

Board of Directors

Agenda and papers of a meeting to be held

2pm – 3.30pm
Tuesday 26th July 2011

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

Board of Directors
2.00pm – 3.30pm, Tuesday 26th July 2011

Agenda

Preliminaries

1. Chair's Opening Remarks

Ms Angela Greatley, Trust Chair

2. Apologies for Absence

3. Minutes of the Previous Meeting

(Minutes attached)

p.1

For approval

4. Matters Arising

Reports & Finance

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

For noting

Non-Executive Directors as appropriate

6. Chief Executive's Report

(Report attached)

p.9

Dr Matthew Patrick, Chief Executive

For discussion

7. Finance & Performance

a. Finance & Performance Report

(Report attached)

p.13

Mr Simon Young, Director of Finance

For discussion

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

(Report attached)

p.23

For approval

Mr Simon Young, Director of Finance

Quality & Development

8. Education and Training Report

(Report attached)

p.28

Ms Trudy Klauber, Dean

For discussion

9. Service Line Report – Developmental CAMHS

(Report attached)

p.38

Dr Sally Hodges, Associate Clinical Director, CAMHS

For discussion

10. Payment by Results

(Report attached)

p.48

Dr Jessica Yakeley, Associate Medical Director

For discussion

Conclusion

11. Any other business

12. Notice of future meetings

Thursday 15th September 2011: Board of Governors
Tuesday 27th September 2011: Board of Directors
Tuesday 18th October 2011: Directors' Conference (*Strategy*)
Tuesday 25th October 2011: Board of Directors
Tuesday 8th November 2011: Directors' Conference (*Plan Review*)
Tuesday 29th November 2011: Board of Directors
Thursday 1st December 2011: Board of Governors
Tuesday 31st January 2012 : Board of Directors
Thursday 2nd February 2012 : Board of Governors
Tuesday 28th February 2012 : Board of Directors
Tuesday 27th March 2012 : Board of Directors
Tuesday 24th April 2012 : Board of Directors
Thursday 3rd May 2012 : Board of Governors
Tuesday 29th May 2012 : Board of Directors
Tuesday 26th June 2012 : Board of Directors
Tuesday 31st July 2012 : Board of Directors
Thursday 13th September 2012 : Board of Governors
Tuesday 25th September 2012 : Board of Directors
Tuesday 30th October 2012 : Board of Directors
Tuesday 27th November 2012 : Board of Directors
Thursday 6th December 2012 : Board of Governors

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

Board of Directors Meeting Minutes

Part One, 2.30pm – 4.30pm, Tuesday 28th June 2011

Present:			
Ms Angela Greatley Trust Chair	Mr Martin Bostock Snr Independent Director	Ms Lis Jones Nurse Director	Ms Trudy Klauber Dean
Ms Louise Lyon Trust Director	Ms Joyce Moseley Non-Executive Director	Dr Matthew Patrick Chief Executive	Dr Ian McPherson Non-Executive Director
Dr Rob Senior Medical Director	Mr Richard Strang Deputy Trust Chair	Mr Simon Young Director of Finance	
In Attendance:			
Miss Louise Carney Trust Secretary (minutes)	Dr Rita Harris CAMHS Director (item 8)	Prof. Andrew Cooper Social Work (item 13)	Dr Richard Graham Clinical Director: Adolescent (item 14)
Mr Stan Ruszczynski Clinical Director: Portman (item 15)	Mr Namdi Ngoka Deputy Director of HR (items 16 & 17)		
Apologies:			
Mr Altaf Kara Non-Executive Director			

Actions

AP	Item	Action to be taken	Resp	By
1	3	Miss Carney to amend minutes	LC	Immed
2	3	Miss Carney to amend minutes	LC	Immed
3	9	Miss Carney to update and circulate final version of Board objectives	LC	Immed
4	14	Ms Moseley to forward Loughton Report to Dr Graham	JM	Immed
5	16	Mr Ngoka to investigate whether the Trust can send the Staff Survey to a percentage of staff, rather than all staff	NN	Jul 11

Actions Agenda item

Future Agendas

1. Trust Chair's Opening Remarks

Ms Greatley welcomed everyone to the meeting.

2. Apologies for Absence

As above.

3. Minutes of the Previous Meeting

Board of Directors Meeting, 24th May 2011

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

Extraordinary Meeting of the Board of Directors, 2nd June 2011

AP2 The minutes were approved subject to some minor typographical amendments.

4. Matters Arising

Ms Lyon confirmed that there had been no changes to the Quality Report since the Annual Report and Accounts were approved, and would not be submitted an amended version to Monitor.

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

Angela Greatley, Trust Chair

Ms Greatley noted that she had attended meetings on competition and co-operation, patient safety, and Mr Lansley's health reforms, the launch event for the Foundation Trust Network, which was now independent of the NHS Confederation, and a meeting of London NHS Chairs.

Ms Greatley reminded Board members of the Department of Health publication *The Month*, which she recommended as a helpful update on the health landscape.

6. Chief Executive's Report

The Board discussed the Health & Social Care Bill. It was agreed that Mr Young would present a paper on the introduction of Payment by Results to mental health care. Dr McPherson queried the position of mental health in clinical networks. Dr Patrick and Ms Greatley confirmed that nothing had as yet been mentioned on mental health. It was agreed that it was important to follow these developments and to promote the case for mental health wherever possible.

7. Finance & Performance Report

Mr Young noted that the Trust was on target to make a small surplus for Q1 and would achieve a Financial Risk Rating of 3. Mr Young explained that there were some variances in the budget, and income in some areas was below budget. This was being discussed with Service Line Directors. Mr Young noted, however, that it was difficult to review income and identify savings at the same time, and the Executive needed to ensure that Directors have sufficient support to ensure that nothing was overlooked during this difficult time.

Mr Young noted that the Trust's cash balance was slightly below Plan, but he expected to be able to cover this shortfall. The Trust was forecast to achieve its £150k surplus. A significant amount of the Trust's contingency reserve had been used, and the balance of this was now £186k.

Mr Young reported that there had been a delay in chasing student debt, which was in part due to a staffing shortage, which had now been sorted.

Mr Young reported that the Voluntary Redundancy Scheme had produced significant savings, across both clinical and non-clinical Directorates. Plans

had been made for all approved applications but were not yet finalised. Mr Young explained that voluntary redundancies identified in the Monroe Family Assessment Service would not count towards the targeted savings in CAMHS, but towards the MFAS service redesign. Mr Young noted that he would provide a fuller report on the productivity programme in July, as previously agreed.

Mr Strang noted that departmental consultancy was falling below budget, and queried this. Mr Young noted that departmental consultancy is a small part of overall activity, and is largely reliant on staff going out and selling this product, but the priority for the Trust at the moment was identifying savings. Mr Strang queried why this had not been budgeted for. Dr Senior noted that predicting Local Authority spending was very difficult, but agreed that the Trust should have been better at this. Dr Patrick noted that budgets were interrogated by the Trust's Management Committee and were not approved unless they were realistic. Mr Young confirmed that the Trust was concerned about departmental consultancy and was looking into it.

Mr Strang requested more information on the credit note issue highlighted in paragraph 2.2.2. Mr Young explained that the Finance Directorate had received two requests for invoices with different wording, and had assumed they were for different things, so two invoices had been sent. Action was being taken to address this issue and avoid recurrence, but Mr Young confirmed that this did not represent a large part of the Trust's budget.

8. Gloucester House Steering Group Annual Report

Dr Harris noted that one of the main challenges for the Day Unit, an independent school, was that Local Authorities want more in-house, locally-delivered services.

Dr Harris noted that commissioners for Gloucester House are education commissioners, not health commissioners, and education budget cuts are significant.

The Board discussed accommodation. Dr Patrick noted that there were several possible options, and Ms Key, Director of Corporate Governance & Facilities was discussing these with Dr Kasinski, Unit Director and Ms Nicholson, Head Teacher.

Ms Jones queried how Learning Support Team would influence Gloucester House. Dr Harris noted that the Team would free up Teachers' time and would bring a difference discipline into the house.

Ms Klauber queried whether people were aware of the significance of developments such as returning to mainstream education. Dr Senior noted that this was a major achievement for the pupils at Gloucester House. Mr Young noted that the Steering Group had seen reports that are sent to commissioners with considerable detail on the outcomes for pupils; it was

agreed that these achievements should be publicised more widely.

9. Board of Directors' Objectives

Ms Greatley explained that the Board objectives were derived from the Annual Plan. Board members individual objectives flow from these Board objectives.

Board members suggested the following inclusions / amendments:

- Supporting Governors as their role develops
- The Health & Social Care Bill
- Member engagement being the responsibility of the Trust
- Succession planning
- Engagement should not just be local

AP3 The objectives were approved subject to the above amendments. Miss Carney to update and circulate final version.

Ms Moseley queried how the Board monitors its performance against these objectives. Miss Carney noted that this forms part of the Annual Review of the Board of Directors, and that there would also be a mini-review of progress against objectives in November 2011.

Ms Lyon noted that monthly reviews will not necessarily take the form of a specific Board report, but things will be reported to the Board in various other reports.

10. Clinical Quality, Safety, & Governance Committee Quarter Four Report

Dr Senior explained that the new report format presented a top-line summary of key issues from each workstream that reports to the Clinical Quality, Safety, and Governance Committee. The Board confirmed that they found the format of the report very helpful.

Dr Senior confirmed that at 1.1.4.3 the Trust did want its staff to report incidents, and does not wish to appear complacent about its relatively low rate of incidents.

11. Business Development & Investment Committee Terms of Reference

Mr Strang explained that the wording of paragraph 8.7 had been amended to reflect the role of the Business Development Council, which considers all

proposals before they are sent to the Committee.

Mr Strang explained that paragraph 11.1 had been amended to remove the requirement to send minutes to the Audit Committee, as there were no control issues to consider.

12. Committee Reports & Minutes

Nothing to report.

13. Munro Report

Prof. Cooper highlighted one of the suggestions of the Munro Review was the suggestion of devolvement of child protection to local levels. Prof. Cooper reported on the conference on 24th June, which had been a success. Ms Moseley noted that the Allan Review would link with the Munro Review. Dr McPherson noted that the Trust was good at holding risk, and should make its knowledge and training on child protection available to professionals.

14. Service Line Report: Adolescent Directorate

Mr Strang requested more information on paragraph 2.1, which noted that less than half of referrals to the Directorate were accepted. Dr Graham noted that the Directorate struggled with the single point of entry. Agreement had to be sought for each case from the local service, and the level of approval is vastly disproportionate to the level of interest. Dr McPherson queried the proportion of accepted cases of those that get through. Dr Graham noted that most of the cases are accepted. If the level of risk associated with the patient is thought to require inpatient care, the patient will not even be seen for an assessment but will be referred elsewhere.

AP4

Ms Moseley noted Tim Loughton MP had recently produced a report on care for 16 – 25 year olds. Ms Moseley to forward to Dr Graham.

Ms Jones queried how work with Mental Health Strategies was being taken forwards. Dr Graham noted that the Directorate was looking at opportunities. Ms Lyon noted that proposals would come as part of the Productivity Programme in July.

15. Service Line Report: Portman Clinic

Mr Ruszczynski noted that the Portman Clinic had made £0.25m of savings prior to budget-setting, and was now looking for further savings, but questioned for how long it would be able to continue to make cuts.

Ms Moseley asked for further information on the role referred to in paragraph 3.3 (Assistant Psychologist focusing on audit and research. Mr Ruszczynski noted that this role was not income-generating, but had been

of significant help with providing Commissioners with important information.

Dr McPherson noted that there may be offender health publications with significant opportunities for the Portman Clinic.

Dr Patrick noted that the Portman Clinic was currently contributing 8% to the Trust's overheads, whilst the average contribution from other Directorates was around 20%, and queried whether it would be possible for the Directorate to bridge the gap without a fundamental review of the model of the clinic.

Mr Young suggested that it should be possible to devise a model that uses staff time more productively. Mr Young noted that this was true of other Directorates as well as the Portman. Mr Ruszczyński noted that a piece of work was underway to identify how clinical staff spent their time and to devise new models of working. Mr Ruszczyński was focusing on how to maintain the core principles of the Directorate whilst adapting to the new environment. Mr Ruszczyński noted the pressure and encouragement from the Board.

Mr Strang queried whether income projections (upper and lower limits) had been calculated for the opportunities listed in paragraph 8.4. Mr Ruszczyński noted that many opportunities were very short-term, and so it was often difficult to predict income, and to identify an adaptable future model.

16. Staff Survey Report

Mr Ngoka noted that the question on training asked about training in the last twelve months, whereas the Trust's requirements were for all staff to have training every 24 months.

Mr Bostock queried the response rate, noting that 49% of staff did not take part. Mr Ngoka noted that other Trusts sent the survey to a sample of staff, whereas the Trust sent the survey to all staff. Mr Ngoka to investigate whether the Trust could send the survey to a percentage of staff instead of all staff. It was also noted that the survey was an annual requirement, and many staff who had been at the Trust for many years may well be bored with completing the survey.

Mr Bostock queried what format the survey took. Mr Ngoka noted that it was in a paper format. It was a national survey and the Trust had no say in how the survey was carried out.

Ms Moseley queried how many disabled staff the Trust had. Mr Ngoka noted that 25 staff had identified themselves as disabled in the survey. Last year, the Trust had undertaken an exercise, and had identified eight disabled staff. It had been suggested that staff may be more willing to answer questions anonymously.

Ms Klauber noted that career progression opportunities were significantly smaller for non-clinical staff than clinical. This is not necessarily an easy issue to address.

Ms Greatley congratulated the Trust on its high score in so many areas. Dr Patrick noted that last year the Trust had been identified as having the highest engagement levels of any NHS organisation.

17. Workforce Statistics

Mr Ngoka noted that the NHS London received workforce data from NHS trusts from electronic staff databases, which they interrogate and provide monthly benchmarked analysis.

Mr Young noted the equal opportunities statistics for Asian ethnic groups applying for non-clinical posts in the last year. It was agreed that the Trust should investigate the recruitment of ethnic groups through the Equalities Committee's Race and Employment Sub-Group.

Mr Bostock requested that future reports identify trends in data over years.

18. Any other Business

None.

19. Notice of Future Meetings

Miss Carney noted that the Directors' Conference on 12th September had been cancelled, and was being replaced by an away day to consider strategy on 18th October. Miss Carney informed the Board that the Annual General Meeting would be held on 11th October.

Outstanding Action Part 1

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date
1	Apr-11	12b. Data Assurance Overview	Ms Lyon to include target date column	Louise Lyon	Apr-11
2	Apr-11	4. Matters Arising	Dr Senior to liaise with auditors to align terminology	Rob Senior	Jun-11
3	Apr-11	12a. Quality Report	Ms Lyon to liaise with Dr Hodges on communicating Quality Report to patients and public	Louise Lyon	Jun-11
4	May-11	16. Annual General Meeting	Board members to provide feedback on AGM plan to Dr Hodges	Board of Directors	Jun-11
5	May-11	17. Equalities Report	Management to address bullying and harassment in Staff Survey Action Plan	Management Committee	Jun-11
6	Apr-11	4. Matters Arising	Dr Patrick to update Board of Directors on Big White Wall contract	Matthew Patrick	Jul-11
7	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	Jul-11
8	Jan-11	7a. Finance & Performance Report	Ms Lyon to report back on structure of consultancy work	Louise Lyon	Jul-11
9	Apr-11	7c. Operational Risk Register	Mr Young to give consideration to preparing Board paper on performance management	Simon Young	Sep-11
10	Mar-11	8. Health & Social Care Bill Update: Governance in NHS Foundation Trusts	Miss Carney to investigate insurance policies for Directors	Louise Carney	Sep-11
11	May-11	8. Board Committee Annual Review: Patient & Public Involvement Committee	Dr Hodges to develop a PPI mission statement	Sally Hodges	Sep-11
12	May-11	10. Trust Policies: Data Quality Policy	Ms Thomas to give consideration to how responsibilities outside of departments are covered in appraisals	Susan Thomas	Sep-11
13	Mar-11	8. Health & Social Care Bill Update: Governance in NHS Foundation Trusts	Miss Carney to update Board of Directors on Governors' and Directors' responsibilities as appropriate	Louise Carney	As appropriate
14	Apr-11	5. Trust Chair's and Non-Executive Directors' Reports	Ms Greatley to update Board of Directors on developments with London mental health chairs and CEO's groups	Angela Greatley	As appropriate
15	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
16	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

Red denotes actions overdue

Amber denotes actions due this month

Board of Directors : June 2011

Item : 6

Title : Chief Executive Report

Summary :

The report covers the following items:

1. Introduction
2. Productivity
3. RiO and Trust IT Solutions
4. Communications
5. UCL Partners
6. And Finally...

For : Discussion

From : Chief Executive

Chief Executive Report

1. Introduction

- 1.1 July is always a weary time of year within the Trust. This year is no exception. The Voluntary Redundancy Scheme, while successful, does mean that we are saying goodbye to a significant number of colleagues. In addition, very necessary work on service redesign creates an inevitable degree of strain. At the same time we are currently involved in an unusually high amount of tendering work after a noticeably quieter period.
- 1.2 These factors also illustrate a tension, about which I recently wrote to all staff; namely that between the processing of loss and our enthusiasm for development. Of course loss relates not only to the colleagues to whom we are saying goodbye, but also to the changing and developing nature of the organisation. Making space for thought and discussion about these matters is, I believe, of real importance in support of our more ambitious and outward looking thinking and planning.

2. Productivity

- 2.1 Progress against productivity planning will be reported separately. I will note here, however, that the Voluntary Redundancy Scheme was successful within the Trust in contributing very significantly towards required savings. Work on the service redesign that will allow for staff redeployment to cover work with fewer staff, while maintaining or improving quality of services, is ongoing.
- 2.2 The Productivity Programme Board, chaired by Simon Young and including Rita Harris, Louise Lyon and Susan Thomas, has overseen and led the process very well. I think it is better to think of these changes as evolutionary, however, as opposed to thinking of them as one off interventions. As such, the demand for time and focus on this area will continue, and whatever changes we make now will need to be kept under review with the possibility of reviewing their effectiveness and the need for further developments.

3. RiO

- 3.1 In October 2015, the contract between Connecting for Health and BT, the local service provider for the RiO solution in London, comes to an end. Between now and 2015, BT are contracted to roll out a further two releases of RiO, R1 and R2. It is important now, however,

that all trusts currently deploying the RiO solution consider their options post-2015.

- 3.2 The need for trusts to start considering their options early is in part related to the need to ensure IMT and business continuity, and in part related to the management of financial risks. If continuity is not secured then contract extensions beyond 2015 could be costly.
- 3.3 With these considerations in mind, the London Program for IT (LPfIT) is encouraging organisations to begin an evaluation of options now. This process will be supported by the LPfIT Program Board and by the 2015 strategy sub-committee.
- 3.4 Within London, as a group of mental health trusts we are considering the merits of a consortium approach to the options appraisal and possible procurement. The matter is complicated, however, by the fact that five of the ten mental health trusts are now also providers of community services, requiring potentially different IT solutions.
- 3.5 There are a number of key questions that have yet to be answered in relation to the end of the contract: is it necessary or desirable to try and roll out two further RiO releases, or would it be better to establish a stable pre-transition platform on R1; will it be possible to contract for RiO directly with CSE (the software company) following 2015; will financial penalties for early or indeed late departure be borne by individual trusts or supported by the London Program? It is planned that answers to these questions should be available before the end of the year.
- 3.6 In the meantime, it is important that all trusts continue developing their own local data warehouse solutions that provide easy and flexible reporting and the interrogation of data from a range of sources including but beyond just RiO (e.g. outcome monitoring).

4. Communications

- 4.1 At the last Board of Directors meeting, Julia Smith presented plans for integrating Business Developing and Marketing across the organisation (this was in closed session). Since that time I have decided that we should also integrate the communications function with Business Development and Marketing.
- 4.2 Communications serves more than just marketing within the Trust. Having said this, our Communications Lead, Sally Hodges, now has increasingly demanding management responsibilities within CAMHS. It is primarily for this reason that I have made the decision, to ensure

that both CAMHS and Communications can both receive the attention and time that they require. Sally, who has done a tremendous job as Communications Lead, will continue as the Trust PPI Lead.

- 4.3 From a timing point of view, we are currently advertising and appointing to key communications posts, which represents another reason for acting now rather than later.

5. UCL Partners

- 5.1 UCL Partners recently invited the four member mental health trusts to take up a place on the Board of UCLP. The Chief Executives of the four trusts (Barnet, Enfield & Haringey MHT, Camden & Islington FT, North East London FT and Tavistock & Portman FT) met recently to consider the offer and have agreed to take it up. The cost of the place is £50k per year, split between the four organisations. One of us will take up the place for the first year, but it will make sense to have a rotating arrangement.

6. And Finally...

- 6.1 All of you will have seen the article in the Health Service Journal at the beginning of the month, reporting research that identified the Trust as one of 19 lead performers from all NHS organisations.
- 6.2 Whilst we should always exercise a degree of scientific caution in relation to such data, it is also nice that the strength of our contribution and in particular staff group are recognised. Our staff in particular are both dedicated and talented, and the experience of patients, students and others who come into contact with the Trust owes something to everybody who works here in whatever capacity.

Dr Matthew Patrick
Chief Executive Officer
July 2011

Board of Directors : June 2011

Item : 7a

Title : Finance & Performance Report

Summary :

After three months a surplus of £63k is reported (before restructuring costs), £18k above the planned surplus of £45k. Income shortfalls on Directorate Consultancy and Productivity schemes have been offset by under spends in Training and Central Functions.

The Trust has approved 24 applications for voluntary redundancy. The one-off costs are expected to be £900k. These staff will in most cases be leaving in the next 3 months, and with the net savings from these posts, together with other changes, we expect to meet our savings targets for the year. While a number of other risks to income and expenditure remain, we expect to meet our overall financial plans for the year.

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

The cash balance at 30 June was £2,536k, £780k below Plan. It is expected that most or all of this shortfall should be recovered over the coming months. Cash will reduce – as planned – due to the payment of redundancy and early retirement costs, but the balance is projected to remain satisfactory.

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

This report focuses on the following areas:

- Finance

For : Discussion

From : Director of Finance

Finance & Performance Report

1. External Assessments

1.1 Monitor

- 1.1.1 The Annual Plan, as approved by the Board, was submitted to Monitor in May. Following their review, a response is expected in July or August. The Plan should lead to a Financial Risk Rating of 3.
- 1.1.2 The Quarter 1 results should also lead to a rating of 3; and it is currently expected that the actual rating for the year will remain at 3 in subsequent quarters.

2. Finance

2.1 Income and Expenditure 2011/12

- 2.1.1 After three months the trust is reporting a surplus of £63k, £18k above plan. Income is £55k below budget, and expenditure £73k below budget. Some of these variances are due to timing, and the forecast for the year remains in line with Plan.
- 2.1.2 Consultancy income is £63k under budget; TCS under target by £9k and departmental consultancy under by £54k. Other Income is £50k below target mainly due to under achieved productivity schemes in Adult £45k and Adolescent £22k. Clinical Income is £50k above target: this includes the Day Unit being £21k above Plan, and £50k of one-off items, offsetting other shortfalls. These main income sources and their variances are discussed in sections 3, 4 and 5 below. Income over the first three months will have been affected by the unusual number of holidays in April and by the current work on service redesign.
- 2.1.3 The cumulative expenditure under spend of £73k is due to £22k on non-pay and £51k on pay across the organisation. The majority of the non-pay under spend is £71k within DET apportioned across the courses and departments; this has been offset by over spends of £30k in IT for Maintenance, £24k in HR due to legal costs and £27k in TCS for consultancy fees.
- 2.1.4 Although the total pay budget is £51k under spent, CAMHS is currently £155k over spent. This is partially due to the rephasing of the vacancy control factor which had an adverse effect of £84k. The vacancy control factor was rephased to reflect the likely profile of vacancies across the year, with fewer vacancies in the latter part of the year due to the planned restructure and voluntary redundancy scheme.
- 2.1.5 24 applications for voluntary redundancy have been approved. Some of these staff have already left; and with at most 2 exceptions, the leaving dates are on or before 9 September. Costs will be reduced slightly earlier than expected, and the budget requirement to find an additional £500k savings should be achieved.
- 2.1.6 The redundancy and early retirement costs for these 24 staff are

estimated at £900k, and this amount has been accrued in June, though the payments will be made in the coming months. The costs are therefore reported slightly earlier than in the Plan, but the overall forecast for the year is unaffected by this timing change. A small number of further redundancies may be agreed, bringing the total cost up to – or possibly slightly exceeding – the planned figure of £1,000k.

2.1.7 Without effective action and controls, forecast income for the year would be £155k below budget as in Appendices A and B. Larger shortfalls than this should be covered firstly by the under spending discussed above; and then by the budgeted contingency reserve. As work on service redesign progresses, attention also needs to focus on delivery of income against Plan.

2.2 Cash Flow (Appendix C)

2.2.1 The actual cash balance at 30June was £2,536k, compared to the revised Plan of £3,316k. Receipts from NHS, General Debtors, SHA and Students are all below Plan; £216k of the General Debtors shortfall is due to a delayed agreement with a partner organisation which is now resolved, so payment should be in August. Payments to Suppliers were also below Plan. Debt recovery is currently being reviewed and action plans are to be agreed: internally for student debt, and with SBS for other sources of income.

	Cash Flow year-to-date		
	Actual £000	Plan £000	Variance £000
Opening cash balance	4,712	4,712	0
Operational income received			
NHS (excl SHA)	1,757	1,823	(66)
General debtors (incl LAs)	1,135	1,676	(541)
SHA for Training	2,675	2,762	(87)
Students and sponsors	452	600	(148)
Other	56	54	2
	6,075	6,915	(840)
Operational expenditure payments			
Salaries (net)	(3,655)	(3,628)	(27)
Tax, NI and Pension	(2,743)	(2,687)	(56)
Suppliers	(1,744)	(1,954)	210
	(8,142)	(8,269)	127
Capital Expenditure	(112)	0	(112)
Interest Income	3	3	0
Payments from provisions	0	(45)	45
PDC Dividend Payments	0	0	0
Closing cash balance	2,536	3,316	(780)

2.2.2 The cash forecast allows for some delayed receipts (including the £216k mentioned above) to come in over the next few months, and for other items to be largely in line with Plan. The projections are cautious, and at present the year-end balance is forecast at £528k, lower than Plan; but this will be reviewed further in September, and should increase, subject as always to achieving our income and expenditure plan.

2.3 Training

2.3.1 Training income is £32k above budget in total after the first quarter, with higher course and fee income; there is a shortfall on Child Psychotherapy Trainees but this is due to slightly lower numbers, and is offset by lower costs.

2.3.2 Income from university partners is expected to be close to budget. Initial indications of student recruitment for the academic year starting in October are reported separately to this meeting. At this stage, there is no reason to expect fee income from students and sponsors to be short of budget; but this will not be known more firmly until October.

2.4 Better Payment Practice Code

2.4.1 The Trust has a target of 95% of invoices to be paid within the terms. Up to 30 June, we have achieved 91% for Non NHS invoices and 90% for all invoices.

2.5 Statement of Financial Position (aka Balance Sheet)

2.5.1 Appendix D reports the SoFP at 30 June, compared to Plan and also to the opening balances for the year. As reported above, restructuring costs have been accounted for in June rather than in September and October as assumed in the Plan; this has increased the current liabilities, and is the primary reason that the overall figure for Assets Employed is £948k below Plan. Debtors are also higher than Plan, but this includes £1,047k of accrued income.

2.6 Capital Expenditure

2.6.1 Up to 30 June, expenditure on capital projects was £116k. The majority of which was £78k towards the boiler replacement project. The table below details the 2011/12 annual budget and the current spend to date against each of the individual projects.

Capital Projects 2011/12

	Budget for full year	Actual to June 2011
	£000	£000
Day Unit Relocation	50	0
Seminar Room / Common Room	44	3
Toilets	95	0
Electrical Boards	45	0
Boiler Replacement	175	78
Total Estates	409	81
IT	250	35
Total Capital Programme	659	116

3. Patient Services

3.1 Activity and Income

- 3.1.1 All contract values have now been agreed. Total contracted income for the year is in line with budget. After three months, there is a small favourable variance on cost and volume activity of £14k. However, this includes an under performance of £8k with Haringey. Camden Adults are currently over performing by 42% but the contract only allows for 2.5% to be paid. Part of the budgeted income for the year is dependent on meeting our CQUIN¹ targets agreed with commissioners and achievement is reviewed on a quarterly basis.
- 3.1.2 Variances in other elements of clinical income are shown in the next table.
- 3.1.3 The income for Named Patient Agreements (NPAs) was £44k after three months which is £13k below budget, with £4k shortfalls in both Adult and the Portman. The forecast for the year without action would be a shortfall of £80k.
- 3.1.4 Court report income (which is budgeted at £285k for the year, of which £210k is for the Portman) was £1k above budget after three months.
- 3.1.5 Monroe income is above budget by £5k after 3 months. The annual budget was reduced from £780k to £504k this year.
- 3.1.6 Day Unit was £21k above target as they had 14 pupils against a budgeted target of 12.5. However, student numbers are likely to decrease over the year.
- 3.1.7 Project income is £54k above budget year-to-date, including some one-off items (2.1.2 above). The forecast is £50k above budget for the year.

¹ Commissioning for Quality and Innovation

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	2,374	2,353	-0.9%		-33	Small underachievement due to CQUIN element plus old year credit note.
Cost and vol variances	2	14			7	
NPAs	57	44	-21.7%	-50	-80	
Projects and other	489	543		-	50	Income matched to costs, so variance is largely offset.
Day Unit	264	285	8.0%	84	0	
Monroe	114	119	4.8%	24	0	
FDAC 2nd phase	103	92	-10.8%	-42	-31	Income matched to costs, so variance is largely offset.
Court report	71	72	1.5%	4	0	
Total	3,474	3,523		20	-87	

3.2 **Clinical performance** (provided by the Director of Service Development & Strategy)

3.3 There were a total of 33 waits of 11+ weeks for first attended appointments across the Trust services during Quarter 1. Of these 19 were in GIDS; new staff are now being recruited (slightly later than budgeted) and will increase the capacity of this service.

4. **Consultancy**

4.1 TCS income was £143k up to June, compared to the budget of £152k. Current forecasts for July expect the in-month budget of £51k to be exceeded by £20k. Our forecast for the year assumes at present that budget is achieved for the remaining nine months.

4.2 Departmental consultancy is £55k below budget after three months. The majority of the shortfall is within CAMHS which is currently £50k below target. Actions to recover the shortfall will be required to deliver against Plan.

Mr Simon Young
Director of Finance
15th July 2011

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

APPENDIX A

		Jun-11			CUMULATIVE			FULL YEAR 2011-12		
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST OUTTURN £000	BUDGET VARIANCE £000
INCOME										
1	CLINICAL	1,161	1,262	101	3,474	3,523	50	13,899	13,803	(95)
2	TRAINING	1,342	1,388	45	3,944	3,976	32	16,544	16,598	54
3	CONSULTANCY	110	99	(11)	324	261	(63)	1,351	1,287	(63)
4	RESEARCH	14	6	(8)	42	19	(23)	167	167	0
5	OTHER	68	72	4	204	154	(50)	818	767	(50)
TOTAL INCOME		2,696	2,827	131	7,988	7,933	(55)	32,778	32,623	(155)
OPERATING EXPENDITURE (EXCL. DEPRECIATION)										
6	CLINICAL DIRECTORATES	1,436	1,533	(97)	4,301	4,423	(122)	17,303	17,391	(89)
7	OTHER TRAINING COSTS	578	552	26	1,652	1,492	160	7,098	7,028	70
8	OTHER CONSULTANCY COSTS	52	67	(15)	156	158	(2)	589	553	36
9	CENTRAL FUNCTIONS	536	565	(28)	1,613	1,576	38	6,355	6,351	4
10	TOTAL RESERVES	0	0	0	0	0	0	399	266	133
TOTAL EXPENDITURE		2,603	2,716	(114)	7,723	7,649	74	31,744	31,589	155
EBITDA		93	111	17	266	284	19	1,034	1,034	(0)
ADD:-										
12	BANK INTEREST RECEIVED	1	1	(0)	3	3	(0)	11	11	0
LESS:-										
11	DEPRECIATION	42	42	(0)	127	127	(0)	509	509	0
13	FINANCE COSTS	0	0	0	0	0	0	0	0	0
14	DIVIDEND	32	32	(0)	96	97	(0)	386	386	0
RETAINED SURPLUS BEFORE RESTRUCTURING		20	37	17	45	63	19	150	150	(0)
15	RESTRUCTURING COSTS	0	901	(901)	0	901	(901)	1,000	1,000	0
RETAINED SURPLUS AFTER RESTRUCTURING		20	(863)	(884)	45	(837)	(882)	(850)	(850)	(0)
EBITDA AS % OF INCOME		3.5%	3.9%		3.3%	3.6%		3.2%	3.2%	

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

APPENDIX B

	Jun-11			CUMULATIVE			FULL YEAR 2011-12		
	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST £000'S	REVISED BUDGET VARIANCE £000
INCOME									
1 NHS LONDON TRAINING CONTRACT	605	605	0	1,814	1,814	0	7,254	7,254	0
2 TRAINING FEES & OTHER ACA INC	480	535	55	1,356	1,410	54	6,028	6,081	54
3 POSTGRADUATE MED & DENT'L EDUC	24	14	(10)	35	26	(10)	141	141	0
4 JUNIOR MEDICAL STAFF	69	77	9	242	256	15	966	966	0
5 CHILD PSYCHOTHERAPY TRAINEES	166	158	(8)	498	471	(27)	2,155	2,155	0
6 R&D	14	6	(8)	42	19	(23)	167	167	0
7 CLINICAL INCOME	964	1,022	57	2,900	2,931	31	11,554	11,467	(87)
8 DAY UNIT	88	89	1	264	285	21	1,055	1,055	0
9 MONROE	44	47	3	114	119	6	504	504	0
10 FDAC	42	65	24	125	116	(9)	500	491	(9)
11 TCS INCOME	47	49	2	152	143	(9)	613	605	(9)
12 DEPT CONSULTANCY INCOME	63	50	(13)	173	118	(55)	737	682	(55)
13 COURT REPORT INCOME	24	40	16	71	72	1	285	286	1
14 EXCELLENCE AWARDS	10	10	0	29	29	0	116	116	0
15 OTHER INCOME	58	62	4	175	125	(50)	702	651	(50)
TOTAL INCOME	2,696	2,827	131	7,988	7,933	(55)	32,778	32,623	(155)
EXPENDITURE									
16 EDUCATION & TRAINING	390	365	25	1,088	970	119	4,679	4,620	59
17 PORTMAN CLINIC	110	129	(19)	330	342	(12)	1,316	1,316	0
18 ADULT DEPT	259	250	9	778	770	8	3,109	3,109	0
19 MEDNET	21	25	(5)	62	50	11	246	235	11
20 ADOLESCENT DEPT	132	163	(31)	396	427	(32)	1,723	1,723	0
21 C & F CENTRAL	668	713	(46)	2,016	2,161	(145)	8,075	8,175	(100)
22 MONROE & FDAC	91	104	(13)	274	253	20	905	905	0
23 DAY UNIT	64	67	(3)	192	194	(2)	751	751	0
24 SPECIALIST SERVICES	84	72	12	230	212	18	1,083	1,083	0
25 COURT REPORT EXPENDITURE	8	10	(2)	24	12	11	95	95	0
26 TRUST BOARD & GOVERNORS	9	10	(1)	26	28	(2)	106	106	0
27 CHIEF EXECUTIVE OFFICE	26	27	(1)	78	78	(1)	311	311	0
28 PERFORMANCE & INFORMATICS	58	58	(0)	186	180	7	708	701	7
29 FINANCE & ICT	101	111	(10)	304	321	(17)	1,200	1,220	(20)
30 CENTRAL SERVICES DEPT	182	178	4	546	535	11	2,165	2,165	0
31 HUMAN RESOURCES	55	59	(5)	169	188	(19)	646	665	(19)
32 CLINICAL GOVERNANCE	35	55	(20)	102	93	9	409	400	9
33 TRUST DIRECTOR	37	45	(7)	101	93	8	403	395	8
34 PPI	19	15	4	58	48	10	231	221	10
35 SWP & R&D & PERU	22	20	2	66	44	22	264	264	0
36 R&D PROJECTS	0	0	0	0	0	0	0	0	0
37 PGMDE	5	8	(3)	16	13	2	63	63	0
38 NHS LONDON FUNDED CP TRAINEES	166	165	1	498	471	26	2,155	2,155	0
39 TAVISTOCK SESSIONAL CP TRAINEES	7	7	0	22	20	2	88	88	0
40 FLEXIBLE TRAINEE DOCTORS	9	7	3	28	17	11	113	102	11
41 TCS	48	60	(12)	145	146	(1)	542	506	36
42 DEPARTMENTAL CONSULTANCY	4	7	(3)	11	12	(1)	47	47	0
43 DEPRECIATION	42	42	(0)	127	127	(0)	509	509	0
44 PROJECTS CONTRIBUTION	(7)	(13)	6	(22)	(32)	10	(87)	(98)	10
45 IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	(0)	0	0	(0)	0
46 CENTRAL RESERVES	0	0	0	0	0	0	399	266	133
TOTAL EXPENDITURE	2,645	2,759	(114)	7,850	7,776	74	32,253	32,098	155
OPERATING SURPLUS/(DEFICIT)	51	68	17	138	157	19	525	525	(0)
47 INTEREST RECEIVABLE	1	1	0	3	3	0	11	11	0
48 UNWINDING OF DISCOUNT ON PROVISION	0	0	0	0	0	0	0	0	0
49 DIVIDEND ON PDC	(32)	(32)	(0)	(96)	(97)	(0)	(386)	(386)	0
SURPLUS/(DEFICIT) BEFORE RESTRUCTURING	20	37	17	45	63	19	150	150	(0)
50 RESTRUCTURING COSTS	0	901	(901)	0	901	(901)	1,000	1,000	0
SURPLUS/(DEFICIT) AFTER RESTRUCTURING	20	(863)	(883)	45	(837)	(882)	(850)	(850)	(0)

Appendix C

Cash Flow 2011/12

2011/12 Plan

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	4,712	4,770	4,010	3,316	2,872	2,366	1,607	1,401	1,422	1,118	1,572	1,505	4,712
Operational income received													
NHS (excl SHA)	541	623	659	976	1,007	890	877	1,008	888	877	1,009	888	10,243
General debtors (incl LAs)	742	374	560	519	425	650	533	485	450	839	565	472	6,614
SHA for Training	914	934	914	914	933	914	914	934	914	914	934	914	11,047
Students and sponsors	300	150	150	100	0	200	650	250	100	500	100	100	2,600
Other	18	18	18	18	18	18	18	18	18	18	18	18	216
	2,515	2,099	2,301	2,527	2,383	2,672	2,992	2,695	2,370	3,148	2,626	2,392	30,720
Operational expenditure payments													
Salaries (net)	(1,209)	(1,210)	(1,209)	(1,210)	(1,209)	(1,710)	(1,661)	(1,162)	(1,161)	(1,162)	(1,161)	(1,161)	(15,225)
Tax, NI and Pension	(900)	(894)	(894)	(894)	(894)	(894)	(894)	(858)	(858)	(858)	(858)	(858)	(10,554)
Suppliers	(349)	(756)	(849)	(761)	(687)	(576)	(584)	(595)	(605)	(614)	(615)	(613)	(7,604)
	(2,458)	(2,860)	(2,952)	(2,865)	(2,790)	(3,180)	(3,139)	(2,615)	(2,624)	(2,634)	(2,634)	(2,632)	(33,383)
Capital Expenditure	0	0	0	(100)	(100)	(60)	(60)	(60)	(50)	(60)	(60)	(109)	(659)
Interest Income	1	1	1	0	1	1	1	1	1	0	1	1	10
Payments from provisions	0	0	(45)	(6)	0	0	0	0	0	0	0	0	(51)
PDC Dividend Payments	0	0	0	0	0	(193)	0	0	0	0	0	(193)	(386)
Closing cash balance	4,770	4,010	3,316	2,872	2,366	1,607	1,401	1,422	1,118	1,572	1,505	963	963

2011/12 Actual/Forecast

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	4,712	3,376	3,516	2,536	2,375	1,932	1,172	966	987	684	1,137	1,070	4,712
Operational income received													
NHS (excl SHA)	691	725	341	1,109	1,007	890	877	1,008	888	877	1,009	888	10,310
General debtors (incl LAs)	618	238	279	519	425	650	533	485	450	839	565	472	6,073
SHA for Training	0	1,707	968	914	933	914	914	934	914	914	934	914	10,960
Students and sponsors	198	92	162	200	0	200	650	250	100	500	100	100	2,552
Other	4	22	30	18	18	18	18	18	18	18	18	18	218
	1,511	2,784	1,780	2,760	2,383	2,672	2,992	2,695	2,370	3,148	2,626	2,392	30,113
Operational expenditure payments													
Salaries (net)	(1,243)	(1,210)	(1,202)	(1,210)	(1,209)	(1,710)	(1,661)	(1,162)	(1,161)	(1,162)	(1,161)	(1,161)	(15,252)
Tax, NI and Pension	(900)	(917)	(926)	(894)	(894)	(894)	(894)	(858)	(858)	(858)	(858)	(858)	(10,609)
Suppliers	(705)	(497)	(542)	(761)	(687)	(576)	(584)	(595)	(605)	(614)	(615)	(613)	(7,394)
	(2,848)	(2,624)	(2,670)	(2,865)	(2,790)	(3,180)	(3,139)	(2,615)	(2,624)	(2,634)	(2,634)	(2,632)	(33,255)
Capital Expenditure	0	(21)	(91)	(50)	(38)	(60)	(60)	(60)	(50)	(60)	(60)	(109)	(659)
Interest Income	1	1	1	0	1	1	1	1	1	0	1	1	10
Payments from provisions	0	0	0	(6)	0	0	0	0	0	0	0	0	(6)
PDC Dividend Payments	0	0	0	0	0	(193)	0	0	0	0	0	(193)	(386)
Closing cash balance	3,376	3,516	2,536	2,375	1,932	1,172	966	987	684	1,137	1,070	528	528

Appendix D

STATEMENT OF FINANCIAL POSITION

	Plan	Actual	Actual
	30 June 2011	30 June 2011	31 March 2011
	£000	£000	£000
Non-current assets			
Intangible assets	105	130	111
Property, plant and equipment	12,682	12,701	12,603
Total non-current assets	12,787	12,831	12,714
Current assets			
Inventories	1	1	1
Trade and other receivables incl. accrued income	1,533	2,808	2,422
Cash and cash equivalents	4,310	2,529	4,712
Total current assets	5,844	5,338	7,135
Current liabilities			
Trade and other payables	(1,112)	(461)	(2,031)
Provisions	(6)	(31)	(51)
Tax payable	(550)	(565)	(558)
Other liabilities incl. deferred income	(3,113)	(4,210)	(3,469)
Total current liabilities	(4,781)	(5,267)	(6,109)
Total assets less current liabilities	13,850	12,902	13,740
Non-current liabilities			
Provisions	(60)	(60)	(60)
Total non-current liabilities	(60)	(60)	(60)
Total assets employed	13,790	12,842	13,680
Financed by (taxpayers' equity)			
Public Dividend Capital	3,403	3,403	3,403
Revaluation reserve	7,840	7,840	7,840
Income and expenditure reserve	2,518	1,599	2,437
Total taxpayers' equity	13,761	12,842	13,680

Board of Directors : July 2011

Item : 7b

Title : Quarter 1 Governance, Quality & Finance Declarations

Summary:

The Board is asked to approve three declarations to Monitor for Quarter 1:

- The Board confirms that all targets and indicators have been met (after application of thresholds) over the period and that sufficient plans are in place to ensure that all known targets and indicators which will come into force during 2011/12 will also be met.
- The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.
- The Board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months

This report has been reviewed by the Management Committee on 14 July.

This report focuses on the following areas:

- Quality
- Patient / User Safety
- Risk
- Finance

For : Approval

From : Director of Corporate Governance and Facilities;
Trust Director;
Director of Finance & SIRO

Quarter 1 Governance, Quality and Finance Declarations

1. In-year Governance Declaration

1.1 Performance against healthcare targets and indicators

1.1.1 The Monitor template for our quarterly return sets out a list of targets and indicators, in line with the Compliance Framework 2011/12 document. The targets and indicators which apply to this Trust are given in the table below.

1.1.2 All 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	Weighting	Quarter 1 Result	
Data completeness: 99% completeness on all 6 identifiers	0.5	Achieved	
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	0.5	Achieved	
Indicator	Weighting	Quarter 1 Result	
Risk of, or actual, failure to deliver mandatory services	4.0	No	
CQC compliance action outstanding	2.0	No	
CQC enforcement notice currently in effect	4.0	No	
Moderate CQC concerns regarding the safety of healthcare provision	1.0	No	
Major CQC concerns regarding the safety of healthcare provision	2.0	No	
Unable to maintain, or certify, a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements	2.0	No	
		Total score	0
		Indicative rating	

1.2 Care Quality Commission registration

1.2.1 The Trust was registered by the CQC on 1 April 2010 with no restrictions. Actions continue to ensure that this status is retained; assurance is considered at the quarterly meetings of the CQSG Committee.

1.2.2 The Trust remains compliant with the CQC registration requirements.

1.3 Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability

1.3.1 The self-certification was reviewed and approved by the Board in April 2010.

1.4 Data Completeness

1.4.1 As reported previously, this target is now 99% completeness on *six* data identifiers. The Informatics department confirm that we met this target in the first quarter:

	% Completeness
Commissioner Code	100%
Registered GP Practice	99%
Gender	100%
Birth Date	100%
Postcode	100%
NHS Number	100%

1.5 Other matters

1.5.1 The Trust is required to report any other risk to compliance with its authorisation. The Compliance Framework gives – on pages 62 and 63 – a non-exhaustive list of examples where such a report would be required, including unplanned significant reduction in income or increase in costs; breach of borrowing limits; removal of a director for abuse of office; or significant non-contractual dispute with an NHS body.

1.5.2 There are no such matters on which the Trust should make an exception report.

2. Quality declaration

2.1 At the time of approving the Annual Plan in May, the Board reviewed this declaration in some depth and approved it. The

arrangements are unchanged since then, and no event has occurred to alter our view.

3. Finance declaration

- 3.1 The Annual Plan showed that the Trust expected to retain a Financial Risk Rating of 3 for each quarter of 2011/12 and for both the following years. This month's finance and performance report shows that while risks to this result remain, we expect to achieve it.

4. Conclusion

- 4.1 This report has been compiled in collaboration with the Director of Governance and Facilities, and the Trust Director. We believe that it gives the Board the assurance needed in order to approve all three declarations.

Simon Young
Director of Finance
14 July 2011

Board of Directors : July 2011

Item : 8

Title : Education and Training Report

Summary:

This report covers the following items:

1. Introduction
2. Financial Position at July 2011
3. Recruitment position at end of June 2011
4. Negotiations on renewal of National Training Contract
5. Update on E-Learning

This report has been reviewed by the Management Committee on 14 July.

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:

- Risk
- Finance

For : Discussion

From : Dean

Education & Training Report

1. Introduction

- 1.1 The Government's "pause for reflection" has included education and training commissioning in the NHS. However, we have been told that the NHS London Education commissioning structure and plan have been authorised to continue development and the Trust has been actively involved in all consultations with the current commissioners and working for full compliance with our four current Contract Managers.
- 1.2 There have been indications that education and training commissioning funding is to be protected in the next financial year, but we fully expect either a further efficiency reduction, or, at best, flat funding for 2012/13.
- 1.3 Indications are that our reputation for high quality, the buoyancy of our year on year recruitment and our entrepreneurial enthusiasm are understood by the SHA and our National Contract Managers are willing to spend more time in discussion of our plans and how to put our ideas forward, encouraging our e-learning project and supporting our enterprise.
- 1.4 Reorganisation of courses into clusters in CAMHS and SAMHS is planned and proposed clusters of Tutors and administrators will be asked to comment on how best to deploy fewer resources. Clustering of courses has been widely welcomed and there is broad understanding that high AFC banding will no longer be automatic for Organising Tutors. Cluster or Portfolio Managers are expected to take managerial responsibility for delivery of financial and quality targets and manage tasks and planning of shared modules where practicable.
 - 1.4.1 Course leads and distinctive course identities will be preserved. The plan will be developed in shadow form during the first term of the new academic year.
 - 1.4.2 Savings are not expected immediately except in some visiting lecturer budgets where available time in staff work plans will be used for teaching where possible.
- 1.5 The post of Dean and Director of Education and Training has been advertised with a view to making a September appointment with an expectation of the new post-holder taking up the role in January 2012.

2. Financial Position at July 2011 (Appendix 1)

- 2.1 Forecasts indicate that we are broadly on plan to deliver on Plan. We are currently showing a small negative variance of £12,602.
- 2.2 CPD programme and recruitment are set to grow (Appendix 3) in-year as new ideas are developed and we have already delivered some successful conferences and have other major events planned for September.
- 2.3 HEFCE (higher education funding) will remain broadly the same as last year, but looking forward there will be year on year decreases in M-level funding (levels to be announced this week to universities) and zero funding for M-level courses by 2013/14. We have validated all our professional doctorates as research degrees and, subject to a consultation by HEFCE, there may be a chance of retaining student number funding for around 150 professional doctorate students after that date.
- 2.4 In view of the above we shall embark on planning for tuition fee increases to replace the declining HEFCE which will need to be linked to sound communication through the website and other channels about the reasons why we, like the universities, will need to raise fees considerably to cover our costs. We shall need to be mindful of the need to manage recruitment levels, in line with the conditions of our National Contract. Students and potential students will be well aware of the rise in all tuition fees and we shall probably be able to keep fees relatively lower than our competitors, while still delivering better student-teacher ratios and small group and individual teaching and supervision where required.

3. Recruitment position end of June 2011 (Appendix 2)

- 3.1 Recruitment for 2011/12 is broadly in line with the position at the end of June 2010. One or two courses are recruiting less well and explanations are offered in the notes to the recruitment table.
- 3.2 There are one or two courses which are cause for concern – marked red or amber in the Appendix 2, and we have initiated further targeted marketing on the web and using our current students to encourage inquiries from colleagues and friends who are likely to be interested in our approach.
- 3.3 There is uncertainty about whether all who apply and are offered places taking them up if funding or day release or both are withdrawn so we shall not be confident of the position until we

report to the Management Committee and the Board of Directors with more solid information in October and November 2011. I shall report in September 2011 on the position at that point.

- 3.4 E-learning developments need to be actively pursued to compensate for any potential recruitment deficit in our existing programmes.

4. Negotiations on renewal of National Training Contract

- 4.1 Two meetings to consider the annual report on 2010/11 and a new National Contract have taken place.
- 4.2 Renewal of the contract is expected for October 2011, providing continuity.
- 4.3 Discussions have focused on encouragement for boldness in describing our achievements and our approach and in briefing our Contract Managers about our e-learning strategy and plans so that the Contract Managers can put the Trust's case to its commissioners of non-medical education and training (CNMET) in July, and its Education Commissioning System Management Group in August.
- 4.4 It is hoped to renew the National Contract for five years, if possible and include clauses about the level of reduction in any given year. We would like to expect level funding for the coming financial year but decisions on levels of efficiency savings will be made nationally.
 - 4.4.1 An indication was provided that we expect to continue to deliver traditional M- and D-level courses and CPD where recruitment appears to be holding up, except in children's social work.
 - 4.4.2 The Trust will seek academic accreditation of some CPD with university partners.
 - 4.4.3 The Trust's relational training model will not be changed by its aims with e- and distance-learning. There will be experimentation with didactic distance learning modules and written assignments, but clinical students will join face to face groups at the Tavistock Centre or other centres supplemented by trying out small group teaching using Skype and Elluminate Live. Synchronous and asynchronous learning will be developed. On-line modules that are self-contained will inevitably be trialled and developed.
 - 4.4.4 The e-learning plan is incremental and not to be delivered at the expense of current delivery.

5. E-Learning Update (Appendix 4)

- 5.1 The E-Learning Unit has accomplished its first phase of establishment and has developed appropriate working practices – in staff training, project development, financial planning, marketing and support for the subject experts. There are promising developments in terms of partnerships particularly with the OU and also with NHS London.
- 5.2 Priorities have been identified for the next period.
- 5.3 Initial income targets may be optimistic but longer term forecasts remain promising. An active campaign is launched to encourage staff across the Trust to achieve £30k income from internet video supervision.

Ms Trudy Klauber
Dean
15th July 2011

Training Fees and Other Academic Income 2010/11

Appendix 1

<u>Education and Training</u>	<u>July 2011</u>	<u>Financial Year 11/12 Plan</u>											
Training fees and other academic income	AY 09/10	AY 10/11	AY10/11	AY10/11	AY11/12	AY11/12	FY 10/11	FY 10/11	FY 10/11	FY11/12	FY11/12	FY11/12	Notes
	<u>Actual</u>	<u>Plan</u>	<u>Forecast</u>	<u>Actual</u>	<u>Plan</u>	<u>Forecast</u>	<u>Plan</u>	<u>Actual</u>	<u>Variance</u>	<u>Plan</u>	<u>Forecast</u>	<u>Variance</u>	
	£	£	£	£	£	£	£	£	£	£	£	£	
Contract Income													
National training contract										7,383,980	7,383,980	0	(1)
Child Psychotherapy trainee salaries										1,796,758	1,769,433	-27,325	(2)
Child Psychotherapy tuition	376,896	397,264	405,381	409,992	393,992	401,992	390,925	405,139	14,214	374,925	405,325	30,400	
LCPPD b/f							95,000	0	-95,000	62,272	62,272	0	
NHSL CPPD	233,985	220,000	266,231	266,231	240,000	233,802	225,827	210,987	-14,840	250,930	247,314	-3,615	
	610,881	617,264	671,612	676,223	633,992	635,794	711,752	616,126	-95,626	688,127	714,911	26,785	
<u>Other Training and Academic Income</u>													
Tuition Fees	2,208,105	2,356,683	2,281,127	2,361,388	2,478,328	2,478,328	2,299,515	2,233,016	-66,499	2,382,643	2,356,750	-25,893	(3)
Partner Centres	74,130	61,295	70,429	62,400	70,000	60,000	61,295	71,971	10,676	68,971	61,000	-7,971	(4)
Commissioned Income	363,258	394,584	366,799	347,543	409,205	402,278	381,692	354,091	-27,601	356,933	379,472	22,538	(5)
Fee Income	2,645,493	2,812,562	2,718,355	2,771,331	2,957,533	2,940,606	2,742,502	2,659,078	-83,424	2,808,548	2,797,222	-11,325	
HEFCE	833,932	583,681	744,046	729,334	638,840	640,750	626,764	852,368	225,605	682,676	677,660	-5,016	(6)
CPD Courses							233,309	397,113	163,804	362,921	352,000	-10,921	(7)
Research funding							23,252	12,752	-10,500	0	10,000	10,000	(8)
E-learning							10,000	0	-10,000	30,000	30,000	0	(9)
Conferences							137,700	76,251	-61,449	84,800	90,000	5,200	(10)
CWDC Income							137,059	83,226	-53,834	103,770	103,770	0	
Other Income							1,168,084	1,421,710	253,626	1,264,166	1,263,430	-737	
							4,622,337	4,696,913	74,576	4,760,841	4,775,563	14,723	
										13,941,579	13,928,976	-12,602	

Notes

(1) Reduction of 3% on previous financial year

(3) AY10/11 credits in new financial year

(5) Exact fees for 3 cohorts through SEEL updated

(7) Nearing target - will be compensated by conference income

(9) On target

(2) Payments to be uplifted in Q3 to reflect new starters

(4) Budget reflect M7D income in error

(6) Low rates assumed in budget should buffer against PGT, now PGR in AY11/12; HEFCE claim may be lost

(8) Funds b/f from previous FY

(10) Will exceed target but remaining prudent at Q1

Appendix 2

Course Recruitment Comparison Data 2010/11

Course Code	2010/11 at June 2010	2010/11 at June 2011	Course Code	2010/11 at June 2010	2010/11 at June 2011
CPD25		3	D82		
D1	19	11	D86		7
D10	2	11	D9	5	2
D10D	2	2	D90		1
D11	5	7	M1	4	6
D12	24	29	M10	3	4
D18	8	6	M14	3	
D1R			M16	21	18
D24	15	14	M21	6	6
D30	7	11	M22	4	4
D32	1		M25	2	3
D34	1		M26	3	5
D35	2	1	M3		
D35/M35	1		M33	5	1
D4	27	58	M34		4
D42	1		M4	1	
D4AK	1	3	M42	2	1
D4AL	1		M5	5	4
D4AS		1	M6	1	33
D4K	6	1	M7	71	67
D4S	1	3	M7D	2	
D4X	2	2	M7K	1	
D58	41	38	M7L	3	
D58L	8	5	M7O		1
D59	17	12	M80	2	
D60	7	7	M80 As. Centres	1	
D60M	3	1	M9	10	9
D65	6	12	P20	3	6
D67	8	8	PC4	4	7
D7		2	PC4INT		1
D77	1				

	2010/11 at June 2010	2010/11 at June 2011
Total	406	416

Difference < 5	
Difference 5 – 10	
Difference > 10	

1. Course Recruitment

1.1 Recruitment is looking somewhat similar to the situation exactly a year ago which is hopeful.

1.2 Final student numbers for these courses, across all years, were 834.

- 1.3 We have RAG rated differences year on year and we know that D10 (*Consultation and the Organisation*) had an anomalous year in 2010-11 – we have speculated this related to redundancies and potential redundancies in the public sector, since D12 also did very well – *Introduction to Counselling and Psychotherapy*. Both courses create the potential for a change of career.
- 1.4 We have actually recruited many more students to M6 Systemic Psychotherapy training this year, but these have not yet been approved and enrolled. M7 usually recruits 50 or more per year.
- 1.5 D65 is an Advanced Diploma for mental health nurses and we had no commissions from NHS London Trusts for 2011-12, these went instead to Tavistock Consulting programmes.
- 1.6 D65 course team is creating an honours degree programme to recruit Project 2000 Nurses who are required to become graduates within a very few years from now. Funding is difficult as is staff release.
- 1.7 Course D1 is a course for teachers which traditionally recruits 11-18 students in year 1 and it recruits late (August and September).

Appendix 3

CPD Update July 2011¹

INCOME			See Note 1 See Notes 2 & 3	Predicted ²
Department	2009/10	2010/11		2011/12
CAMHS	£116,816	£180,207		£137,000
Adolescent	£136,556	£107,549		£105,000
Adult	£17,152	£50,921		£45,000
Portman	£21,838	£21,648		£25,000
TCS	n/a	£26,540		£40,000
Total	£292,362	£386,865		£352,000

STUDENT NUMBERS		
Department	2009/10	2010/11
CAMHS	423	498
Adolescent	282	277
Adult	184	345
Portman	101	81
TCS	n/a	24
Total	990	1,225

Notes

1. CPD58 (c. £50K) only runs every two years, ran in March 11, did not run in FY 2009/10
2. CPD59 income not shown - moved to April (previously held in March) in 2011 so will show up in 2011/12 figures (c. £22K)
3. CPD61 moved from adolescent to Tav.Cons. service line (c. £26K)
4. Income derived from NHS London internal funding not included in these figures

¹ Figures as per financial year 2010/11 (reported by academic year in July 2010). Gross income shown

² Predicted income of courses confirmed as of 06/07/2011. More training courses will be planned over the year and this figure will increase

Appendix 4

E-Learning Activities

Table 1: E-learning activities within the project and current status

Objectives	Start date	Projected completion date	Status
Establish Unit with regular meetings and method of work	Jan 2011	May 2011	Completed
Appointment of staff; Project Manager post	Jun 2011	End of Jun 2011	In progress
Developing partnerships	Jan 2011	Expected to have draft agreement with OU 24/06/2011	In progress
Staff training first phase: Skype; Elluminate Live; Wimba Create	Feb 2011	May 2011	Completed
Staff training second phase: Elluminate Live; Wimba Create	Jun 2011	Jul 2011	In progress
Development of filming skills team to create video content pod and vod	Apr 2011	First projects filmed Jun 2011	Completed
Delivering Skype supervisions	Feb 2011	Some initial take-up but short of expected	In progress
Developing and producing e-distance learning projects using live and any time methods	Mar 2011	Initial projects being managed	In progress
Identification of core modules for distance learning development through curriculum review	Jun 2011	Oct 2011	In progress

Board of Directors : July 2011

Item : 9

Title : Service Line Report: Developmental CAMHS

Summary:

CAMHS developmental Service line report, statistics for previous year and proposed changes.

This report has been reviewed by the following Committees:

- Management Group 14th July 2011

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

This report focuses on the following areas:

- Quality
- Risk
- Finance

For : Discussion

From : Associate Clinical Director, CAMHS

Service Line Report – Developmental CAMHS

Executive Summary

1. Introduction

- 1.1 The service line consists of four teams that between them provide a generic CAMH service for 21 contractual areas (currently PCTS), specialist autism and learning and complex disabilities work, and a community based drug and alcohol service for young people in Barnet.

2. Areas of Risk and/or Concern

- 2.1 In the current financial climate all contracts are at risk. Work with commissioners / GPs and local providers are essential to ensure our contracts are maintained and developed.
- 2.2 The Service Line is undergoing a complete reorganisation. We are introducing 'consultation and review' clinics and clinical clusters. The drivers for this are:
 - 2.2.1 To improve the quality of the service we provide (though better care planning, outcome measurement, linking with research and training)
 - 2.2.2 To make productivity savings (i.e. to reduce our outgoings to be in line with our income)
 - 2.2.3 To develop a better structure for growth (to have clusters that will better support the development of clinical research and specialist trainings / CPD)
 - 2.2.4 To better develop and quantify our unique contribution to CAMHS
- 2.3 Any significant change process involves risks; to posts, staff morale initially, and coherence.
- 2.4 A further risk is the need to ensure that we meet the CQUIN targets, as we may be financially penalised if not.

3. Proposed Action Plan

- 3.1 As part of the Trust-wide Productivity Programme, a dedicated working group has been working on developing service models that

will reduce costs. This working group pre-dated the Productivity Programme and had been working on developing service models to improve quality and improve service delivery.

- 3.2 The working group is now building upon the pre existing work (with the other teams in the Directorate) to develop more efficient and therefore cost effective procedures for managing clinical care. This work has included looking at referral criteria, care plans, developing systematic review procedures and staff work plans. This work also includes developing effective systems for gathering data required for the CQUIN targets.
- 3.3 The working group has also involved representatives from the currency project and RiO to ensure that any changes implemented are consistent with other current developments and drivers.
- 3.4 The working group reports to the CAMHS Project Team, which in turn reports to the Trust Productivity Programme Board.
- 3.5 It is envisaged that through the work above, clinical time will be freed up within the service line. The time generated will be used for the following:
 - 3.5.1 Cost savings through job re-evaluation and redundancy where necessary
 - 3.5.2 Working with commissioners and local providers to ensure contracts are maintained and that the services we provide are complementary and supportive to local services within each contract area
 - 3.5.3 Seizing new opportunities such as working on developing services where new funding streams are possible. This will primarily be on developing the cross trust autism assessment and treatment services, psychotherapy / training within schools service and court work
 - 3.5.4 Developing and shaping clinical services in line with national as well as local initiatives such as Children and Young Peoples IAPT

Main Report

4. Overview of the Service

- 4.1 The Developmental Service Line consists of four clinical teams; two generic CAMHS teams, the Learning and Complex Disabilities Service and Barnet young peoples drug and alcohol service. The Service Line is also holding management of the Fostering and Adoption Team, whilst the management structures are being revised. This Service Line does the majority of work on our main contracts in C&F (excluding Camden) such as Haringey, Barnet, Islington, Enfield as well as other smaller contracts.
- 4.2 Team Two is a multidisciplinary team that takes its referrals primarily from Barnet. It has 3.6 WTE staff. Referrals come into the team through the central intake system in the department. Barnet is in the process of developing a single point of entry (SPE) system. Fortunately owing to the experience gathered through developing the SPE in Camden and the good working relationship the CAMHS Director has established with the CAMHS commissioner in Barnet, we have been asked to take a central role in developing this SPE.
- 4.3 Team Three is a multidisciplinary team that takes its referrals primarily from Haringey. It has 4.2 WTE (soon to reduce to 3.2 through redundancy savings) and also houses the trust's autism service for children. Haringey now has a single point of entry, so Haringey referrals go straight into the team from this single point.
- 4.4 The Learning and Complex Disabilities Service is a multidisciplinary team that takes its referrals directly and is funded through the London Contract for specialist services (a contract shared with the Portman Clinic). It consists of 2.9 WTE (soon to reduce to 2.3 through retirement) and its services are unusual in that they span the full age range.
- 4.5 Barnet Young Peoples' Drug and Alcohol Service (YPDAS) is a specialist community service that has been commissioned to provide universal, targeted and specialist drug and alcohol education and treatment services in Barnet. It has been commissioned by the Local Authority, and given the likelihood that all children's services will eventually be Local Authority commissioned in part, this is a key development for the Service Line. The Team consists of 4.8 WTE and is currently undergoing a separate review, as its funding is ring-fenced.
- 4.6 There are a number of smaller service development areas in the Service Line such as the New Rush Hall project and Vernon House (commissioned child psychotherapy clinical and training service in schools) and the link with the Royal National Orthopaedic hospital,

where we employ then second three sessions of psychiatry and five of psychology.

- 4.7 Another developmental area is court work, which has an intake through a workshop and the numbers of cases coming through are steadily increasing. Some of the resources from the MYFC will be used to pick up some of this work, and they have a separate court work target.

5. Activity Data

- 5.1 The activity data is from 1st April 2009 to 31st March 2010. During this time the following numbers of cases were seen

Team	Number of New Cases	Number of Appointments
Team Two	51	38
Team Three	81	55
LCDS	46	21

- 5.2 The referrals coming into the Teams in this Service Line tend to be more specialist in nature (for example complex multigenerational difficulties) in line with the changing requirement of commissioners. This has an impact on our training capacity and business model for future services.
- 5.3 The Barnet service is commissioned via a block contract, and we have now completed one full year of this contract. The service has met all its targets for engaging with young people over the first year and extending the referral base to include NHS referrals and a wider BME referral rate and the commissioners gave us very positive feedback at the end of year one.

6. Follow Up and DNA Statistics

- 6.1 These statistics cover the period 01.01.10 - 31.12.10 (i.e. the last year.

	Team Two	Team Three	LCDS
Referrals accepted	57	81	46
Attended appointments	1,668	3,434	960
DNAs	128	161	42
Appointments per case in-year	29.2	21.3	20.86
DNA rate	7.67%	4.68%	4.37%

- 6.2 In 2010 there were 16 cases that breached the 11 weeks target. These were all owing to the need to get either funding agreed (NPA's) or more information was needed before work could be started.

7. Financial Situation

7.1 The service line budget is just under £1.7m. All the contracts have now been agreed for the year and the majority of the contract income is secure for the year (with the CQUIN funding being dependent on achieving specific targets). The service line has additional targets for court work, NPA's and autism diagnosis (ADOS) training. At this point in time we are under performing by about £20k on our NPA target, but over performing on our court work target by £28k.

	Actuals	Budget	Variance
INCOME			
<u>DIRECT:</u>			
NPA's	7,150	28,624	-21,474
Court Work	58,160	29,630	28,530
NRHS	147,215	138,500	8,715
LCDS	4,153	3,000	1,153
RNOH	83,200	78,200	5,000
Barnet YP D&A Service	306,806	319,000	-12,194
Barnet SPE	6,084	5,000	1,084
ADOS Training	13,330	28,000	-14,670
Other	22,395	13,908	8,487
<u>CLINICAL:</u>			
SLA Developmental CAMHS	531,999	534,544	-2,545
SLA LCDS	387,079	390,971	-3,892
<u>TRAINING:</u>			
National Contract	113,592	113,592	0
<u>BUILDINGS</u>			
Buildings	6,001	11,993	-5,992
	1,687,163	1,694,961	-7,798
OPERATING EXPENDITURE (EXCL. DEPRECIATION)			
<u>CLINICAL DIRECTORATES</u>			
Management Developmental CAMHS	-113,888	-53,828	-60,060
LCDS	-224,994	-223,328	-1,666
Team 2	-278,911	-328,676	49,765
Team 3	-372,807	-393,356	20,548
New Rush Hall School	-66,159	-73,914	7,755
Royal National Orthopaedic Hospital	-68,738	-71,811	3,072
Barnet YP D&A Service	-247,244	-271,150	23,906
PCCS	-10,837	-8,962	-1,874
Non Pay Developmental	-21,028	-15,051	-5,977
CAMHS Management	-67,341	-56,162	-11,179
<u>BUILDINGS</u>			
Buildings	-293,540	-292,374	-1,166

	-1,765,488	-1,788,612	23,123
CONTRIBUTION	-78,325	-93,650	15,325
<u>CENTRAL FUNCTIONS</u>			
Income	28,788	21,615	7,173
Expenditure	-233,592	-234,299	707
RETAINED SURPLUS	-283,129	-306,335	23,205
SURPLUS as % of income	-17%	-18%	
CONTRIBUTION as % of income	-4%	-5%	

8. Clinical Quality

- 8.1 High quality supervision of case work is embedded in the culture of the Trust, where reflective practice is a given. The Team Leaders are members of the service redesign group where systems to ensure the quality indicators are met are being developed.
- 8.2 The Service Line has also been working on ensuring that the systems for obtaining the outcome measures are in place across all of the Teams.
- 8.3 The Trust PPI Lead manages this Service Line, and therefore patient experience data is regularly reviewed across the Service Line, for example data from the Children's Survey is fed into the service redesign work. The PPI Committee are in the process of developing the range of methods for obtaining feedback from service users, such as extending the work of the Adolescent Directorate in getting the ESQ's completed over the telephone. We are looking at developing visual 'straw polls' and surveys for the computer points.

9. Complaints, Compliments and Patient Feedback

- 9.1 There have been no complaints relating to work undertaken in the Service Line. The Team Leaders have reviewed the feedback from the Patient's Survey and the Children's Survey to ensure that clinicians are aware of the concerns patients have raised generally about clinical practice, so that this can be acted on accordingly.

10. Clinical Governance and Audit

- 10.1 The annual case file audit was conducted across the Directorate, and the Service Lines. Teams participated in this. The concerns raised in the audit have been fed into the service redesign workgroup and are been addressed within the systematic review of clinical work

processes. In the most recent case note audit the LCDS scored 100%, though the other Team's scores have deteriorated.

11. Patient Safety Incidents

11.1 There were no recorded patient safety incidents within this Service Line over the last year.

12. Service Developments and proposed work plan

12.1 The Trust Wide Autism Service

12.1.1 We have now trained a range of professionals in autism diagnostic assessment tools, and alongside this are developing a more comprehensive assessment service that not only looks at diagnostic issues, but assesses a range of related issues including a person's mental health. The service is able to provide recommendations for treatment, a range of appropriate treatments and consultation to local services where needed. We are developing information on this service and have started to market it with commissioners.

12.2 The Schools Based Psychotherapy and training service

12.2.1 We have a contract with New Rush Hall and Vernon House schools to provide training consultation and psychotherapy within the schools. This is funded from the schools budget. Several other schools have approached us to ask for a similar service, and we are in the process of developing a business plan to extend and promote this work.

12.2.2 Other disabilities services, such as autism trainings and specialist treatments for Tuberous sclerosis are in development. We have recently appointed a new psychiatrist, Dr Petrus DeVries, who has started the process of developing a national Tuberous Sclerosis clinical service with us, and he has negotiated with the TS society to 'pump prime' this development in order to get it off the ground.

12.3 Improving relationships with commissioners and local service providers

12.3.1 Our core contracts are dependent on commissioners seeing the value in continuing to commission our services, and on the local services who gate keep referrals seeing a value in working in partnership with our services. This requires ensuring these relationships are given attention and that we

are responsive to meeting the gaps in local service provision where appropriate.

12.4 Any risk issues not mentioned above e.g. significant additions to the risk register

12.4.1 None to report

Sally Hodges
Associate Clinical Director
15th July 2011

Tavistock & Portman NHS Foundation Trust
LCDS CQUIN Targets 2010/11

Clinical Quality Performance Indicator	Service	Threshold	Method of Measurement	Existing Data Collection?	Reporting Frequency
<p>Improving Patient Experience for people with learning disabilities.</p> <p>To implement actions to improve patient experience, by implementing recommendations from a consultation project with people with learning disabilities.</p> <p>To develop leaflets specifically for PWLD based on their feedback (complaints, information for patients, Trust leaflet) so that they are accessible for people with learning disabilities. June 2010</p> <p>To develop content for the children's website specifically for children with learning disabilities. July 2010</p> <p>To develop an action plan based on Hackney People's First consultation. July 2010</p>	LCDS	March 2011	Report at end of period	N	Quarterly

Board of Directors : July 2011

Item : 10

Title : Payment by Results

Summary:

This report summarises the Department of Health's introduction of payment by results (PbR) for mental health, and the progress on its implementation within the Trust.

This report has been reviewed by the Management Committee on 14th July 2011.

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

This report focuses on the following areas:

- Finance

For : Discussion

From : Associate Medical Director

Payment by Results

1. Introduction

- 1.1 Payment by Results (PbR) was introduced for the acute sector in 2003/04. At its simplest, PbR is just a list of prices: Price x Activity = Providers' (e.g. hospitals) income. PbR does not affect the total amount of money available, but is meant to provide a clear and transparent method of funding, where the money follows the patient/service user.
- 1.2 In 2008, *High Quality Care For All* set out the Department of Health's plan to have a national mental health currency available for use in 2010/11. Since then, currencies have been developed for use in the commissioning of mental health services for adults of working age and older people. The White Paper, *Equity and excellence: liberating the NHS*, states that the DoH will "implement a set of currencies for adult mental health services for use from 2012/13, and develop currencies for child and adolescent services." It also committed to "developing payment systems to support the commissioning of talking therapies."
- 1.3 Currency refers to the unit for which payment is made. The price/tariff refers to the set price for a given currency unit. The Care Pathways and Packages approach, developed initially by six mental health trusts in the North East and Yorkshire and Humber SHAs, is the currency that has been developed. Patients/service users are assessed with a standard assessment tool derived from HoNOS called the Mental Health Clustering Tool (MCHT), and are allocated to empirically derived care clusters/groups. The tool takes into account not only the patient's psychiatric diagnosis, but the severity of their mental disorder and its impact on their functioning in all areas of life. See the example given in Appendix 1. There are 20 different clusters under three main groups: 'non-psychotic', 'psychosis', and 'organic'. These clusters will be the currency unit so that, for example, you would commission for 50 people in cluster one, 20 people in cluster two, etc. Patients should be clustered at designated times: at assessment, and at recommended review periods in treatment, according to their cluster.

2. Timescales

- 2.1 The mental health PbR development national project is now moving into the implementation phase. 2011/12 is a 'preparatory/shadow year'. All service users accessing mental health care (post GP or other referral) that are working age adults and older people's services,

must be allocated to a cluster by 31st December 2011. Providers and commissioners need to be planning for their discussions on mental health service provision and start implementation of currencies with local prices in 2012/13. The earliest possible date for a national tariff for mental health (if evidence from the use of a national currency presents a compelling case for a national price) is 2013/14.

- 2.2 The clusters only apply to patients over 18. The Trust has been taking a leading role in early work to develop a currency for CAMHS patients, and we plan to continue this involvement.

3. Progress on Payment by Results in the Trust

- 3.1 **PbR Work Group:** A PbR work group was established last year led by Simon Young, Finance Director, and Jessica Yakeley, Associate Medical Director. The PbR Work Group has met several times and also includes Carl Doherty, Deputy Director of Finance, Julia Smith, Director of Service Development & Strategy, Allan Archibald, Head of Informatics, Robin Bonner, Head of Service Development and Agreements, Michael Mercer, Unit Head of the Adult Department, Limor Abramov, Clinical Governance Lead, Adolescent Department, Stan Ruszczyński, Director Portman Clinic, and Christine Hochleitner, EA to Associate Medical Director.
- 3.2 **Patient population to be clustered in the Trust:** All patients over 18 in the Adult Department, Adolescent Department, Portman Clinic and LCDS should be clustered. Patients in MedNet may be exempt due to the special commissioning of this service by the London Deanery.
- 3.3 **Training in the Clustering tool:** JY organised a one-day training on Mental Health PbR and clustering delivered by the Royal College of Psychiatrists in September 2010. This was attended by key clinicians in the above directorates, who have subsequently cascaded training in how to use the clustering tool to all other clinicians in their respective directorates. Clustering is now discussed routinely in Unit and other clinical meetings.
- 3.4 **Cluster results to date:** The Adult department began routinely clustering patients last year, the Portman and Adolescent Department more recently. The results of preliminary clustering show that the majority of patients in the Trust come into the non-psychotic clusters, specifically clusters three ('non-psychotic, moderate severity'), four ('non-psychotic, severe'), seven ('enduring non-psychotic disorders, high disability') and eight ('non-psychotic chaotic and challenging disorders'). A few patients in the adolescent department have been allocated to clusters in the psychotic group,

but most fall into the non-psychotic. This is markedly different from the clustering profile of the other mental health trusts in London in which many patients are in the psychotic group of clusters, and reflects our particular patient population, many of whom present with personality difficulties and disorders.

- 3.5 Clinicians are for the most part able to fit their patients into a specific cluster. The Portman originally had concerns that their patients, particularly those diagnosed with paraphilias or gender identity disorders, may not fit into any of the current clusters. However, most clinicians have been able to fit their patients to a cluster, and there does not appear to be an argument for Portman patients to have a different clustering system, for example, that which is being developed for forensic services. As with patients in the other directorates, the majority of Portman patients fall into clusters three, four, seven, and eight.
- 3.6 In the last two months, clinicians have started to cluster all patients, both those in assessment, and those already in treatment. We are asking clinicians to cluster all patients over 18 by September 2011, in advance of the DoH deadline of December 2011.
- 3.7 **Recording clustering:** There is on-going discussion as to how to best record the clustering of patients in the Trust. Because the Trust is keeping clinical paper records for the time being, we are recommending that the cluster rating forms are filed in the patient's paper notes. The clinician must also record the cluster number on the relevant assessment, review or end of treatment forms (CPA forms) that are routinely used. These forms have already been adapted to include a 'cluster box' for the cluster number to be recorded. We recommend that the MCHT rating form should also be incorporated into these forms to ensure completion, and summary guidance in how to cluster should be written and made available on the Intranet.
- 3.8 However, this cluster data also needs to be collected into a central database. Rather than create a separate database, the PbR group recommend that it would be most economical and efficient to input this data into RiO, which already is adapted to record the clustering of patients. Administrative staff in each Directorate would be responsible for inputting each patient's cluster number from the CPA forms into RiO.
- 3.9 The Portman Clinic has reservations regarding confidentiality and the safety of clinical data in the RiO electronic system given its links to the 'spine', and are therefore putting forward the case for their patients clusters not to be entered onto RiO, but for there to be a separate database for this. This needs further discussion.

3.10 Audit of the recording of cluster information, including the cross checking of cluster numbers between the papernotes and RiO, will need to be included in the annual case note audit, to ensure the accurate transmission of data from the case notes to RiO.

3.11 **Review periods:** The recommended review period for the majority of clusters in the non-psychotic group that our patients fall into is six months. At this point in treatment, patients should be re-clustered, although re-clustering should take place earlier if there is a clinical indication. The PbR Work Group recommend that clinicians in the Trust should routinely re-cluster all patients in treatment at six monthly periods (unless there is a clinical indication to do so earlier), and that this should coincide with the routine treatment reviews of patients, which currently takes place termly. We therefore recommend that treatment review should be changed for all patients over 18 in the Trust to six monthly, to take place at set periods: the end of June and the end of December, rather than the current termly reviews of spring, summer and winter. This will involve somewhat of a culture change for clinicians but should be welcomed as review paperwork will be reduced from three times a year to two.

4. Action Plan

- 4.1 All patients over 18 (except MedNet) to be clustered by 30th September 2011.
- 4.2 Summary guidance regarding clustering to be written by JY by 30th September 2011.
- 4.3 CPA forms to be amended to include cluster rating form.
- 4.4 Further discussion needed regarding the recording of clustering of Portman patients.
- 4.5 Incorporate cross checking of RiO cluster entries with paper notes cluster records into next year's case note audit.
- 4.6 Take recommendation to review all patients six monthly to the meeting of clinical governance leads.

Dr Jessica Yakeley
Associate Medical Director
14th July 2011

Example extract from 2011/12 Mental Health Clustering Booklet

CARE CLUSTER 7: Enduring Non-psychotic Disorders (High Disability)											
<p>Description:</p> <p>This group suffers from moderate to severe disorders that are very disabling. They will have received treatment for a number of years and although they may have improvement in positive symptoms considerable disability remains that is likely to affect role functioning in many ways.</p> <p>Likely diagnoses:</p> <p>Likely to include: F32 Depressive Episode (Non-Psychotic), F33 Recurrent Depressive Episode (Non-Psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction/Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F50 Eating Disorder and some F60.</p> <p>Impairment: Likely to seriously affect activity and role functioning in many ways.</p> <p>Risk: Unlikely to be a major feature but safeguarding may be an issue if any responsibility for young children or vulnerable dependent adults.</p>											
<table><tr><td>Must score</td><td></td></tr><tr><td>Expected to score</td><td></td></tr><tr><td>May score</td><td></td></tr><tr><td>Unlikely to score</td><td></td></tr><tr><td>No data available</td><td></td></tr></table>		Must score		Expected to score		May score		Unlikely to score		No data available	
Must score											
Expected to score											
May score											
Unlikely to score											
No data available											

No	ITEM DESCRIPTION	SCORE				
		0	1	2	3	4
2	Non-accidental self injury					
3	Problem drinking or drug taking					
4	Cognitive Problems					
5	Physical Illness or disability problems					
6	Hallucinations and Delusions					
7	Depressed mood *					
8	Other mental and behavioural problems *					
9	Relationships					
10	Activities of daily living					
11	Living conditions					
12	Occupation & Activities					
13	Strong Unreasonable Beliefs					
A	Agitated behaviour/expansive mood					
B	Repeat Self-Harm					
C	Safeguarding other children & vulnerable dependant adults					
D	Engagement					
E	Vulnerability					