to the young person and parent / carer to complete while in the waiting room prior to their appointment. This change in procedure has helped to improve patient / carer engagement. The return rate for the C-GAS/PIR-GAS was 62.3%. Further work is required to increase the return rates for the Goal-Based Measure, as the return rate was only 21%. For this reason, we have agreed that the collection of time 1 and time 2 data for the GBM will one of our CAMHS CQUINs indicators for 2011/12.

Table 1: Outcome Monitoring Returns – CAMHS

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

1.1.2 The CORC (expanded) protocol is now used for every new patient referred to our CAMH services and teams.

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

The *Under Fives Service* is currently piloting a series of outcome measures: The Goal-Based Measures, the PIR-GAS, and the CGAS, according to age, at Time 1 and 2. As there are no standard

outcome measures for babies under 18 months, the Service is piloting the BCL (Behaviour Checklist) as an outcome measure. The PSI (Parenting Stress Index) is also included at Times 1 and 2. In addition, the Service has devised two forms: Parent Evaluation Form (Times 1 and 2), and the Clinician Evaluation Form (Times 1 and 2), which is hoped will provide more information about the intervention process, and its efficacy. [The piloting of these measures is continuing.](#)

The *Fostering and Adoption Service* are piloting the Assessment Checklist for Children (ACC) (Tarren-Sweeney), [and currently inputting the data into the Tarren-Sweeney database.](#) But, further work is required in order to evaluate the results, before considering wider implementation.

1.1.4 The last target involved improving the data collection for CAMHS across a number of areas, in order to obtain the information required for the CAMHS dataset. This includes information such as the child / young person's presenting problem, school, GP etc., required for all of the children and young people attending CAMHS. This was obtained for the majority of children / young people by the end of Quarter Three in 2010/11.

In summary, for Quarters One and Two, there has been an improvement in the return rates for the majority of outcome measures, compared to previous years. We have been successful in rolling out the CORC protocol to all the relevant CAMH services and teams, and in gathering all the relevant information required for each patient attending our Service, and we have begun to pilot the use of new specialised outcome measures. [The improvement in return rates indicates that the CAMHS, over the past year, has made some progress in improving the engagement of patients, their families and significant others in the process of thinking about the child or young person's difficulties, and their functioning in different situations.](#)

"When the child psychologist visited my son's school, he was superb in helping them understand my sons' problems and prompting a SEN referral."

(Parent, Child and Family)

Priority 1.2: Adult Outcome Monitoring Programme

Clinical Outcome Monitoring	
1.2 Adult Outcome Monitoring Programme:	
Targets for 2010/11	Progress
1.2.1. To further increase the return rates of forms from patients in the Adult Department.	1.2.1. Return rates from patients have largely remained consistent with previous years.
1.2.2. The data from the new outcome measures currently being piloted within the Adult Brief Therapy Service will be evaluated.	1.2.2. Data from the PHQ-9, GAD-7 and the WASAS is being collected for 2 groups of patients within this Service.

1.2.1 The outcome measure used by the Adult Department is the CORE (Clinical Outcomes for Routine Evaluation) system. Although the return rates have remained consistently high over the past few years at the pre-assessment stage with return rates of over 90%, it was hoped that a change in the protocol would help to increase the return rates at the post-assessment stage where, rather than post the forms, clinicians hand the CORE forms to patients. However, the response rates in Quarters One and Two in 2010/11 have largely remained consistent with previous years, except for the end of treatment return rates which have dropped by 4% to 46.7% (see Table 2 below). It is believed that the reason for this slight decrease in return rates is due to data capturing difficulties resulting from the implementation of RiO in November 2010, and the transfer over from the previous Patient Administration System, Care Notes. As a consequence, any outcome monitoring forms distributed during Quarters One and Two in 2010/11, but returned after this period, may not have been captured as it was not possible to record these returned forms on RiO.

Table 2: Outcome Monitoring Returns - Adult

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

- 1.2.2 In the Adult Brief Therapy Service, three new outcome measures: PHQ-9 (Patient Health Questionnaire - 9); GAD-7 (Generalised Anxiety Disorder - 7) and the WASAS (Work and Social Adjustment Scale) have been selected for use in evaluating this Service along with a client satisfaction questionnaire. These measures are currently being piloted in the Adult Department with Interpersonal Therapy (IPT) and Brief Psychotherapy with a small sample of patients to help evaluate these therapies and the benefits for patients presenting with anxiety and depression. Although the initial findings suggest that patients receiving these therapies are improving, the patient numbers are too small to allow for a meaningful analysis of the outcome data at this stage.

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

“It was helpful to be able to talk about things that I had never mentioned to anyone before. And that gradually I was able to understand myself much more than I had before. ”

(Patient, Adult)

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

2. Access to Clinical Service and Health Care Information for Patients and Public	
Targets for 2010/11	Progress
2.1. In 2009 the Trust website was redesigned to ensure it provided the appropriate access to information. After the site has been live for a year a survey will be conducted through the Members' Newsletter to check that the site is functioning as it should.	2.1. This survey has been included in the Spring 2011 Members' Newsletter, but the findings are not yet available for inclusion in this Report.
2.2. The Communications Team will prepare a series of downloadable leaflets on Life Issues which will offer information and advice in relation to common issues encountered across the life span. The series will be launched in 2010/11 and will make a contribution to promoting public health and well-being.	2.2. The leaflets were published in March 2011 and are available on the Trust Website.
2.3. Following a consultation with People First, the Trust will develop information leaflets suitable for people with learning disabilities and will make these available from 2010/11.	2.3. These leaflets have been produced and approved by People First.

2.1 We view the Trust's website as a key portal of access to, and a key route for, disseminating information about the Trust and its services. In 2008, a strategic decision was made to redesign the website to ensure that it was fit for purpose and, in response to feedback from patients, to ensure that the website was organised around the typical questions asked by patients (and our student users). The website has been completely revised and the new site was launched in July 2009.

Now that the site has been live for over a year, the Trust has conducted a further survey through a web-link included in Spring Members' Newsletter, and on the Trust Website to ensure that the site is functioning as it should. The findings are not yet available for inclusion in this Report.

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

2.2 The Communications Team has prepared a series of downloadable leaflets on Life Issues which offer information and advice in

relation to common issues encountered across the life span. The series was launched in March 2011 and will make a contribution to promoting public health and well-being.

- 2.3 Following a consultation with People First, an advocacy group run for and by people with learning disabilities, the Trust has developed information leaflets suitable for people with learning disabilities.

In summary, in the time since the re-designed website went live, patients have been invited to provide feedback, which have led to further improvements. However a more comprehensive survey has been undertaken recently, and the findings will be included in the 2011/12 Quality Report. With the launch of Camden’s new children’s emotional well-being website in October 2010, and the development of information leaflets suitable for people with learning disabilities in addition to downloadable leaflets on Life Issues, the Trust is increasing its efforts to facilitate improved access for different patient groups and to provide information to promote emotional and mental well-being.

Priority 3: Improvements to the built environment and facilities

3. Improvements to the Built Environment and Facilities	
Targets for 2010/11	Progress
3.1. To conduct a survey of the improvements to the built environment and facilities.	3.1. This survey has been included in the Spring 2011 Members' News letter.
3.2. To maintain a rolling programme of refurbishments, and plans for improvements to the use of the external spaces.	3.2. The refurbishments are ongoing.

- 3.1 In 2009, the Trust focused on the refurbishment of high traffic ground floor areas, responding to concerns that had been raised in previous patients’ surveys about the “tired” condition of the building. Such comments were far from universal, with many patients giving positive feedback about the ‘feel’ of the building and praise for the artwork.

During 2010/11, there were various other improvements made to the building, such as increased capacity of toilet facilities, including access to disabled toilet and shower facilities, installation of more efficient lighting and light sensors throughout many areas of the building and making seminar room doors acoustically and

thermally efficient. Surveys are planned on a yearly basis to ensure that regular feedback on the environment and facilities is obtained. A web-link has been included for the survey in the Spring 2011 Members' Newsletter

- 3.2 As the Patient and Public Involvement and Communications Lead is a member of the Trust's Design Advisory Group, this ensures that there is a process in place for improving and maintaining the quality of the environment based on a range of views including patients, Governors, Members and staff on an on-going basis.

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

Priority 4: Patient and Public Involvement

The Trust places great importance in patient and public involvement and aims to elicit feedback from as wide a range of our service users as possible, including patients and their families, students and professionals who attend conferences and courses.

4. Patient and Public Involvement	
Targets for 2010/11	Progress
4.1. Complete a stakeholder consultation on the quality of our clinical services in liaison with the Patient and Public Involvement Committee.	4.1. Two stakeholder consultations took place in 2010/11.
4.2. Complete and report on consultations involving patients and carers.	4.2. The PPI Committee have been consulted on RiO and various other issues.
4.3. Develop and evaluate more creative ways of obtaining feedback.	4.3. The PPI Psychology Assistant was appointed in March 2011 and will carry forward this initiative to 2011/12.

The Trust places great importance in patient and public involvement and aims to elicit feedback from as wide a range of our service users as possible, including patients and their families, students and professionals who attend conferences and courses.

The Patient and Public Involvement Committee consists of PPI Leads for all departments within the Trust, representatives from central services, training,

education services and research. There are three patient and public involvement representatives from the patient / local public population as well as two Governors and a Non-Executive Director. There is a close link with the Communications Team to ensure that communications with patients and the public are optimised.

- 4.1 In liaison with the PPI Committee, the Trust Director, PPI and Communications Lead, and the Quality Standards and Reports Lead completed Stakeholder Consultation meetings in September 2010 and March 2011, which included patient and public involvement representatives, a Non-Executive Director, and to which Governors were invited, in order to explore the ways the Trust could improve the quality of its clinical services. The three main issues discussed included: The need for patients to be provided with adequate information about the treatments / therapies offered by the service the patient attends, to facilitate patients making informed decisions about their treatment; the possibility of patients being offered a follow-up appointment, to help evaluate the outcome of treatment; and the different aspects of the patient experience from the time they walk into the building until the time they leave. It was agreed that the issues explored would be considered further by the Trust and the PPI Committee, and followed up at our subsequent Stakeholder Consultation meetings.
- 4.2 Over the past year, The Patient and Public Involvement Committee have been consulted about various initiatives, including patient information leaflets, updating the Trust website, developing a scheme to fund membership projects and also for feedback following the implementation of these initiatives. In addition, the PPI Team has obtained feedback from patients and carers on RiO.
- 4.3 The plan to develop more creative ways of obtaining feedback, including themed open meetings will be taken forward by the new PPI Psychology Assistant, who joined the Trust in March 2011.

In summary, over the past year the Trust has undertaken a series of stakeholder consultations around improving the quality of clinical services; [the PPI Team has obtained feedback from patients and carers on RiO and other issues, and with the recruitment of the new PPI Psychology Assistant plans to develop more creative ways of obtaining feedback.](#)

Priority 5: Maintaining a High Quality Effective Workforce

The Trust performed extremely well in the 2010 National NHS Staff Survey undertaken by the Care Quality Commission, and showed better than average scores for a large number of survey questions especially those relating to staff job satisfaction; staff recommending the Trust as a place to work and receive treatment; staff motivation; being able to use flexible work options, and the Trust’s commitment to work-life balance. These were questions for which the Trust ranked in the top 20% of mental health/ learning disability trusts. On a less positive note, there was a decrease in the number of staff taking part in the survey compared with previous years, with the Trust having a response rate of 51% in 2010, compared with 57% in 2009, and 55% in 2008.

The sickness absence rates for staff for 2010/11 was low, at 1.4%, which again could be seen as related to staff motivation and satisfaction at work.

5. Maintaining a High Quality, Effective Workforce	
Targets for 2010/11	Progress
5.1. To put in place a range of measures to reduce work related stress.	5.1. Training has been provided to staff on time and workload management, along with stress awareness training and briefing sessions.
5.2. To maintain a well-trained, flexible and creative workforce through providing personal development plans, supporting Continuing Professional Development and continuing to support workshops aimed at enhancing clinical learning and development.	5.2. A comprehensive action plan was developed in response to the Annual Staff Survey 2009, where many of the actions identified have been completed, and other actions are in the process of being completed.

5.1 During 2010/11, the range of training provided to staff was expanded to include the provision of time and workload management and stress awareness training and briefing sessions to staff. The feedback has been largely positive, with scores ranging from ranging from 6-9, for the “Managing Pressure Positively” workshop for staff responding to the question: ‘From a scale of 1 to 10 how confident and motivated do you feel in taking these steps with 10 being very motivated and confident?’ This has been reflected in the 2010 Staff Survey, with fewer staff (17%) reporting work-related stress compared to 26% in 2009. While the number of staff reporting that they work extra hours has increased from 75% in 2009 to 83% in 2010, the number of staff reporting job satisfaction has remained high at 3.94 (with a score of 5 indicating that staff are satisfied with their jobs), which is reasonably

consistent with the figure of 3.98 obtained for 2009, with the Trust ranking in the “best” 20% of trusts, when compared to trusts of a similar type. However, there has been a slight decrease in the number of staff saying that they would recommend the Trust as a place to work or receive treatment, from 4.30 in 2009 to 4.14 in 2010. Although, the Trust still ranks in the “best” 20% of similar trusts for this finding, the reasons for this warrant further exploration.

- 5.2 The Trust is committed to maintaining a well-trained and flexible workforce. The Trust performed well on the 2010 Staff Survey for the section of the survey related to staff training and the support provided from the line management structure for staff, with the Trust ranking in the top 20% of mental health/learning disability trusts for four out of a total of six questions, and “better than average” for the remaining questions covering this area. In the past year, as part of the comprehensive action plan developed in response to the 2009 Staff Survey, and further developed in 2010, the Trust has provided appraisal training for managers, providing an extended Management Development Program for middle and senior managers and training in improving communication. The use of Personal Development Plans (PDPs), which in 2010/11 were completed for 82% of staff, has contributed to the identification of training needs for the majority of staff and enabled the Trust to establish a coherent training programme for 2010/11, which is relevant to the needs of its staff group.

Table 3: Staff Survey Feedback

	2008	2009	2010
Percentage of staff working extra hours	84%	75%	83%
Well-structured appraisals received	34%	49%	46%
Work-related stress	46%	26%	17%
Job satisfaction	-	3.98*	3.94*
Recommend the Trust as a place to work and receive treatment	-	4.30*	4.14*

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

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

2.1.2 Quality Priorities for 2011/12

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

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

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

Targets for 2011/12

2.1.2.1. Outcome Monitoring

We recognise that demonstrating clinical effectiveness is a priority. In 2010/11 we managed to achieve reasonable return rates for the questionnaires we used for outcome monitoring, particularly at initial stages (Time 1) of assessment and treatment. Our next goal is to improve our Time 2 return rates, which will enable us to begin to evaluate pre- and post-assessment/treatment changes, and provide the necessary information for us

to determine our clinical effectiveness. However, as we are in the process of improving our Trust outcome monitoring system, as described in Part 2 (Section 2.1.1), we first need to have an opportunity to test the new OM system, to ensure that it allows us to derive the necessary data for analysis. For this reason, for 2011/12 we also plan to confine our reporting on outcome monitoring to two of our services, with the following targets: i) To achieve a return rate of 60% for Time 2 and Time 2 for the Goal-based Measure for CAMHS, as agreed as one of our 2011/12 CAMHS CQUINs indicators with our commissioners, and ii) To achieve a return rate of 60% for the CORE for Time 1 and Time 2 for those patients in the Adult Department who have completed the CORE at Time 1, and who have completed their assessment between April 2011 and January 2012. This will allow us to test the OM System within the same time frame as one of the CQUINs indicators we have agreed for the Adult Department for 2011/12, using a similar patient cohort.

Outcome Monitoring
CAMHS (Child and Adolescent Mental Health Service):
Target for 2011/12
1. To achieve a return rate of 60% for the Goal-based Measure for Time 1 and Time 2 (for those patients who completed the GBM at Time 1)
Adult Department
Target for 2011/12
2. To achieve a return rate of 60% for the CORE for Time 1 and Time 2 (for those patients who completed the CORE at Time 1)

2.1.2.2. Access to Clinical Services and Health Care Information for Patients and Public

We are awaiting the feedback from the survey included in the Spring 2011 Members' Newsletter, along with the feedback on the downloadable leaflets from the Trust Website. This will be included in the 2011/12 Quality Report.

It is evident from the Trust's Annual Patient Survey, our PPI Committee and Stakeholder's meetings that patients wish to have more information provided about the treatments / psychological therapies available. For this reason, for 2011/12 we aim to achieve the following targets:

Access to Clinical Services and Health Care Information for Patients and Public
Targets for 2011/12
1. To increase the number of leaflets available for the range of psychological therapies offered by the Trust.
2. To increase the information available on the Trust Website for the treatments/ psychological therapies offered by the Trust.

2.1.2.3. Patient and Public Involvement

In order to improve the quality of our services, and to know what we need to work on to improve, the feedback from patients as part of our annual survey is extremely important. In addition, we greatly value the feedback we have received from the two consultation meetings with Stakeholders (PPI representatives, Non-Executive Directors) and Governors this year, along with the feedback from the PPI Committee, to the extent that this feedback has contributed to the targets we have set for 2011/12 for our Priority 2 (Access to Clinical Services and Health Care Information for Patients and Public). Therefore, we plan to continue with our stakeholders meetings, and to extend the use of the patient satisfaction questionnaire (adapted version) to the Adult Department, as one of our CQUINs targets. Both the stakeholders meetings and the patient satisfaction questionnaires will provide us with real-time feedback, which we plan to use to improve the quality of our services for patients, carers and trainees.

The PPI Committee are keen to develop relationships between governors and members of the foundation trust, and patient and public involvement. This will be a key priority for work over the coming year. We aim to do this by i) promoting service user involvement within the organisation, where children and young people attending the Child and Family Department will be encouraged to become members, and ii) improving links with local black and minority ethnic (BME) groups, by establishing contact with VAC (Voluntary Action Camden) and other BME community groups based in Camden.

In addition, now that we have a PPI Psychology Assistant in post, we plan to take forward our plans to develop and evaluate more creative ways of obtaining feedback. These will include i) Considering the feasibility of establishing patients groups and forums, to facilitate patients providing feedback on their treatment, to help improve the quality of services, and ii) for the Trust to consider utilising social media, such as Facebook, Twitter and event websites to promote links with the public. For 2011/12 we aim to achieve the following targets:

Patient and Public Involvement
Targets for 2011/12
1. To continue with our stakeholders meetings
2. To encourage more patients to become members
3. To improve links with local black and minority ethnic (BME) community groups
4. To consider the feasibility of establishing patient forums to help improve the quality of services
5. To consider using social media, such as Facebook, Twitter and event websites to promote links with the public

2.1.2.4. Maintaining a High Quality Effective Workforce

We have achieved a good record of attendance for the Level 3 training for Safeguarding of Children, but clearly recognise that we need to improve on the levels of attendance for the Mandatory training/INSET Day, Trust-wide Induction and for the number of staff completing local inductions. We have action plans in place to help achieve these improvements. However, because of the importance of mandatory training, and staff being properly inducted to the Trust, we have decided to include this as a priority for 2011/12, with the following targets:

Maintaining a High Quality Effective Workforce
Targets for 2011/12
1. For 75% or more of Trust staff to have attended the mandatory training/INSET day once every 2 years, as required
2. For 75% or more staff joining the Trust to have attended Trust-wide Induction
3. For 75% or more staff joining the Trust to have completed their Local Induction

Finally, progress towards achieving the targets outlined in the priorities for 2011/12 will be reported quarterly to the Board of Directors via the Clinical Quality, Safety and Governance Committee (CQSG), and Patient Public Involvement (PPI) Committee. The Framework for Data Quality and Procedures will be used to identify any gaps and risks in the process.

2.2 Statements of Assurance from the Board

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

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

The income generated by the NHS services reviewed in 2010/11 represents **approx 50% [exact figure to be confirmed]** per cent of the total income generated from the provision of NHS services by The Tavistock and Portman NHS Foundation Trust for 2010/11.

Participation in Clinical Audits and National Confidential Enquiries

During 2010/11 **one** national clinical audits and **two** national confidential enquiries covered NHS services that The Tavistock and Portman NHS Foundation Trust provides.

During 2010/11, The Tavistock and Portman NHS Foundation Trust participated in **100%** national clinical audits and **100%** national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

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

- **The National Audit of Psychological Therapies for Depression and Anxiety**
- **Confidential Enquiry into Suicide and Homicide by People with Mental Illness (CISH)**

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

- **The National Audit of Psychological Therapies for Depression and Anxiety**
- **Confidential Enquiry into Suicide and Homicide by People with Mental Illness (CISH)**

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- The National Audit of Psychological Therapies for Depression and Anxiety 100%
- Confidential Enquiry into Suicide and Homicide by People with Mental Illness (CISH) 100%

The report of **one** national clinical audit was reviewed by the provider in 2010/11 and The Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. **No actions to be taken until the results are nationally reported in October 2011.**

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

Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by The Tavistock and Portman NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 73.

The use of the CQUIN Framework

A proportion of The Tavistock and Portman NHS Foundation Trust's income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between The Tavistock and Portman NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at [provide a weblink, tbc]

The total financial value for 2010/11 was £119,000 and the Trust expects to receive £109,480.

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

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

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

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

Information on the Quality of Data

The Tavistock and Portman NHS Foundation Trust did not submit records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. [This is because the Tavistock and Portman NHS Foundation Trust is not a Consultant-led, nor an in-patient service.](#)

The Tavistock and Portman NHS Foundation Trust Information Governance Assessment Report overall score for 2010/11 was [100% at level 2 or above for all key requirements](#) and was graded [green for key requirements](#).

The Tavistock and Portman NHS Foundation Trust will be taking the following actions to improve data quality:

- [Completing and implementing a new policy on data quality which has been drafted with expert advice from the Trust's External Auditors; and](#)
- [Build on and improve the validation and sign off procedure introduced during 2010/11 for all data entries in this report.](#)

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

Part 3: Other Information

3.1 Quality of Care Overview: Performance against selected indicators

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

3.1.1 Patient Safety Indicators

Quality Domain	Indicator	2008/09	2009/10	2010/11
Patient Safety	NHS Litigation Authority Level	-	Level 1 achieved (Feb 2009)	Level 2 achieved (March 2011)
	Incidents*:			
	All reported incidents	187	264	365
	Patient Safety Incidents	Not reported	53	54
	Monitoring of Adult Safeguard Alerts	Not reported	2	4
	Electronic Recording of Children in Need	-	-	**
	Attendance at Trust Wide Induction Days	66%	85%	64%
	Completion of Local Induction	Not reported	Not reported	39%
	Attendance at Mandatory Training***	Not reported	Unable to provide a comparative figure because of a different reporting system	64%
	Safeguarding of Children - Level 3 Training	Not reported	94%	88%

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

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

*** Staff are expected to attend training every 2 years. In order to achieve this 100% attendance is expected over a 2 year period. Therefore, the figure reported shows the % of staff up to date with mandatory training at year end.

3.1.1.1 NHS Litigation Authority Level

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

3.1.1.2 Patient Safety Incidents

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

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

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

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

[In 2010/11](#), the Trust has not had an incident that has rated more than 8 on the Trust risk matrix, i.e. all incidents have been rated as suitable for no further action or for local review only, and none have triggered an investigation under the Trust's serious investigation procedure.

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

3.1.1.3 Monitoring of Adult Safeguards

The importance of safeguarding vulnerable adults, by identifying and reporting those adults who might be at risk of [physical or psychological abuse](#), has been highlighted to staff in the Trust. This has been through the implementation of various education and awareness initiatives, including mandatory training provided at the Trust INSET day and team meeting presentations, which [promote the Trusts policy and procedure for Safeguarding Adults](#). In addition, the Trust has formally appointed a senior clinical member of staff as Vulnerable Adults Adviser.

3.1.1.4 Attendance at Trust-wide Induction Days and Local Induction

As Trust turnover is low we provide Trust-wide induction three times per year, where all staff are expected to attend. However, in light of poorer attendance this year, compared to 2009, an action plan to improve attendance has been implemented. This includes individual invitations to attend the induction day and the potential sanctions if non-attendance is identified as deliberate.

Reporting on local induction was identified by the NHSLA as non-compliant with Trust procedure and an action plan is in place to increase reporting, including [potential sanctions if non-attendance is identified as deliberate](#).

3.1.1.5 Attendance at Mandatory Training

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

All staff are expected to attend mandatory training every two years and in light of poorer attendance this year, an action plan to improve attendance has been implemented. This includes invitations sent to all staff who are required to attend, notification sent to line managers and the potential for sanctions if non-attendance is identified as deliberate. In addition, attendance is also raised and discussed in staff appraisals. In the context of the findings from the 2010 staff survey, which indicates that overall staff

engagement is good, the attendance at mandatory training events and inductions in 2010 was not as good as expected. While the staff survey shows staff to be working longer hours, it appears that there is not adequate recognition amongst staff of the importance of attending mandatory training and induction events. For this reason, and because local induction was identified by the NHSLA as non-compliant, it has been agreed that local induction, along with mandatory training and the Trust-wide Induction will be included as quality indicators under Priority 4 (as described in Section 2.2.1.4) for 2011/12.

3.1.1.6 Safeguarding of Children

The Trust has made it mandatory for all staff from CAMHS and the Adolescent Directorate to be trained in Safeguarding of Children Level 3, where staff are required to attend Level 3 training every 3 years, and their attendance is monitored. By year end, 88% of staff requiring Level 3 training had attended this training.

3.1.1.7 Infection Control

Although the Trust has no in-patient beds and does not provide the types of services which are associated with higher risks of infection, such as those provided by acute hospitals, we nevertheless take steps to maintain high standards on cleanliness in all parts of the building, and to reduce the risk of infections, as follows:

- We have a policy in place regarding infection control
- All staff are informed of the policy during INSET, Induction and mandatory training days
- We have placed alcohol hand rubs on all floors near lifts/doorways
- We have installed hazard waste spill kits in areas of likely/possible occurrence
- The Health and Safety Manager and Trust Risk Advisor are on email alerts list from Department of Health in relation to infection control
- A poster campaign regarding washing hands is included in all toilets and kitchenettes
- Annual 'flu jabs are arranged for staff with the Royal Free Hospital

3.1.2 Clinical Effectiveness Indicators

Quality Domain	Indicator	2008/09	2009/10	2010/11
Clinical Effectiveness	Monitor number of staff with Personal Development Plans	92%	93%	82%
	Outcome monitoring returns:			
	Child and Family	See Section 2.1.1 (Priority 1.1), Table 1		
	Adolescent	See Section 3.1.2.3, Table 4		
	Adult	See Section 2.1.1 (Priority 1.2), Table 2		
	Portman	See Section 3.1.2.4, Table 5		

3.1.2.1 Monitor Number of Staff with Personal Development Plans (PDPs)

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

The number of staff with PDPs in 2010/11 was 82% which is a decrease on the 93% achieved in 2009/10 and lower than the target return rate of 90%. However, the staff group who have not completed a PDP in 2010 include those staff who are on a career break, sick leave, new starters, or those who have not submitted their PDPs by the Trust deadline.

3.1.2.2 Range of Psychological Therapies

Over the years, the Trust has increased the range of psychological therapies available, which enables us to offer treatment to a greater range of patients, and also offer a greater choice of treatments to all of our patients. We have established expertise in systemic psychotherapy and psychoanalytical psychotherapy and continue to support staff development and innovative applications of these models.

Over the last year we have continued to strengthen our capacity to offer a range of interventions through a staff training and supervision programme. Examples of developments include, support for training in Interpersonal Therapy (IPT) through which a number of staff across the Trust have completed practitioner level training and a smaller number have achieved

supervisor status. We continue to offer specialist supervision and training in Cognitive Behaviour Therapy (CBT) for CAMHS staff and specialist

supervision and training for CBT for Post Traumatic Stress Disorder for the adult and adolescent trauma service. An increasing number of staff have been trained in Eye Movement Desensitisation and Reprocessing (EMDR) for children with post traumatic stress disorders. In addition, a group of staff have been trained in Dynamic Interpersonal Therapy (DIT), now recognised as an approved treatment within the Improving Access to Psychological Therapies Programme. This innovative therapy was developed by a member of our staff in partnership with colleagues at the Anna Freud Centre, London. We continue to develop our work in range of other models including, Family and Schools Together (FAST), Relationship Development Intervention (RDI) and Mentalisation Based Therapy (MBT).

During the past year, there has been the opportunity to embed the increased range of therapeutic approaches, though this remains work in progress. Leading on from this, our priority for next year will be to train staff to increase their capacity to identify treatment choices, including a range of psychological therapies, for patients and to present the range of treatment options clearly so that patients are confident that they have been offered choices where appropriate.

“I was able to talk about things, sometimes very painful things, without fear. It was a relief and it allowed me to realise how important the type of treatment (talking) was and how relieved and how changed I am as a result of it. Even my friends noticed it”

(Patient, Adult)

3.1.2.3 Outcome Monitoring Returns – Adolescent

Table 4: Outcome Monitoring Returns – Adolescent

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

As indicated in the 2010/11 Quality Report, the Adolescent Department planned to introduce some new outcome monitoring measures in order to encourage more young people to provide feedback on their mental well-being and increase the rate of returns.

As part of this process, the Adolescent Department sought feedback from young people on a variety of outcome measures, presented to different groups of adolescents over the course of a series of focus groups.

On the basis of this feedback, since January 2011 the Adolescent Department has been implementing CORE (Clinical Outcomes for Routine Evaluation), with young people aged 18 and over and using the SDQ (Strengths and Difficulties Questionnaire), with young people up to the age of 18, as recommended by CORC.

However, because of the difficulties encountered with outcome monitoring for Quarter Three and Four (described in section 2.1.1), we have decided to focus our report on considering the data for Quarters One and Two.

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

**“I had plenty of say in decisions. I was asked, rather than told”
(Patient, Young Person)**

3.1.2.4 Outcome Monitoring Returns – Portman

Table 5: Outcome Monitoring Returns – Portman

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

The Portman Clinic is a specialist NHS outpatient psychotherapy clinic offering treatment for adults, adolescents and children with problems of criminality, violence, sexual deviation and anti-social personality disorder. It has a national catchment area. Direct and indirect patient services offered by the Clinic include assessment for psychotherapeutic treatment (individual, group, couple and family); extended assessment and psychodynamic formulation to inform the patient’s local service based treatment programme. In addition, the Clinic provides consultation and advice to the professional network involved with the patient; risk assessment reports; reports to criminal or family courts, tribunals and inquiries; and consultancy and supervision to individuals, teams and institutions.

Although there are limitations to using the CORE as a measure of outcome for a forensic population receiving psychotherapeutic treatment, there was seen to be a noticeable improvement, at least for Quarters One and Two in 2010/11 for the completion of CORE forms by patients and clinicians at the post-assessment stage, when compared to the 2009/10 return rates.

However, clinicians at the Portman Clinic have been interested in finding an outcome measure which they consider more relevant for their patient group. For this reason, as part of the 2010/11 CQUINs framework, the Portman has been piloting the use of the Shedler-Western Assessment Procedure (SWAP) with adults. The return rate achieved for was 100% for the thirty-five patients included in this CQUINs indicator at the end of Quarter Four in

2010/11, which supports the decision to identify an outcome measure which is better suited to this group of patients.

**"I realised that it was myself that was keeping me stuck in a destructive cycle. It has changed my life."
(Patient, Portman, Clinic)**

3.1.3 Patient Experience Indicators

Quality Domain	Indicator	2008/09	2009/10	2010/11
Patient Experience	Complaints received	8	9	10
	Patient feedback:			
	Patients who would recommend the Trust	73%	69%	71%
	Patients rating care 'excellent' / 'very good' / 'good'	73%	70%	65%
	Patients who felt they were listened to and treated with respect and dignity	Different criteria used so unable to compare	92%	86%
	Patients rated the Trust's facilities as very good or good	Different criteria used so unable to compare	82%	79%
	DNA rates:			
	Trust Wide			
	First Attendances	9.5%	8.6%	10.5%
	Subsequent Appointments	10.4%	11.0%	10.4%
	Adolescent			
	First Attendances	Not reported	9.7%	10.1%
	Subsequent Appointments	Not reported	17.5%	17.0%
	Adult			
	First Attendances	Not reported	8.5%	7.3%
	Subsequent Appointments	Not reported	9.0%	8.6%
	Child and Family			
	First Attendances	Not reported	9.2%	10.0%
	Subsequent Appointments	Not reported	9.8%	7.4%
	LCDS			
	First Attendances	Not reported	2.8%	3.2%
	Subsequent Appointments	Not reported	8.9%	4.3%
	North Camden CAMHS			
	First Attendances	Not reported	9.0%	11.9%
	Subsequent Appointments	Not reported	11.1%	12.0%
	Portman			
	First Attendances	Not reported	7.0%	9.1%
	Subsequent Appointments	Not reported	9.6%	10.1%
	South Camden CAMHS			
	First Attendances	Not reported	12.8%	17.3%
	Subsequent Appointments	Not reported	15.0%	13.7%
Waiting Times: Number of patients waiting 11 weeks and over for their first appointment				
Internal cause	Not reported	Not reported	26	
External cause	Not reported	Not reported	27	

¹ Trust-wide figures we included in the 2009/10 report were for Quarter 4. The table above includes the correct figures.

3.1.3.1 Complaints Received

In 2010/11, a total of 10 formal complaints were received. These were all managed in line with the Trusts complaints policy.

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

3.1.3.2 Patient Feedback

The Trust does not participate in the NHS Patients Survey but conducts its own survey annually. In 2010/11, 675 surveys were sent out and 118 returned, which represents a response rate of 17.5%, compared to 18.2% in 2009. There was an increase in the number of surveys completed by respondents from the Portman (10% in 2010, 9% in 2009, 7% in 2008) and the Adolescent Department (16% in 2010, 14% in 2009, 4% in 2008). The number of surveys completed by respondents from the Adult Department was similar to recent years (32% in 2010, 35% in 2009, 34% in 2008) and we continue to seek ways to improve on this, while there was a decrease in the number of surveys completed by respondents from the Child and Family Department (30% in 2010, 33% in 2009, 37% in 2008).

Overall the results of the patient survey are positive. The qualitative comments provide very useful information from patients which Clinical Governance Department Leads will scrutinise in order to improve services. We continue to seek ways to improve upon the return rates and each department will set its own specific and measurable targets to improve the patient experience over the forthcoming year.

3.1.3.3 DNA Rates

Compared with other mental health trusts, where the DNA (Did Not Attend) rate is reported at around 14%, the Trust-wide DNA rate for patients in 2010/11 [which also include the DNA rates for the Gender Identity Disorder Service (GIDS), a National Service, and the Tavistock Haringey Service (THS), a locally commissioned service] is below average. However, the Trust-wide DNA rates for first attendances has increased from 2009/10 to 2010/11, but yet does not exceed the 11% upper limit, which is the quality standard outlined in our patient services contracts. In addition, the DNA rate for 2010/11 for subsequent attends has decreased. As DNA rates can be regarded as a proxy indicator of patient's satisfaction with their care, the lower than average DNA rate for the Trust can be considered positively.

The 2010/11 DNA rates for most of the departments are below 11%, with the exception of the South and North Camden CAMHS teams and the Adolescent Department. Children, young people and families from Camden attending the child and adolescent services provided by the Tavistock constitute a particularly deprived group, with 69% of patients coming from the most deprived 40%, and only 17% from the least deprived. It is recognised that patients from deprived backgrounds experience greater difficulties accessing mental health services, even when services are provided in community settings, as is the case for the South CAMHS Team.

The DNA rates for the Adolescent Department are not unexpected, as ambivalence amongst adolescents about attending and engaging with mental health services is characteristic of this patient group, but where the DNA rates for the Adolescent Department compare favourably with other similar adolescent teams/services. Notwithstanding this, in circumstances where it is deemed clinically appropriate, the Team Administrator, or clinician will text the young person to remind them of their appointment.

3.1.3.4 Waiting Times

Prior to their first appointment, patients will be contacted and offered two possible appointments, and invited to choose one of these appointments. If neither appointment is convenient for the patient, they will be offered an alternative appointment by the same therapist where possible. This system on the whole helps to facilitate patients engaging with the service. The majority of patients are seen within eleven weeks of the Trust receiving the referral. However, during 2011/12 fifty-three patients had to wait for longer than eleven weeks. There were both factors external to the Trust and internal to the Trust which contributed to these delays.

During 2010/11 twenty-seven patients had to wait eleven weeks and longer for their first appointment due to **external factors**. The factors included Named Patient Agreement (NPA) applications, where the patient's PCT has to agree to authorise the funding, as the PCT does not have a contract with the Trust; insufficient information in the referral; difficulty contacting the patient due to a change of address; the patient requesting that the appointment is delayed for after they return from holiday and for other reasons unrelated to the Trust.

During this time, twenty-six patients had to wait eleven weeks and longer for their first appointment due to **internal factors**. These included a number of reasons, related to clinicians' availability (including those appointments

involving 2 clinicians, where it was difficult to find an appointment date which both clinicians could attend etc) and due to administrative factors.

A list of breached first appointments is issued at the end of each quarter for each service, together with reasons for the long wait and, if appropriate, actions to be taken to prevent recurrence.

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3.2 Performance against Key National Priorities

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

The Trust has collected all the information deemed necessary, but taken the decision not to collect marital status, which has also been removed from requirements in the Compliance Framework for 2011/12. Feedback from clinicians has indicated that in many cases this question is irrelevant and/or unnecessarily intrusive for patients. In addition, the Trust does not believe that this information is something which demonstrates the quality of the service.

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

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

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- 7.65. Where the board of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of the external auditor, the audit committee should make a statement in the annual report explaining their recommendation and the reasons for the governors taking a different position (*Code of Governance F.3.5*).
- 7.66. An explanation of how, if the auditor provides non-audit services, auditor objectivity and independence is safeguarded (*Code of Governance F.3.8*).
- 7.67. An explanation from the directors of their responsibility for preparing the accounts and a statement by the auditors about their reporting responsibilities (*Code of Governance F1.1*). (The auditor's statement should be contained in the audit report).

Nominations Committee

- 7.68. The names of the chair and members of the nominations committee should be disclosed (*Code of Governance A.1.2*).
- 7.69. The number of meetings and individual attendance by directors at each should also be disclosed (*Code of Governance A.1.2*).
- 7.70. A description of the work of the nominations committee, including the process it has used in relation to board appointments. This should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director (*Code of Governance C.1.14*).

Membership

- 7.71. This section of the annual report should include:
- a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership;
 - information on the number of members and the number of members in each constituency; and
 - a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.
- 7.72. Contact procedures for members who wish to communicate with governors and/or directors (*Code of Governance G.1.4*).

Quality reports

- 7.73. NHS foundation trusts should include a report on the quality of care they provide within their annual report. The aim of this quality report is to improve public accountability for the quality of care. The quality report must contain (in the following order):
- Part 1. Statement on quality from the chief executive of the NHS foundation trust;
 - Part 2. Priorities for improvement and statements of assurance from the board;
 - Part 3. Other information; and
 - Annex. Statements from primary care trusts, Local Involvement Networks and Overview and Scrutiny Committees.
- 7.74. More detail on each of these areas and template statements are provided in Annex 2. This annex also provides details of how NHS foundation trusts can adapt their quality

report to meet the requirement to publish a quality account, in line with the NHS (Quality Accounts) Regulations 2010, as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011.

- 7.75. Monitor will also require NHS foundation trusts to obtain a limited assurance report from their external auditors on the content of the quality report, and to include it in the annual report. This will report on whether anything has come to the attention of the auditor that leads them to believe that the content of the quality report has not been prepared in line with the requirements set out in this *NHS Foundation Trust Annual Reporting Manual 2010/11* and is not consistent with the other information sources detailed in section 2.1 of the detailed guidance.

NHS foundation trusts are also required to obtain external assurance from their external auditor over at least two mandated indicators and one local indicator included in their quality report. As a minimum, the outcome from this external exercise over the indicators should be a 'governors' report' to Monitor and the NHS foundation trust's board of governors. A limited assurance report over the two mandated indicators will be required from 2011/12. *Detailed guidance for external assurance on the quality reports* can be found on our website.

The deadline for the annual report containing the quality report is **7 June 2011**. The deadline for the signed limited assurance report and the governors' report is **30 June 2011**.

Staff survey

- 7.76. Each NHS foundation trust will be required to include a section in its annual report on its staff survey results covering:

a) Commentary

- Statement of approach to staff engagement - each NHS foundation trust will be required to include a statement of its approach to staff engagement and what mechanisms are in place to monitor and learn from staff feedback.

b) Summary of performance – results from the NHS staff survey

- NHS foundation trusts will be required to provide a summary of the key findings from *the most recent* NHS staff survey, with a focus on details of the top 4 and bottom 4 scored answers and comparison to the prior year and national average performance. A table of information will be required setting out as a minimum:
 - the response rate;
 - the top 4 ranked scores; and
 - the bottom 4 ranked scores.

- 7.77. Action plans to address areas of concerns

- The commentary on the key findings from the survey and each NHS foundation trust will include a summary of its plans to address specific areas of concern emerging from staff surveys and any plans to rectify these shortfalls in the short and medium term.

c) Future priorities and targets

- The commentary should include a statement on the key priorities to improve staff feedback it has (or plans to) put in place and what mechanisms are in place to

Annex 2 to Chapter 7: Quality report requirements

NHS foundation trusts also have to publish a separate quality account each year, as required by the NHS Act 2009, and in the terms set out in the NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011 (collectively “the Quality Accounts Regulations”).

Note that the exemption for community health services under the Quality Accounts Regulations has now been narrowed to NHS Continuing Healthcare. Where an NHS foundation trust has provided and/or subcontracted community health services *during 2010/11*, an NHS foundation trust should include such community health services in the review of services in the quality report. Where an NHS foundation trust begins to provide or subcontract community health services on or after 1 April 2011 they should not be included in the review of services. They should be considered for inclusion in the priorities for improvement for 2011/12.

Monitor’s annual reporting guidance for the quality report incorporates the requirements set out in the Department of Health’s Quality Accounts Regulations (denoted by the black text below) and additional reporting requirements set by Monitor (denoted by the red text).

The quality report must contain (in the following order):

Part 1. Statement on quality from the Chief Executive of the NHS foundation trust

- *A statement signed by the Chief Executive summarising the NHS foundation trust’s view of the quality of the NHS services that it provided or sub-contracted during 2010/11. The statement must outline that to the best of that person’s knowledge the information in the document is accurate.*

Part 2. Priorities for improvement and statements of assurance from the board

Priorities for improvement

- *For quality improvement priorities for 2010/11 identified in the 2009/10 report, trusts should include the performance in 2010/11 against each priority, and where possible the performance in previous years; and*
- *At least three priorities for quality improvement for NHS services that the NHS foundation trust intends to provide or sub-contract in 2011/12 – agreed by the board. Trusts must include how progress to achieve the priorities will be monitored, measured and reported. Trusts should also include a rationale for the selection of those priorities and whether/how the views of patients, the wider public and staff were taken into account. The report should identify the quality improvement priorities for 2011/12 with the expectation of reporting on these in future annual reports.*

Statements of assurance from the board

- Information on the review of services, in the following form of statement:

During 2010/11 the [name of provider] provided and/or sub-contracted [number] NHS services.

The [name of provider] has reviewed all the data available to them on the quality of care in [number] of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents [number] per cent of the total income generated from the provision of NHS services by the [name of provider] for 2010/11.

The data reviewed should aim to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience - and indicate where the amount of data available for review has impeded this objective;

- Information on participation in clinical audits and national confidential enquiries, in the following form of statement:

During 2010/11 [number] national clinical audits and [number] national confidential enquiries covered NHS services that [name of provider] provides.

During 2010/11 [name of provider] participated in [number as a percentage] national clinical audits and [number as a percentage] national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that [name of provider] was eligible to participate in during 2010/11 are as follows: [insert list].

The national clinical audits and national confidential enquiries that [name of provider] participated in during 2010/11 are as follows: [insert list].

The national clinical audits and national confidential enquiries that [name of provider] participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

[insert list and percentages]

The reports of [number] national clinical audits were reviewed by the provider in 2010/11 and [name of provider] intends to take the following actions to improve the quality of healthcare provided [description of actions].

The reports of [number] local clinical audits were reviewed by the provider in 2010/11 and [name of provider] intends to take the following actions to improve the quality of healthcare provided [description of actions].

- Information on participation in clinical research, in the following form of statement:

The number of patients receiving NHS services provided or sub-contracted by [name of provider] that were recruited during that period to participate in research approved by a research ethics committee was [insert number].

- Information on the use of the CQUIN framework, in the following form of statement:

Either:

A proportion of [name of provider] income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between [name of provider] and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

Or:

[name of provider] income in 2010/11 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because [insert reason].

NHS foundation trusts may choose to expand further upon their agreed goals and the rationale behind them (e.g. how they fit with local/regional strategies).

NHS foundation trusts should include a statement which includes a monetary total for the amount of income in 2010/11 conditional upon achieving quality improvement and innovation goals, and a monetary total for the associated payment in 2010/11.

- Information relating to registration with the Care Quality Commission and periodic/special reviews, in the following form of statement:

[name of provider] is required to register with the Care Quality Commission and its current registration status is [insert description]. [Name of provider] has the following conditions on registration [insert conditions where applicable].

The Care Quality Commission (has/has not) taken enforcement action against [name of provider] during 2010/11.

Either:

[name of provider] has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2010/11 [insert details of special reviews and/or investigations]. [name of provider] intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission [insert details of action].

[name of provider] has made the following progress by 31 March 2011 in taking such action [insert description of progress].

Or:

[name of provider] has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

- *Information on the quality of data, in the following form of statement:*

Either:

[name of provider] submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: [percentage] for admitted patient care; [percentage] for outpatient care; and [percentage] for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was: [percentage] for admitted patient care; [percentage] for outpatient care; and [percentage] for accident and emergency care.

Or:

[name of provider] did not submit records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

[Name of provider] Information Governance Assessment Report overall score for 2010/11 was [percentage] and was graded [insert colour from IGT Grading Scheme].

[Name of provider] will be taking the following actions to improve data quality [insert actions].

Either:

[name of provider] was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were [percentages].

Or:

[name of provider] was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

NHS foundation trusts should include an explanatory note for clinical coding stating:

- o that the results should not be extrapolated further than the actual sample audited;*
- and*
- o which services were reviewed within the sample.*

Part 3. Other information

- o An overview of the quality of care offered by the NHS foundation trust based on performance in 2010/11 against indicators selected by the board in consultation with stakeholders, with an explanation of the underlying reason(s) for selection. The indicator set selected must include:*
 - o at least 3 indicators for patient safety;*
 - o at least 3 indicators for clinical effectiveness; and*
 - o at least 3 indicators for patient experience.*

For those indicators selected by the NHS foundation trust, the report should refer to historical data and benchmarked data where available, to enable readers to understand progress over time and performance compared to other providers. References of the data sources for the indicators should be stated, including whether the data is governed by standard national definitions.

Where these indicators have changed from the indicators used in the 2009/10 report, the NHS foundation trust should outline the rationale for why these indicators have changed.

Where the quality indicators are the same as those used in the 2009/10 report and refer to historical data, the data reported should be checked to ensure consistency with the 2009/10 report. Where inconsistencies exist, NHS foundation trusts are required to include an explanatory note on any changes in the basis of calculation.

- o Performance against key national priorities*

An overview of performance in 2010/11 against the key national priorities from the Department of Health's Operating Framework. This must include performance against the relevant indicators and performance thresholds set out in Appendix B of the Compliance Framework.

- o NHS foundation trusts can also choose to use Part 3 to include other additional*

content relevant to the quality of NHS services.

Annex: Statements from primary care trusts, Local Involvement Networks and Overview and Scrutiny Committees.

- NHS foundation trusts must send copies of their quality reports to their relevant lead commissioning primary care trusts (PCTs), Local Involvement Networks (LINks) and Overview and Scrutiny Committees (OSCs) for comment prior to publication, and should include these comments in their published quality reports.
- The lead commissioning PCTs will have a legal obligation to review and comment, while LINks and OSCs will be offered the opportunity to comment on a voluntary basis. There are specific timeframes for seeking and receiving responses.

Annex: Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2010 to June 2011
 - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
 - Feedback from the commissioners dated XX/XX/20XX
 - Feedback from governors dated XX/XX/20XX
 - Feedback from LINks dated XX/XX/20XX
 - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX;
 - The [latest] national patient survey XX/XX/20XX
 - The [latest] national staff survey XX/XX/20XX
 - The Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX
 - CQC quality and risk profiles dated XX/XX/20XX
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed

definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive

Board of Directors : April 2011

Item : 12b

Title : Data Assurance Overview

Summary:

The Data Assurance Overview provides a summary of the information contained on the Data Validation forms, which have been completed for the date entries included in the Draft Quality Report, and signed off by the Director responsible for the data. It includes information regarding the: Assurance over the data item; gaps / risks in data assurance, and a data quality confidence rating.

This report has been reviewed by the following Committees:

- Management Committee, 21st April 2011

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

This report focuses on the following areas:

(delete where not applicable)

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

For : Approval

From : Trust Director

Quality Report - Data Assurance Overview

Clinical Indicators	Indicator(s) / Targets	Qualitative / Quantitative	Manager Responsible for Data	Director Responsible for Data	Assurance Over Data	Gaps / Risks in Data Assurance	Data Quality Confidence Rating
Priorities							
1. Clinical Outcome Monitoring:							
- CAMHS	<p>1. Self report SDQ (Age 11 - 17) (Child and Family)</p> <p>2. Parent and Teacher SDQ (Child and Family)</p> <p>3. CGAS (Age 4 - 16) (Child and Family)</p> <p>4. PIR-GAS (Age 4 and under) (Child and Family)</p> <p>5. Goal-based measure</p> <p>Targets:</p> <p>1. To increase the return rates for CAMHS to 60% and above.</p> <p>2. To implement the expanded protocol across all CAMHS services within the directorate for every new patient referred.</p> <p>3. To pilot the new outcome measures within the Learning and Complex Disabilities Service, the Under Fives Service and the Fostering and Adoption Service.</p> <p>4. To improve data collection in CAMHS across an agreed range of domains.</p>	Quantitative	Caroline McKenna	Rob Senior	To accommodate the changeover from CareNotes to RiO there is an interim manual cross checking procedure in place between the systems that has increased reliability.	A project plan has been drawn up to address the gaps regarding data completeness and reliability. It is in the process of being presented to the Management Committee, who have agreed the plan in principal. This will address the risks associated with the current process.	Amber
- Adolescent	<p>1. YASR / YSR (Age 12 - 30)</p> <p>2. CBCL / YABCL (significant other)</p> <p>3. YABCL (Therapist)</p> <p>4. CBCL (Therapist)</p> <p>5. Self report SDQ (Age 11 - 16.5)</p> <p>6. Parent SDQ</p> <p>7. CORE (Age 16.5 - 25)</p>	Quantitative	Caroline McKenna	Rob Senior	To accommodate the changeover from CareNotes to RiO there is an interim manual cross checking procedure in place between the systems that has increased reliability.	A project plan has been drawn up to address the gaps regarding data completeness and reliability. It is in the process of being presented to the Management Committee, who have agreed the plan in principal. This will address the risks associated with the current process.	Amber
- Adult	<p>1. CORE: Pre-Assessment</p> <p>2. CORE: Post-Assessment</p> <p>3. CORE: End of Treatment Form</p> <p>Targets:</p> <p>1. To further increase the return rates of forms from patients in the Adult Department.</p> <p>2. The data from the new outcome measures currently being piloted within the Adult Brief Therapy Service will be evaluated.</p>	Quantitative	Caroline McKenna	Rob Senior	To accommodate the changeover from CareNotes to RiO there is an interim manual cross checking procedure in place between the systems that has increased reliability.	A project plan has been drawn up to address the gaps regarding data completeness and reliability. It is in the process of being presented to the Management Committee, who have agreed the plan in principal. This will address the risks associated with the current process.	Amber
- Portman	<p>1. CORE: Pre-Assessment</p> <p>2. CORE: Post-Assessment</p> <p>3. CORE: End of Treatment Form</p>	Quantitative	Caroline McKenna	Rob Senior	To accommodate the changeover from CareNotes to RiO there is an interim manual cross checking procedure in place between the systems that has increased reliability.	A project plan has been drawn up to address the gaps regarding data completeness and reliability. It is in the process of being presented to the Management Committee, who have agreed the plan in principal. This will address the risks associated with the current process.	Amber
2. Patient & Public Involvement	Stakeholder consultation on the quality of our clinical services in liaison with the Patient and Public Involvement Committee.	Qualitative	Sally Hodges / Justine McCarthy Woods	Sally Hodges	Direct feedback from the consultations will provide the assurance over the data quality.	There are no gaps or risks identified in the data assurance.	Green
	Completing and reporting on consultations involving patients and carers.	Qualitative			Direct feedback from the consultations will provide the assurance over the data quality.	There are no gaps or risks identified in the data assurance.	Green
	Developing and evaluating more creative ways of obtaining feedback.	Qualitative			Feedback from these various different methods will provide the assurance over the data quality.	There are no gaps or risks identified in the data assurance.	Green
3. Improvement to the build environment & facilities	Feedback survey on completed refurbishments: A further survey of the improvements to the built environment and facilities will be undertaken in 6 months.	Qualitative	Sally Hodges / Trudy Klauber (student feedback)	Sally Hodges	The feedback from the next built environment and facilities survey will provide the assurance over the data quality.	There are no gaps or risks identified in the data assurance.	Green
	Rolling programme of refurbishments: A programme of refurbishments is in hand and plans are in development for improvements to the use of external spaces.	Qualitative	Pat Key	Pat Key	The feedback from the next built environment and facilities survey will provide the assurance over the data quality.	There are no gaps or risks identified in the data assurance.	Green
	Website feedback: After the site has been live for a year we will conduct a further survey through the members' newsletter to check that the site is functioning as it should	Qualitative	Sally Hodges	Sally Hodges	The feedback from the website survey provides assurance over the data quality.	There are no gaps or risks identified in the data assurance.	Green

Clinical Indicators	Indicator(s) / Targets	Qualitative / Quantitative	Manager Responsible for Data	Director Responsible for Data	Assurance Over Data	Gaps / Risks in Data Assurance	Data Quality Confidence Rating
4. Access to clinical service and healthcare information for patients and public	Leaflets on Life issues: The Communications Team are preparing a series of downloadable leaflets on Life Issues which will offer information and advice in relation to common issues encountered across the life span. The series will be launched in 2010/11 and will make a contribution to promoting public health and well-being.	Qualitative	Sally Hodges	Sally Hodges	Feedback from the PPI consultations will provide the assurance over the data quality.	There are no gaps or risks identified in the data assurance.	Green
	Leaflets for people with learning disabilities: Following a consultation from People First, the Trust has developed information leaflets suitable for people with learning disabilities and will make these available from 2010/11.	Qualitative	Sally Hodges / Nancy Sheppard	Sally Hodges	The feedback from the Hackney People First revisit will provide the assurance over the data quality.	There are no gaps or risks identified in the data assurance.	Green
5. Maintaining a high quality effective workforce	Feedback from staff surveys 1. We aim to put in place a range of measures to reduce work related stress. 2. We aim to maintain a well-trained, flexible and creative workforce through providing personal development plans, supporting Continuing Professional Development and continuing to support workshops aimed at enhancing clinical learning and development.	Quantitative	Namdi Ngoka	Susan Thomas	A summary of the results is produced along with a Board Report. In addition an action plan for the 2009/10 survey is in place.	There are no gaps or risks identified in the data assurance.	Green
Other targets							
Patient safety:							
NHSLA	Level 2 (February 2011)	Quantitative	Jane Chapman	Pat Key	The data undergoes an external validation via the NHSLA Team.	There are no gaps or risks identified in the data assurance.	Green
No. of patient safety incidents	Number of incidents reported	Quantitative	Jane Chapman	Pat Key	The data is obtained directly from the incident report forms.	There are no gaps or risks identified in the data assurance.	Green
Monitoring of adult safeguard alerts	Number of alerts and statement of progress	Quantitative	Elisa Reyes-Simpson	Rob Senior	The data is stored, tracked and updated by both the Governance and Risk Lead and the Vulnerable Adults Advisor via an excel spreadsheet.	Uncertainty exists over whether all adult safeguards alerts are highlighted to the Governance and Risk Lead and the Vulnerable Adults Advisor, as it appears that clinicians are unsure of the both the definition of a vulnerable adult and the alert process that is in place within the Trust.	Amber
Electronic recording of Children in Need	Statement reflecting progress	Qualitative	Rita Harris	Rita Harris	The Trust has introduced RiO as an administration system. Within RiO it has not been possible to establish an electronic recording system for 'children in need'. We are investigating alternative solutions.		Amber
Attendance at INSET days	% attendance of staff who are required to attend	Quantitative	Namdi Ngoka	Susan Thomas	The data is managed by one individual within the Staff Training and Development Team, who for for local inductions requests the checklists from Line Managers new starter packs to confirm completion and for trust-wide induction transfers the attendance information from the paper sign-in sheet to both OLM and a local excel spreadsheet. Follow ups occur for all non-attending individuals, requesting a reason for non-attendance.	The current staff list is manually updated which has the potential of creating gaps in the data, as it is possible that not all Trust staff are captured. An action plan has been implemented to increase attendance at trust-wide induction days. This includes separate invitations to induction and the potential for sanctions if non-attendance is identified as deliberate.	Amber
Attendance at mandatory training	% attendance of staff who are required to attend	Quantitative	Namdi Ngoka	Susan Thomas	The data is managed by one individual within the Staff Training and Development Team, who emails all staff who are required to attend with the date of the mandatory training. They are asked to confirm their attendance via return email and managers of the requested attendees are also informed. Following training, the attendance data is transferred from the paper sign-in sheet to both OLM and a local excel spreadsheet. Follow ups occur for all non-attending individuals, requesting a reason for non-attendance.	The current staff list is manually updated which has the potential of creating gaps in the data, as it is possible that not all Trust staff are captured. An action plan has been implemented to increase attendance at mandatory training. This includes separate invitations to induction and the potential for sanctions if non-attendance is identified as deliberate.	Amber

Clinical Indicators	Indicator(s) / Targets	Qualitative / Quantitative	Manager Responsible for Data	Director Responsible for Data	Assurance Over Data	Gaps / Risks in Data Assurance	Data Quality Confidence Rating
Safeguarding of children	Number and % of CAMHS staff that have received Level 3 child protection training	Quantitative	Namdi Ngoka	Susan Thomas	The data is managed by one individual within the Staff Training and Development Team, who transfers the attendance information from the paper sign-in sheet to both OLM and a local excel spreadsheet. Follow ups occur for all non-attending individuals, requesting a reason for non-attendance.	The current staff list is manually updated which has the potential of creating gaps in the data, as it is possible that not all Trust staff are captured. There are 3 safeguarding training dates scheduled for 2011/12. Staff have been informed of the next training dates and they are also published in the Training Prospectus.	Amber
Clinical Effectiveness:							
Monitoring of staff with PDP	PDPs agreed between staff and manager	Quantitative	Namdi Ngoka	Susan Thomas	PDPs are completed as part of the annual appraisal process and sent to the Staff Training and Development Manager by the end of February each year, who then logs receipt of each PDP on a local spreadsheet. All appraisers of staff members without a PDP are contacted by the Staff Training and Development Manager to ensure that a PDP is in place for the individual concerned. A training needs analysis is completed from all of the PDPs and subsequently the Staff Training Prospectus is produced and distributed Trust wide.	There are no gaps or risks identified in the data assurance.	Green
Outcome monitoring returns data	<p>CAMHS</p> <ol style="list-style-type: none"> 1. Self report SDQ (Age 11 - 17) (Child and Family) 2. Parent and Teacher SDQ (Child and Family) 3. CGAS (Age 4 - 16) (Child and Family) 4. PIR-GAS (Age 4 and under) (Child and Family) 5. Goal-based measure <p>Adolescent</p> <ol style="list-style-type: none"> 1. YASR / YSR (Age 12 - 30) 2. CBCL / YABCL (significant other) 3. YABCL (Therapist) 4. CBCL (Therapist) 5. Self report SDQ (Age 11 - 16.5) 6. Parent SDQ 7. CORE (Age 16.5 - 25) <p>Adult and Portman</p> <ol style="list-style-type: none"> 1. CORE: Pre-Assessment 2. CORE: Post-Assessment 3. CORE: End of Treatment Form 	Quantitative	Caroline McKenna	Rob Senior	To accommodate the changeover from CareNotes to RiO there is an interim manual cross checking procedure in place between the systems that has increased reliability.	A project plan has been drawn up to address the gaps regarding data completeness and reliability. It is in the process of being presented to the Management Committee, who have agreed the plan in principal. This will address the risks associated with the current process.	Amber
Patient experience:							
Patient feedback	<ol style="list-style-type: none"> 1. % listened to and treated with respect 2. % who would recommend the Trust 3. CHI-ESQ 4. Other feedback 	Quantitative	Susan Blackwell	Sally Hodges	The data is managed and controlled by one individual within the Patient and Public Involvement Team, who inputs the data and creates the output reports. The output data is compared to previous years results in order to analyse trends in the data.	There are no gaps or risks identified in the data assurance.	Green
Monitor DNA rate	Number and % of DNA appointments	Quantitative	Allan Archibald	Julia Smith	As there are no data validation checks in place we do not have any confirmation of any input errors by the Trust Administrators, however, we also have no reason to believe that the data is inaccurate.	There are minimal risks that exist within the data. However, it is possible that appointments are not input onto CareNotes / RiO and so are never captured within the DNA rate, and also that some appointments will remain uncoded despite the monthly check that is in place to request this. These incidents present a small risk and should only occur as a result of human error. A process review of the DNA process from point of entry to the final output is in progress.	Amber

Clinical Indicators	Indicator(s) / Targets	Qualitative / Quantitative	Manager Responsible for Data	Director Responsible for Data	Assurance Over Data	Gaps / Risks in Data Assurance	Data Quality Confidence Rating
Monitor rate of complaints received	Number of complaints received	Quantitative	Lotte Higginson	Matthew Patrick	Complaints are received and managed by the Complaints Manager who maintains a spreadsheet and a direct count of all 'new' complaint files.	There are no gaps or risks identified in the data assurance.	Green
Waiting times (from referral to assessment) - should be no longer than 11 weeks	<ul style="list-style-type: none"> 1. Child and Family 2. Adolescent 3. Adult 4. North Camden 5. South Camden 6. Portman 7. LCDS 	Quantitative	Jane Stockwell	Julia Smith	Details of patients waiting for over 11 weeks are sent via email to named individuals within the relevant departments requesting justification and an action plan for each. Following receipt of all justifications a summary report is distributed to the Clinical Directors. The data quality is also checked through the	Rarely input error means that dates are incorrectly entered onto CareNotes or RiO, but these are discovered and corrected during the justification and action plan process.	Green