

## Board of Directors Part One

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

2.00pm–4.00pm  
Tuesday 28<sup>th</sup> May 2013

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

# Board of Directors

2pm–4pm, Tuesday, 28<sup>th</sup> May 2013

## Agenda

### **Preliminaries**

**1. Chair's opening remarks**

*Ms Angela Greatley, Trust Chair*

**2. Apologies for absence**

**3. Minutes of the previous meeting**

(Minutes attached) p1  
For approval

**4. Matters arising**

### **Reports & Finance**

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

*Non-Executive Directors as appropriate*

For noting

**6. Chief Executive's Report**

*Dr Matthew Patrick, Chief Executive*

(Report attached) P8  
For discussion

**7. Finance & Performance Report**

*Mr Simon Young, Director of Finance & Deputy CEO*

(Report attached) P12  
For information

**8. CQSG Report Quarter 4 2012-3**

*Dr Rob Senior, Medical Director*

(Report attached) P18  
For discussion

**9. CQSG Annual Performance Review 2012/13**

*Dr Rob Senior, Medical Director*

(Report attached) P39  
For discussion

### **Corporate Governance**

**10. Constitutional Amendments**

*Ms Julie Hill, Trust Secretary*

(Report attached) P65  
For approval

**11. Corporate Governance Board Statement**

*Mr Simon Young, Director of Finance and Deputy CEO*

(Report attached) P74  
For approval

### **Quality & Development**

**12. Staff Survey 2012, Summary Results, Findings and Action Plan**

*Mr Namdi Ngoka, Deputy Director HR*

(Report attached) P81

For discussion and  
approval

**13. Annual Report and Accounts**

**a) Annual Report**

*Ms Julie Hill, Trust Secretary*

*(Report to follow  
For approval)*

**b) Annual Accounts**

*Mr Simon Young, Director of Finance and Deputy CEO*

*(Report to follow)  
For approval*

**c) Letters of Representation**

*Mr Simon Young, Director of Finance and Deputy CEO*

*(Report to follow)  
For approval*

**14. Quality Report 2012/13**

*Ms Louise Lyon, Trust Director*

*(Report to follow)  
For approval*

**15. Annual Plan**

*Mr Simon Young, Director of Finance and Deputy CEO*

*(Report to follow)  
For approval*

**Conclusion**

**16. Any other business**

**17. Notice of future meetings**

Wednesday, 12<sup>th</sup> June 2013: Directors' Conference, 12noon-5pm\*

Tuesday, 25<sup>th</sup> June 2013: Board of Directors

Thursday, 27<sup>th</sup> June 2013: Council of Governors

Tuesday, 23<sup>rd</sup> July 2013: Board of Directors

Wednesday, 11<sup>th</sup> September 2013: Directors' Conference, 12noon-5pm\*

Thursday, 12<sup>th</sup> September 2013: Council of Governors

Tuesday, 24<sup>th</sup> September 2013: Board of Directors

Tuesday, 29<sup>th</sup> October 2013: Board of Directors

Wednesday, 13<sup>th</sup> November 2013: Directors' Conference, 10am-5pm\*

Tuesday, 26<sup>th</sup> November 2013: Board of Directors

Thursday, 5<sup>th</sup> December 2013: Council of Governors

\*These are informal meetings and are not open to the public.

Meetings of the Board of Directors will be from 2pm until 5pm, and are held in the Board Room. Meetings of the Council of Governors are from 2pm until 5pm, and are held in the Lecture Theatre. Directors' Conferences are from 12 noon until 5pm, except where stated.

## Board of Directors

### Meeting Minutes (Part One) 2pm–4pm, Tuesday 30<sup>th</sup> April 2013

Present:			
Mr Malcolm Allen Dean of Postgraduate Studies	Mr Martin Bostock Senior Independent Director	Ms Angela Greatley Trust Chair	Dr Rita Harris CAMHS Director
Mr Altaf Kara Non-Executive Director	Lis Jones Nurse Director	Ms Louise Lyon Trust Director	Dr Ian McPherson Non-Executive Director
Dr Matthew Patrick Chief Executive	Dr Rob Senior Medical Director	Mr Richard Strang Deputy Trust Chair	Mr Simon Young Director of Finance and Deputy Chief Executive
In Attendance			
Ms Julie Hill Trust Secretary	Dr Justine McCarthy-Woods Quality Standards and Reports Lead (present for items 9A and 11)	Ms Pat Key Director of Corporate Governance and Facilities (present for items 8 and 12)	
Apologies			
Ms Joyce Moseley Non-Executive Director			

#### Actions

AP	Item	Action to be taken	Resp	By
1	3	Minutes to be amended	JH	Immed
2	4	Ms Lyon/Dr Harris to report back to the July Board meeting on the productivity changes and the quality of patient services.	LL/RH	July 13
3	5	Dr McPherson to provide more information to Dr Patrick with a view inviting civil servants to visit and find out more about the work of the Trust.	MP	June 13
4	12	Ms Key to arrange for a link to the CQC's report from the Trust's website.	PK	June 13
5	13	Dr Senior to set up a meeting to discuss how best to review the learning from complaints.	RSe	July 13

#### 1. Trust Chair's Opening Remarks

- 1.1 Ms Greatley, Trust Chair welcomed everyone to the meeting.

#### 2. Apologies for Absence

As above

#### 3. Minutes of the Previous Meeting

##### AP1

The minutes of the meeting held on 26<sup>th</sup> March 2013 were approved after the following amendment had been made:

Minute 8.4, 5<sup>th</sup> line, the words "actual expenditure" to be replaced with "final out-turn".

#### 4. Matters Arising

4.1 Actions which were due had been completed and updates were provided on the following:

##### **Action Point 1 – Future Education and Training Service Line Reports**

Mr Allen, Dean of Postgraduate Studies confirmed that future Education and Training Service Line reports would contain more financial information but pointed out that the report on the agenda for this meeting focussed on the strategic programme of work for the service rather than financial issues.

**Outstanding Actions** - Mr Strang, Deputy Trust Chair reported that he had met with Ms Lyon, Trust Director and Dr Harris, Director of CAMHS to discuss undertaking a short project to ascertain whether the productivity changes had impacted on the quality of patient services. It was noted that the conclusions of the discussions would be reported to the Board in July.

AP2

**Ms Lyon/Dr Harris to report back to the July Board meeting on whether the productivity changes had impacted on the quality of patient services.**

Ms Jones, Nurse Director said that the follow up report on the contribution of the Trust to the care for older people would be presented to the Board in the autumn.

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

5.1 Ms Greatley, Trust Chair reported that she had attended a number of Foundation Trust Network and NHS Confederation events which had all focussed on the Francis Report and its implications for the health sector.

5.2 Mr Strang, Deputy Trust Chair reported that he had attended an event at Deloitte. One of the speakers was Matthew Kershaw, Special Administrator for South London Healthcare NHS Trust. Mr Kershaw had pointed out that one of the consequences of the failure regime was that the solution could have a negative impact on other local Trusts, even if they were not underperforming.

5.3 Mr Strang also reported that he was attended a briefing at KPMG about the recent changes to PAYE, the pension regime and VAT.

5.4 Dr McPherson, Non-Executive Director reported that he had attended a King's Fund event at which the Deputy Director of the Public Inquiry Support Team had given a presentation and had made the point that civil servants in the health field were being encouraged to visit health trusts. **Dr McPherson to provide more information to Dr Patrick with a view inviting civil servants to visit and find out more about the work of the Trust.**

AP3

5.5 Mr Bostock, Senior Independent Director reported that he would be attending a training day on board assurance and safety organised by the

Foundation Trust Network on 3 May and would report back at the next meeting.

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

6.1 The Chief Executive's Report which included the sad news that Maggie Wakelin Saint, former Trust Chair had died. The Board noted with sadness the death of Ms Wakelin Saint and paid tribute to her contribution to the work of the Trust.

6.2 The report also included updates on the NHS Health and Social Care Act, Care Quality Commission visit, Gender Identity Development Service's new base in Leeds, Camden Mental Health Review and the King's Fund's scenario planning tool.

6.3 Dr Patrick reminded the meeting that the King's Fund were keen to pilot the scenario planning tool and if the Trust took up the offer, it would be on the basis that there would be no cost and in return, the Trust would offer the King's Fund feedback on how to improve the product.

6.4 The Board noted the report

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

7.1 The Finance and Performance Report had been circulated. Mr Young, Director of Finance and Deputy Chief Executive reported that at the end of the financial year there was a deficit of £737k after restructuring costs which was significantly better than the budget figure of £1,450k.

7.2 Mr Young referred to section 2.2.2 of the report and pointed out that the figures in relation to the Trust's Public Dividend Capital Payments were incorrect and that the correct figures were as set out in Appendix D of the report. It was noted that there had been a revaluation of the Trust's estate and that the values had increased by £1.5m compared to the current book values which were based on the 2009 valuation after adjusting for additions and depreciation since then.

7.3 Mr Young drew attention to section 5 of the report in relation to Tavistock Consulting and pointed out that the variance below budget was around £49,000 and not £127,000 as stated in the report.

7.4 Dr Patrick paid tribute to the work of the Productivity Programme Board, chaired by Mr Young which had delivered significant cost savings.

7.5 The Board noted the report.

## **8. Capital Expenditure 2013/14 Budget and Plan**

8.1 A report proposing a capital budget of £592,000 for 2013/14 (excluding the proposed Day Unit new build project) had been circulated. Ms Key, Director of Corporate Governance and Facilities reported that the

proposed capital funding projects this year would include updating the seminar rooms and library corridor, replacing the windows at the Portman and upgrading toilets.

8.2 The Board approved the Capital Expenditure 2013/14 budget and plan.

## 9. Quarter 4 Finance and Governance Declarations

9.1 The Quarter 4 Finance and Governance Declarations had been circulated. Mr Young reminded the Board that Monitor were considering replacing the current Compliance Framework with a Risk Assessment Framework from October which included a proposal to change the way liquidity was calculated. Mr Young reported that on behalf of the Trust, he had responded to Monitor's consultation document and had made some suggestions on an alternative calculation and thresholds for the proposed new liquidity ratio which was one half of the "continuity of services risk rating", intended to replace the financial risk rating.

9.2 The Board approved the following declarations:

**For Finance** – the Board anticipated that the Trust will continue to maintain a risk rating of at least 3 over the next 12 months.

**For Governance** – the Board was satisfied that plans in place were sufficient to ensure on-going compliance with all existing targets (after the application of thresholds) as set out in Appendix B of the Compliance Framework and gave a commitment to comply with all known targets going forwards.

**Otherwise** – the Board confirmed that there were no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 17, diagram 8 and page 63) which had not already been reported.

## 9A Quarterly Quality Report, Quarter 4, 2012-2013

9.3 A report providing an update on the Quality Indicators for Quarter 4, 2012-13 had been circulated. Dr McCarthy-Woods, Quality Standards and Reports Lead drew attention to section 3 of the report in relation to Patient Satisfaction with "Helpfulness of Service" and reported that it was pleasing that this had increased in quarter 4 to its highest level over the year.

9.4 Mr Strang commented that it was an excellent report and that the presentation of the data was very clear.

9.5 The Board thanked Dr McCarthy-Woods for her report and noted its contents.

## **10. Corporate Governance Report**

10.1 The Corporate Governance Report covering the enactment of the Health and Social Care Act 2012 relating to the enhanced role for NHS foundation trust governors and Monitor updates had been circulated. The Board noted that the proposed wording of the constitutional changes would be presented to the Board of Directors meeting in May and the Council of Governors meeting in June. The changes would then be approved at the Annual General Meeting.

10.2 The Board noted the report.

## **11. Draft Quality Report 2012/13**

11.1 The draft Quality Report 2012/13 had been circulated. Ms Lyon invited the Board for feedback on the draft report and asked whether there were any suggestions about how to improve the content of future Quality Reports. Dr McCarthy-Woods, Quality Standards and Reports Lead pointed out that there were still gaps in the draft report and that this was because she did not want to include any information until it had been double checked and verified. Dr McCarthy-Woods reported that the report would also be updated to include a section on the outcome of the CQC Inspection visit.

11.2 Ms Greatley said that she was particularly pleased that the report had highlighted the important role of the governors and their contribution to the Trust's work around Quality.

11.3 Dr McPherson, Non-Executive Director asked whether there was anything further that could be done to raise patient awareness of the modality leaflets. Mr Bostock, Senior Independent Director reported that the Patient and Public Involvement (PPI) Committee had discussed the issue and had suggested that it may be better if Clinicians handed patients a modality leaflet as part of their consultation visit. Mr Bostock also made the point that a lot of work had gone into making sure that the modality leaflets were written in plain English.

11.4 Dr Patrick said that the draft Quality Report was a good report and asked whether it would be available to patients, service users and on the Trust's website. Dr McCarthy-Woods replied that in addition to the Quality Report, there would be the Quality Accounts report which would include pictures and the coloured inserts (pages 104-108 of the report) which would be available to patients and others and would be loaded onto the NHS Choices website. The full Quality Report would form part of the Trust's Annual Report and Accounts.

11.5 Mr Bostock commented that although the format and content of the Quality Report improved every year, he wondered whether the public would understand some of its content, for example in relation to the CQUIN targets. Dr Harris suggested adding some context to the CQUIN targets in the report.



11.6 Dr McCarthy-Woods thanked the Board for their suggestions and reported that the deadline for submitting the Annual Report and Accounts which would also include the Quality Report was 30<sup>th</sup> May and the deadline for submitting the Quality Accounts was 30<sup>th</sup> June.

11.7 The Board thanked Dr McCarthy-Woods for producing an excellent draft Quality Report.

## 12. CQC Inspection and Visit March 2013

12.1 A report setting out feedback from a CQC routine inspection visit that took place in March 2013 had been circulated. Ms Key reported that because of the specialist nature of its work, the Trust was one of the very few trusts which had announced CQC inspection visits. Ms Key reported that the Trust was inspected on seven of the CQC's standards and was found to be fully compliant with all seven.

AP4

12.2 Ms key reported that the CQC's report of their inspection visit would shortly be loaded onto the CQC's website. **Ms Key to arrange for a link to the CQC's report from the Trust's website.**

12.3 The Board thanked Ms Key and the other staff who had been involved with the CQC visit and noted the content of the report.

## 13. Annual Complaints Report: Patient Services

13.1 A paper providing a summary of the formal complaints received by the Trust in 2012-13 had been circulated. Ms Greatley reported that she had attended a presentation by the Health Service Ombudsman who had stressed the importance of having robust systems in place to learn lessons from complaints.

AP5

13.2 Dr Patrick reported that the number of complaints and the number of upheld complaints had increased slightly and that this was in line with a general trend across London. Dr McPherson pointed out that the overall number of complaints the Trust received was very low. Mr Bostock reported that complaints came within his remit as the Non-Executive Director link for patient services but he did not know the best way to engage with this area of work. Dr Senior, Medical Director suggested that he, Mr Bostock, Ms Jones and the Complaints Manager should discuss the best way of reviewing complaints to identify any trends and to disseminate any learning from complaints. **Dr Senior to set up a meeting to discuss how best to review the learning from complaints.**

13.3 The Board noted the report.

## 14. Education and Training Report

14.1 A report setting out how the Dean and Training Executive were

planning to begin the implementation and delivery of the new strategic vision for education and training that had been developed over the past year had been circulated.

14.2 Mr Allen reported that the implementation and delivery phase of the new strategic vision for education and training included articulating and developing the vision through consultations with staff and students, re-shaping the portfolio of courses, moving to a modular course system, shaping an international strategy, developing e-learning and enhancing the student relationship. Mr Allen pointed out that the implementation of the transformation programme would be spread across three years.

14.3 Mr Allen corrected the information he had given at the January Board meeting at which he had indicated that some courses were over-subscribed and reported that after investigating the issue further, there were in fact no instances where prospective suitably qualified students were not able to enrol for a particular course.

14.4 Mr Allen reported that he had met with Mr Kara and Mr Bostock last week to discuss developing the e-learning courses. Mr Strang pointed out that conversion rates were falling. Mr Allen reported that conversion rates were a major issue across the Higher Education sector and that a lot of work was going into trying to improve them.

14.5 Mr Kara asked whether the implementation timetable was realistic. Mr Allen reported that recent capacity issues had resulted in some actions being delayed but he was confident that the revised timetable was achievable. Dr Patrick confirmed that sufficient resources would be allocated to the project to ensure that it could be delivered.

14.6 The Board thanked Mr Allen for the report and noted its contents.

## **15. The Gloucester House Day Unit: Business Case for a New Building**

The Board noted that the Gloucester House Day Unit Business Case for a new building would be considered in Part II of the meeting. The proposal was to build a new block at the back of the Tavistock Centre which would provide modern facilities for the Day Unit and would also provide new seminar rooms. The cost of the new building, if approved, would be funded from the subsequent proceeds of selling the property at 33 Daleham Gardens.

## **16. Any Other Business**

There was no other business.

## **17. Notice of Future Meetings**

Noted

## Outstanding Action Part 1

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
1	Oct-12	7. Finance and Performance Report	Mr Strang to discuss further with Dr Harris and Ms Lyon the percentage of time Clinicians spend with patients before and after the productivity changes.	Richard Strang	Jul-13	
2	Nov-12	12. Ageing Population T+P Contribution to Care	Lis Jones to report back to a future meeting on the outcome of the discussions in relation to care for older people.	Lis Jones	Oct-13	
3	Mar-13	8. Finance and Performance Report	Mr Young to include an additional column in next year's budget report to show the final outturn	Simon Young	Apr-14	
4	Mar-13	8. Finance and Performance Report	Mr Young to undertake a sensitivity analysis in relation to the 2013/14 budget.	Simon Young	May-13	
5	Mar-13	12. Equalities Report	Mr Allen to circulate a copy of the sexual orientation statement to the board in due course	Malcolm Allen	When available	

## Board of Directors : May 2013

**Item :** 6

**Title :** Chief Executive's Report

**Summary :**

This paper covers the following items:

1. Introduction
2. Parity of Esteem
3. Integrated Care
4. Payment System Review
5. The work of David Campbell

**For :** Discussion

**From :** Chief Executive

## Chief Executive Report

### 1. Introduction

- 1.1 Over the past month Angela Greatley and I have been meeting with new governors. We are again lucky to have a very able and generous group of individuals prepared to commit time and effort on behalf of the Trust.
- 1.2 Themes that have come up in our conversations have included the difficulty of representing the membership, how to gain a deeper understanding of the work of the Trust, the implications of the 2012 Health and Social Care Act, and some uncertainty around formal roles in terms of governance as opposed to other forms of contribution and how best to strike the balance between the two.
- 1.3 A number of governors are keen to visit various teams within the Trust and many have already agreed to sit of various committees.
- 1.4 One of the committees that has already met is the governors' NED appointment committee with responsibility for starting the NED recruitment process. You will all be aware that Altaf Kara and Richard Strang are both coming towards the end of their terms of office and will both be greatly missed when they leave.

### 2. Parity of Esteem

- 2.1 Mental health has received a significant amount of attention in the press and parliament over the past month. One focus of attention has been on the issue of parity of esteem with physical health.
- 2.2 If you were unlucky enough to have a heart attack in the street you would rightly expect to be being seen by an appropriately trained person within a short space of time. Such a person would be able to evaluate your condition and initiate an effective course of action or treatment.
- 2.3 People who experience a mental health crisis are not so lucky. Indeed, often there is not access to emergency out of hours assessment of the sort of quality one would expect for physical conditions
- 2.4 Norman Lamb, Health Minister, highlighted that the difference in services for people with mental health problems visiting hospital compared with patients with physical conditions is stark and that the

lack of equality in emergency hospital service for mental health patients needed to be addressed.

- 2.5 Not all people with a mental health crisis arrive in hospitals, however. Many have their first contact with the police or other services. Last week Lord Victor Adebawale published his independent report from the Commission on Mental Health and Policing, with a particular focus on the Metropolitan Police Service (MPS). The report is of tremendous importance in that it identifies mental health as a core part of the work of the MPS as opposed to something that interferes with core work.

### **3. Integrated Care**

- 3.1 Norman Lamb was also prominent in the press in relation to his announcement that health economies are being invited to bid to become integration 'pioneers', running large scale experiments in integrated care.
- 3.2 Those awarded pioneer status will be offered support and advice form a central Integrated Care and Support Exchange team located in the Department of Health. It is likely that there will be 10 pioneer sites selected in the first wave.
- 3.3 Mr Lamb, speaking at a King's Fund event, said that pioneer sites would also be offered financial incentives to help patients to be supported in community settings.
- 3.4 Integrated care is widely seen as one way of significantly improving the quality of outcomes, care and experience provided by the health system at a time when financial pressures are relentless. While liaison psychiatry has received an increasing amount of attention, models of truly integrated care across physical and mental health are still rare.

### **4. Payment System Review**

- 4.1 Another indication of the concern that surrounds NHS finances and the value delivered is given by the announcement that Monitor and NHS England are working together to reform the way NHS services are paid for, with the idea that the NHS payment system could do more for patients.
- 4.2 Hospitals are currently paid for through the Payment by Results (PbR) system which has been in operation for nearly a decade. However, it is widely viewed that the system is not sufficiently patient focused or supportive of integrated care or community provision.

- 4.3 Within the present system there remain many perverse incentives which may encourage investigation, admission and treatment within secondary care settings, while many people want their care to be delivered as close to home as possible and for more to be invested in helping them to stay healthy.
- 4.4 At present mental health services are largely commissioned on block contracts which can make this element of the NHS spend vulnerable, as it is easier to reduce than the PbR associated spend which is primarily based on activity levels. There is now a strong argument that all services should be commissioned on the basis of outcomes, and that these should look towards improving population health as well as individual health, and that care should be commissioned across whole care pathways to ensure integration around the patient.

## 5. And Finally

- 5.1 On Thursday 16<sup>th</sup> of May I had the pleasure of speaking at the launch of a new book, *Positions and Polarities in Contemporary Systemic Practice: The Legacy of David Campbell*. The book is edited by Charlotte Burck, Sara Barratt and Ellie Kavner.
- 5.2 David Campbell was a tremendously important systemic psychotherapist who worked for the Trust and who was greatly loved and admired by many. He contributed to many spheres, including our clinical work, our trainings and to organisational consultancy. The book is rich and creative in its contribution and a really fitting tribute to David's life and work.

Dr Matthew Patrick  
Chief Executive Officer  
May 2013

## Board of Directors : May 2013

**Item :** 7

**Title :** Finance and Performance Report

**Summary:**

The Annual Accounts for 2012/13 are presented separately for approval.

After the first month of the new year, a surplus of £250k is reported, £215k above the planned surplus of £35k. This is partly due to the timing of some expenditure. Surpluses are expected in months 2 and 3, although this will reduce over the year.

Analysis by service line is not provided this month.

The cash balance at 30 April was £3,786k. Cash projections are presented to the meeting as part of the Annual Plan.

**For :** Information.

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



## 1. External Assessments

### 1.1 Monitor

- 1.1.1 Monitor's assessment on Quarter 4 is awaited. It is expected that our Financial Risk Rating will remain at 4, and the rating for governance remain green.
- 1.1.2 The Annual Plan is due to be submitted to Monitor at the end of May. Following their review, a response is expected in July. The Plan should lead to a Financial Risk Rating of 3.

## 2. Finance

### 2.1 2012/13

- 2.1.1 The annual report and accounts are due to be approved at this meeting of the Board. They will then be submitted to Monitor, and will be laid before Parliament early in July. The surplus was £1,298k before restructuring costs of £2,035k; exactly in line with the draft figures reported last month.

### 2.2 Income and Expenditure 2013/14

- 2.2.1 After April the trust is reporting a surplus of £250k before restructuring costs, £215k above budget. Income is £95k below budget, and expenditure £311k below budget.
- 2.2.2 The income shortfall for April of £95k is due a £49k shortfall on Consultancy with TCS £32k below target and SAAMHS departmental consultancy being £18k below. Clinical income was £39k below budget which was mainly in CAMHS and due to low pupil numbers on the Day Unit and Court Report income. All the main income sources and their variances are discussed in sections 3, 4 and 5.
- 2.2.3 The favourable movement of £309k on the expenditure budget includes an under spend of £129k by the Family Nurse Partnership (FNP) due to vacancies and lower than expected non pay costs. With training and other activity due to increase across the year, it is expected that FNP costs will be close to budget for the year as a whole.
- 2.2.4 The remainder of the under spend was mostly vacancies spread across the organisation.
- 2.2.5 As noted in 4.1 below, Tavistock Consulting features on both sides of the April variances, with income and expenditure both below budget. Similarly, the Portman underspend of £28k is because a new project has not yet started; and income is correspondingly below budget.

## 2.3 **Cash Flow**

- 2.3.1 The actual cash balance at 30 April was £3,786k; this is an increase of £610k on the opening cash balance of £3,176k. The increased balance was mainly due to a payment in advance (for the whole of Q1) from our NHS education and training commissioners.
- 2.3.2 A full annual cash flow forecast will be included in the Annual Plan and in the June board report.

## 3. **Patient Services**

### 3.1 **Activity and Income**

- 3.1.1 All the major contracts have now been agreed. Total contracted income for the year is expected to be in line with budget. Part of the budgeted income for the year is dependent on meeting our CQUIN<sup>1</sup> targets agreed with commissioners and achievement is reviewed on a quarterly basis.
- 3.1.2 There are more significant variances, both positive and negative, in other elements of clinical income, as shown in the table on the next page. However, the forecast for the year is currently in line with budget in most cases, not in line with the figures shown as "variance based on year-to-date."
- 3.1.3 The income budget for named patient agreements (NPAs) was reduced this year from £205k to £195k. After one month, actual income is £10k below which is due to GID and Complex Needs. This shortfall is expected to recover within the first quarter.
- 3.1.4 Court report income (which is budgeted at £113k for the year, of which £50k is for the Portman and £55k in CAMHS) was £10k below budget after April. This shortfall is expected to be recovered over the course of the year.
- 3.1.5 Day Unit was £15k below target. The service is working to secure the additional income required to meet their revised target.
- 3.1.6 Project income is forecast to be balanced for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.

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

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	836	832	-0.5%	-51	0	
Cost and vol variances	21	21	0.0%	0	0	
NPAs	16	5	-66.9%	-130	0	
Projects and other	212	211		–	0	Income matched to costs, so variance is largely offset.
Day Unit	68	53	-23.1%	-199	0	
FDAC 2nd phase	43	46	7.3%	38	0	Income matched to costs, so variance is largely offset.
Court report	16	5	-66.9%	-76	0	
Total	1,213	1,174		-418	0	

#### 4. Training

- 4.1 Training income is close to budget after April, with the shortfall on Child Psychotherapy Trainees being offset by Training Fees.
- 4.2 Income from university partners remains under negotiation. Apart from this, the other key area of uncertainty is, as always, fee income from students and sponsors for the academic year starting in October.

#### 5. Consultancy

- 5.1 TC income was £52k in April, compared to the phased budget of £84k. The shortfall was offset, however, by savings of £21k, mainly on associates. Our forecast for the year assumes at present that the budget of £1m income (excluding training courses) is achieved. TC are presenting to this meeting a plan to increase income above this, with some increase in resources.
- 5.2 Departmental consultancy is £17k below budget after one month. The majority of the shortfall is within Portman. Actions to recover the shortfall will be required to deliver against plan.

Simon Young  
Director of Finance  
17 May 2013

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST										APPENDIX A		
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2013-14												
										</		

THE TAVISTOCK AND PORTMAN NHS TRUST								APPENDIX B
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2013-14								
All figures £000								
Apr-13				CUMULATIVE			2013-14	
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	REVISED BUDGET	
<b>INCOME</b>								
1	CENTRAL CLINICAL INCOME	517	517	0	517	517	0	6,207
2	CAMHS CLINICAL INCOME	334	302	(32)	334	302	(32)	4,008
3	SAAMHS CLINICAL INCOME	362	355	(7)	362	355	(7)	4,279
4	NHS LONDON TRAINING CONTRACT	605	605	0	605	605	0	7,254
5	CHILD PSYCHOTHERAPY TRAINEES	182	158	(24)	182	158	(24)	2,188
6	JUNIOR MEDICAL STAFF	92	92	0	92	92	0	1,102
7	POSTGRADUATE MED & DENT'L EDUC	7	6	(1)	7	6	(1)	83
8	DET TRAINING FEES & ACADEMIC INCOME	55	57	2	55	57	2	2,201
9	CAMHS TRAINING FEES & ACADEMIC INCOME	544	559	15	544	559	15	6,506
10	SAAMHS TRAINING FEES & ACADEMIC INCOME	124	130	6	124	130	6	1,584
11	TC TRAINING FEES & ACADEMIC INCOME	22	23	2	22	23	2	293
12	TC INCOME	84	52	(32)	84	52	(32)	1,004
13	CONSULTANCY INCOME CAMHS	11	12	1	11	12	1	107
14	CONSULTANCY INCOME SAAMHS	28	10	(18)	28	10	(18)	337
15	R&D	16	18	2	16	18	2	195
16	OTHER INCOME	58	49	(8)	58	49	(8)	693
<b>TOTAL INCOME</b>		<b>3,039</b>	<b>2,944</b>	<b>(95)</b>	<b>3,039</b>	<b>2,944</b>	<b>(95)</b>	<b>38,042</b>
<b>EXPENDITURE</b>								
17	COMPLEX NEEDS	291	280	11	291	280	11	3,389
18	PORTMAN CLINIC	128	95	33	128	95	33	1,527
19	GENDER IDENTITY	96	76	20	96	76	20	1,151
20	BIG WHITE WALL & DEV PSYCHOTHERAPY UNIT	22	18	3	22	18	3	247
21	NON CAMDEN CAMHS	344	318	26	344	318	26	4,003
22	CAMDEN CAMHS	312	336	(24)	312	336	(24)	3,703
23	CHILD & FAMILY GENERAL	10	3	7	10	3	7	449
24	FAMILY NURSE PARTNERSHIP	287	159	129	287	159	129	3,446
25	JUNIOR MEDICAL STAFF	83	81	2	83	81	2	997
26	NHS LONDON FUNDED CP TRAINEES	182	158	24	182	158	24	2,189
27	TAVISTOCK SESSIONAL CP TRAINEES	3	3	0	3	3	0	34
28	FLEXIBLE TRAINEE DOCTORS & PGMDE	30	29	1	30	29	1	361
29	EDUCATION & TRAINING	187	153	34	187	153	34	3,789
30	VISITING LECTURER FEES	132	118	14	132	118	14	1,374
31	CAMHS EDUCATION & TRAINING	122	115	7	122	115	7	1,466
32	SAAMHS EDUCATION & TRAINING	77	73	3	77	73	3	921
33	TC EDUCATION & TRAINING	0	0	(0)	0	0	(0)	0
34	TC	74	53	21	74	53	21	893
35	R&D	15	15	0	15	15	0	169
36	ESTATES DEPT	174	168	6	174	168	6	2,088
37	FINANCE, ICT & INFOMATICS	136	150	(15)	136	150	(15)	1,626
38	TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	81	74	7	81	74	7	978
39	COMMERCIAL DIRECTORATE	56	56	0	56	56	0	672
40	HUMAN RESOURCES	52	51	0	52	51	0	622
41	CLINICAL GOVERNANCE	38	37	1	38	37	1	451
42	PROJECTS CONTRIBUTION	(6)	(5)	(1)	(6)	(5)	(1)	(69)
43	DEPRECIATION & AMORTISATION	46	46	0	46	46	0	550
44	IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	0	0	0
45	PRODUCTIVITY SAVINGS	0	0	0	0	0	0	0
46	INVESTMENT RESERVE	(1)	0	(1)	(1)	0	(1)	152
47	CENTRAL RESERVES	(1)	0	(1)	(1)	0	(1)	296
<b>TOTAL EXPENDITURE</b>		<b>2,969</b>	<b>2,660</b>	<b>309</b>	<b>2,969</b>	<b>2,660</b>	<b>309</b>	<b>37,476</b>
<b>OPERATING SURPLUS/(DEFICIT)</b>		<b>70</b>	<b>284</b>	<b>214</b>	<b>70</b>	<b>284</b>	<b>214</b>	<b>566</b>
48	INTEREST RECEIVABLE	0	1	0	0	1	0	5
49	DIVIDEND ON PDC	(35)	(35)	0	(35)	(35)	0	(421)
<b>SURPLUS/(DEFICIT)</b>		<b>35</b>	<b>250</b>	<b>214</b>	<b>35</b>	<b>250</b>	<b>214</b>	<b>150</b>
50	RESTRUCTURING COSTS	0	2	(2)	0	2	(2)	0
<b>SURPLUS/(DEFICIT) AFTER RESTRUCTURING</b>		<b>35</b>	<b>247</b>	<b>212</b>	<b>35</b>	<b>247</b>	<b>212</b>	<b>150</b>

## Board of Directors : May 2013

**Item : 8**

**Title : CQSG Report, Q4, 2012/13**

### **Purpose:**

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

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

This report is based on assurance scrutinised by the following Committees:

- Management Committee
- Clinical Quality, Safety, and Governance Committee

The assurance to these committees was based on evidence scrutinised by the work stream leads.

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

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

**For : Discussion**

**From : Rob Senior, CQSG Chair**

## CQSG Report, Q4, 2012/13

### 1. Introduction

- 1.1 The overview summary of areas already considered by the CQSG is set out in Appendix 1; the Board of Directors is reminded that ratings are not given in the same way as for the Risk Register.
- 1.2 The focus in this narrative is on areas of concern and interest to which the board should pay particular attention; it is not simply a repetition of red and amber rated elements.

### 2. Findings

- 2.1 Appendix 1 sets out the detail by reporting line, the Q4 column on the right of the table refers to Q4 2013/14, this may change over that reporting period; meanwhile, the main conclusions are:

#### 2.2 Corporate Governance and Risk

- 2.2.1 Investment in staff supporting training had yielded further good outcomes.
- 2.2.2 Implementation process development by the Commercial Directorate is required in order to maintain the good governance rating awarded by the CQC; this has been added to the risk register.

#### 2.3 Clinical Outcomes

- 2.3.1 The new Clinical Governance Office structure is working well and is driving improvements
- 2.3.2 Reporting lines have been changed to reflect activity.

#### 2.4 Clinical Audit

- 2.4.1 A review of compliance with NICE guidelines will generate action plans.

#### 2.5 Patient Safety and Clinical Risk

- 2.5.1 The spike in reports in Q3 appears to have been temporary; the numbers have now reverted to previous levels.
- 2.5.2 A forum to explore complaints is being established.

## **2.6 Quality Reports**

- 2.6.1 The 2012/13 report has been published.
- 2.6.2 Work to improve data quality will enhance this work.

## **2.7 Patient and public involvement**

- 2.7.1 Patient feedback influenced CQUINs.

## **2.8 Information Governance**

- 2.8.1 Toolkit return completed on time and to required standard (Trust is 4<sup>th</sup> best in London)

## **3. Conclusion**

- 3.1 This report gives a comprehensive overview and summary of CQSG's findings. The CQSG did not raise any new concerns.



Corporate Governance and Risk Work stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for end of Q4
To maintain CQC registration without qualification	G	G	G	G	The latest risk profile published by the CQC shows no areas of concern. Following an inspection by the CQC the Trust was found to be compliant with the 7 standards assessed.	
To maintain a green governance rating with Monitor	G	G	G	G	Monitor's rating of the Trust remains green.	
To maintain a highly effective workforce	A	A	G	G	All targets achieved or exceeded.	
Estates and Facilities infrastructure improvements and CQC and NHSLA compliance	G	G	G	A	There was one site visit outstanding at the time of writing but this was since completed.  All estates projects were completed on schedule.	

Managing responses to recommendations and requirements of external bodies	G	G	G	G	Schedule up to date; no deadlines missed.	
Maintain compliance with current NHSLA rating	G	G	G	G	Maintaining compliance with current system requirements.	
Non-clinical incident reports	G	G	G	G		
Specific case reports (serious incidents / SULs)	G	G	G	A	Some work to complete, though this is on schedule.	
Central alert broadcast advice	G	G	G	G	No issues to report.	
Operational Risk Register	G	G	G	G	Some drafting improvements were made to a few entries as directed by the work stream.	
Relocation of Day Unit	G	G	G	G	This is on schedule	
CGR IG compliance	G	G	A	G	Training target achieved on schedule.	

Clinical Outcomes Work Stream						
Task (all new as of November Q2)	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for end of Q4
Implementation of OM project plan		A	A	A	The good support provided through the Clinical Governance Office will be reviewed in the medium term as part of a parallel exercise to support clinically led governance.	
Local ownership of outcome monitoring		A	A	A	Direct access for clinicians to the system is indicated in order to maximise effectiveness	
Functionality of reports		A	A		Reporting line discontinued	
Robust plans are in place for quality data collection		A	A		Reporting line discontinued	
OM internal audit					Reporting line discontinued	
OM tracking system pilot training				G	This is arranged by the Clinical Governance Manager.	
Processes for data collection are robust.				A	Improvements noted; IMT project to address related informatics issues	

Clinical Audit work stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for end of Q4
Development of Clinical Audit Process	G	G	A		Reporting line discontinued	
NICE compliance	G	A	G	G	A gap analysis is being produced following publication of national guidance.	
Confidential inquiries	G	G	G	G	No reports required.	
Completion of annual case note audit	G	G	A		Reporting line discontinued	
CA IG compliance	G	G	A	A	Satisfactory achievement, but a plan for improvement has been commissioned for the IG work stream.	
National audit requirements	A	G	G	G	Only one data collection exercise applies; this is being undertaken.	
Compliance with plan	G	G	A	A	Quarterly monitoring of progress is now in place	
Audit	G	G	G		Reporting line discontinued	

register						
Clinical audit for medical revalidation		A	G		Reporting line discontinued	
NICE quality standards				A	Awaiting publication of standards.	
Audit register				G	In place and being utilised.	

Patient Safety and Clinical Risk Work stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for end of Q4
Clinical incidents	G	G	A	G	No 9+ rated incidents; previous spike in reports did not materialise as a trend.	
Specific case reports (serious incidents / SUIs)	G	G	A	A	One case remains open (reported previously) and until the action plan is delivered the amber will remain in place.	
Hospital acquired infection	G	G	G	G		
New Clinical claims	A	G	G	G	None.	
Complaints responses	G	G	G	G	Year on year increase noted, no trends apparent but a wide ranging discussion will be facilitated to explore complaint management.	
Serious complains update	G	G	G		Reporting line discontinued	
PSCR NHSLA compliance	G	G	G	G	Extant procedures are being updated and followed.	

PSCR CQC compliance	G	G	G	G	No areas of concern noted.	
Central Alert Broadcast advice	G	G	G	G	No alerts applicable	
Supervision of clinicians	G	G	G	G	Procedure being reviewed/updated.	
Revalidation	G	G	G	G	Most appraisals completed; consolidation of data provision underway.	
PSCR risk review	G	G	G	G	Only one 9+ risk included –this relates to recording of safeguarding plans)	
Safeguarding children	A	A	G	A	Discrepancy between RiO and local authority records being explore; no evidence clinicians are not aware in practice.	
Safeguarding adults	G	G	G	G		

Quality work stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for end of Q4
Quality report section of the AR is produced to a high standard	G	G	G	G		
Arrangements to deliver CQUIN are fit for purpose	A	A	A	A	Streamlining data collection is being incorporated into planning for 2013/14.	
That data to be collected has been agreed	G	G	G		Reporting line discontinued	
That data quality procedure is implemented	G	A	G	G	Scheduled review underway.	
That QR components of the AR are submitted on	G	G	G		Reporting line discontinued	



time and in the correct format						
That QR requirements of IG9 are completed	G	G	G	G	Completed on time and to standard.	

PPI work stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for end of Q4
Providing assurance that the Trust adheres to all PPI related policies and procedures	G	G	G	G	Departmental PPI leads promote procedures to teams	
Providing a forum of PPI related matters	A	G	G		Reporting line discontinued	
Discussing the findings of the experience of service questionnaire	A	G	G	G	Findings and action considered quarterly.	
Ensuring that the action plan developed to address the	G				Reporting line discontinued	

finding of the patient survey are implemented						
Ensuring the involvement of patients in service improvement	A	G	G	G	See "To improve the patient experience of diverse groups" above	
To improve the patient experience of diverse groups				G	Formal links with two BME community organisations were established.	
To hold 3 meetings with stakeholders	A	G	G		Reporting line discontinued	
To ensure 3 issues identified in 2011/12 at stakeholder meetings were addressed by March 2013				G	3 issues were identified in the action plan (for CQUINs and quality priorities)	
To increase	A	G	G		Reporting line discontinued	

membership by 10%						
To develop a BME engagement strategy	A	G	G		Reporting line discontinued	
To hold 3 patient forums	A	G	G	G	Three talks were held.	
To increase presence in social media	A	G	G		Reporting line discontinued	
To promote choice through information provision and produce 5 leaflets on modalities	G	G	G		Reporting line discontinued	
To produce 3 further leaflets on modalities				G	Completed	
To work with QR lead to develop	A	G	G	G	The relevant committees include members of the public and patients.	

quality culture and patient centred services						
That PPI IG requirements are completed	A	A	A	G	The outstanding IG task was completed in Q4 to level 2.	
CQC compliance	G	G	G	G	Liaison activity is on-going; no gaps in delivery of work apparent.	

Information Governance Work Stream						
Task	Q1	Q2	Q3	Q4	Action plan for amber and red risks	Predicted position for end of Q4
<b>101</b> Governance Overview	G	G	G	G	Good structures in place.	
<b>105</b> Policy overview	G	G	R	G	IT Manager needs to update ICT Procedure	
<b>110</b> Contractor compliance	G	G	G	G	New contracts review database in place	
<b>111</b> Employee contract compliance	G	G	G	G	Standard NHS contracts are compliant.	
<b>112</b> IG training	A	R	R	G	Trust performance amongst best in England.	
<b>200</b> Data protection compliance	R	R	R	G	Procedure to be agreed and implemented by DET in order to safeguard students' research data. DET IG needs further work in 2013/14.	
<b>201</b> Confidentiality compliance	G	G	A	G		
<b>202 &amp; 203</b> Consent compliance	G	G	A	G		

<b>205</b> Access request compliance	G	G	G	G	Handling in line with procedure.	
<b>206</b> Confidentiality audit compliance	G	G	R	G	Audit to be undertaken by Caldicott Guardian	
<b>207</b> Sharing protocol compliance	G	G	G	G	Protocols in place where indicated.	
<b>209</b> processing outside UK	G	G	G	G	Relates to SBS only.	
<b>210</b> New systems compliance	R	R	R	G	Plan agreed to support Commercial Directorate to integrate IG into service acquisition process, evidence of implementation required; some retrospective amendments remain outstanding to existing contracts; full contract audit indicated.	
<b>300</b> Information security skills compliance	G	A	A	G	All training complete; ICO has directed that the Dean complete further training.	
<b>301</b> Risk assessment of IAs	G	A	A	G	All risk assessments complete	
<b>302</b> Incident Reports	G	G	G	G	'lessons learned' nor forms part of induction and INSET training.	
<b>303</b> Registration Authority compliance	G	G	A	G		

<b>304</b> RA monitoring compliance	G	G	A	G		
<b>305</b> access control compliance	G	A	A	G	Evidence of controls logged.	
<b>307</b> Risk management	R	A	A	G	Mitigation in place for all identified risks.	
<b>308</b> Transfer compliance	G	G	R	G	See 200	
<b>309</b> Business continuity assurance	G	A	A	G	Mitigation in place for all identified risks.	
<b>310</b> Disruption preparation assurance	G	A	A	G	Mitigation in place for all identified risks.	
<b>311</b> Protection of IAs	G	A	A	G	Mitigation in place for all identified risks.	
<b>313</b> Network assurance	G	G	A	G		
<b>314</b> Teleworking assurance	G	G	A	G		
<b>323</b> Protection of IA assurance	G	A	A	G	Mitigation in place for all identified risks.	



<b>324</b> Pseudonymisation assurance	G	G	A	G	Undertaken for all data.	
<b>400</b> IG skills and experience assurance	G	A	A	G	Training needs to be completed by Caldicott Guardian.	
<b>401</b> NHS number assurance	G	G	A	G		
<b>402</b> Accuracy of data input	G	G	A	G	This is being addressed as part of IMT and parallel information development work projects.	
<b>404</b> Audit assurance	G	G	G	G	Clinical records audit used as evidence	
<b>406</b> Monitoring paper records assurance	G	G	G	G	ICO identified practice that needs to be addressed to ensure procedures are always followed in clinical teams.	
<b>501</b> Data definitions compliance assurance	G	G	A	G		
<b>502</b> External data feedback reports	G	G	A	G		
<b>504</b> Benchmark reports	G	A	A	G		

<b>506</b> Service user data accuracy validation	G	G	A	G	See 402	
<b>507</b> Data completeness validation	G	A	A	G	See 402	
<b>508</b> Clinical data input validation	G	G	A	G	See 402	
<b>514</b> Clinical coding audit validation						
<b>516</b> Clinical coding training programme assurance						
<b>601</b> Corporate record management assurance	G	G	G	G	ICO audit has provided limited assurance of compliance, though a range of actions have been agreed.	
<b>603</b> FOI compliance assurance	G	A	A	G	Outstanding training completed in Q4	
<b>604</b> Records lifecycle management assurance	G	G	G	G		

## Board of Directors : May 2013

**Item :** 9

**Title :** CQSG: Annual Performance Review, 2012/13

**Summary :**

The Board of Directors has directed all committees to review and report on their performance annually. Each work stream lead is also required to undertake a review of their performance against their terms of reference; this work contributes to the report overall and these submissions are attached as appendices.

The review indicates that the CQSG has discharged its functions as required by the Board of Directors.

**For :** Discussion

**From :** Rob Senior, CQSG Chair

## CQSG: Annual Performance Review 2012/13

### 1. Introduction

The committee continued to provide assurance that the Trust is delivering on its Annual Plan within the CQSG's areas of interest; the Trust needs to reflect on progress to date and ensure systems, structures, and processes remain fit for purpose. The findings are based on the individual work stream leads' feedback on their own areas, and the meetings of the CQSG.

### 2. Findings

#### *General*

Work streams that existed in another form before incorporation into the CQSG tend to enjoy better support and long serving staff, these benefits provided an advantage and these areas clearly perform well.

The internal and independent external auditors reviewed elements of the committee's work as part of their respective audits; overall the audits indicated that the work streams functioned well.

Several work stream leads have stressed that delivery of Trust objectives must be focussed at team level, not at work stream level; as systems mature this will be an area of on-going development.

Risks noted below have yet to be quantified and added to the risk register.

#### *Corporate Governance and Risk*

The Trust maintained its level 2 certification. Following the visit by the NHSLA, some useful enhancements were made to the policy management process and a Trust Lead for Policy was appointed. The Lead reports to the MC and a gradual improvement in policy management was noted.

The CGR Lead benefited from an experienced and expert team who were able to support the other work stream leads as they developed their own systems and processes to support their work; this support is on-going.

Some changes were made to the TOR as IG elements were transferred to the new IG work stream.

#### *Clinical Outcomes*

A restructuring within the clinical governance office has been achieved with a new staff mix to ensure processes for data collection are robust and fit for purpose. This central hub ensures the collection and data entry of all relevant outcome monitoring measures on the

outcome monitoring tracking system, which has been created in house to assist our data collection and reporting. In addition to this restructure, the clinical governance team with the Informatics team, are rolling out training on this outcome monitoring tracking system to all clinicians, including outreach clinical staff, to enable them to track and enter clinical outcomes and measures as required.

### ***Clinical Audit***

Clinical audit has had increased impetus this year with new processes put in place to ensure the standard, quality and relevance of all audits undertaken within the Trust. All audits now have to be agreed in advance with the Trust audit lead and all audits are logged on the Trust audit database.

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

The Patient Safety work stream has continued to review patient risk issues through the year. Unusually for the Trust we did not have one SUI in the year, but found that the SUI policy and procedure worked well in practice. The work stream received a detailed report and action plan which was approved by the Board. During the year a very low number of reportable incidents occurred, which continues to be the pattern due to the nature of the services that we run. In year the on-going risk that has been identified relates to the identification of children with a child protection plan, via our Rio data base. Work continues to address this.

### ***Quality Reports***

The report has two functions: one forms a section of the Annual Report, the other (Quality Accounts) is a stand-alone document used by the commissioners and others as a guide to quality of the Trust's clinical services. The 2011/12 report was validated by the external auditor and has been incorporated into the annual report having been accepted by the Board of Directors. On-going work to strengthen reporting forms part of the Clinical Information Management Development Group, which will include training clinicians to use the OM (Outcome Monitoring) Tracking System in 2013/14.

### ***Patient and public involvement***

Quarterly reports on the qualitative and quantitative feedback from patients provided us with more accurate and valid data on patient satisfaction than previous patient surveys, and we are now more able to be confident in the trends in feedback from patients. Membership recruitment has focussed on internal events.

### ***Information Governance***

This work continued as business as usual. It is very positive that the Trust did so well (4<sup>th</sup> best performance in London) but slippage in a few key areas would have been highly compromising overall so the Trust continues to aim high. The areas of highest performance reflect the areas which enjoy the highest resource; resourcing is to be addressed as part of on-going development planning for this and related activity.

### 3. Conclusion

The committee has done well to achieve its objectives though some further work to provide greater depth on achievement of Trust objectives is indicated. Themes that the Trust has been addressing (data quality, data management, and good governance) seem to be subject to greater interest externally, though as a result of the work undertaken, the trust will be in a good position to address the challenges ahead, but needs to maintain its commitment to the provision of resources to these areas.

Over the coming year, the Trust will continue to work closely with service users, commissioners and other providers in the provision of high quality services to local residents, and to people from across the country for our specialised services. In particular, work stream leads could usefully develop greater synergies between work areas in order to deliver the Trust's Annual Plan and other high level objectives. The MC will consider how to take this forward in the coming months.

Dr Rob Senior  
CQSG Chair  
May 2013

## Corporate governance and risk work stream annual review 2012/13

This paper is a review of performance against the terms of reference set by the CQSG: the duties are set out in the table below in the left hand column, and on the right the work stream lead has summarised the performance over the year. In addition, the work stream lead has set out highlights, risks, and recommendations for consideration by the CQSG.

### Highlights for 2013

- The improved attendance rates in all areas of mandatory training have been significant. Equally important has been the method by which data is collected which has given the Trust much greater data confidence in this area.
- The announced inspection by CQC was one of very few announced inspections by CQC this year. The assessors were given a detailed timetable covering all the areas in the standards which they wished to inspect. The informal feedback at the end of the day, where they met and interviewed staff, governors and a patient representative, was very positive.
- The NHSLA informed the Trust that no fees would be payable over the next year to reflect the low number of claims.

Duty	Review of performance
The Lead's primary duty is monitoring the Trust's management of corporate governance and non-clinical risk across all areas of the Trust and to provide assurances to the CQSG that regulatory and other external requirements in relation to corporate governance and non-clinical risk are being met, and that the Trust adheres to its approved process for responding corporate governance and non-clinical risk issues that arise in practice.	The CGR Lead is the only lead to attend another work stream meeting (IG); in addition, CGR colleagues provide much support to clinical governance activity and development.

The Lead shall seek assurance that prospective submissions to:	All submissions were received on time and were considered by the work stream group.
CQC (including evidence in support of continued compliance with standards pending an inspection)	There was an announced CQC inspection following the appointment of a new assessor by the CQC; full compliance with all standards was noted in the subsequent report.
NHSLA	The current regime is being reviewed, in the interim the Trust has maintained compliance with current standards to level 2.
Monitor	The Trust was designated 'green' for corporate governance risks by Monitor
are fit for purpose, and where there are short falls in performance that action plans are drawn up and then monitored	No action, apart from maintaining performance as business-as usual, was indicated.
that the Trust maintains an effective risk strategy and associated procedures that are fit for purpose,	The Risk Strategy, the Incident Reporting Procedure and the Serious Incident Procedure were all reviewed. Risk reporting remained brisk indicating staff were confident with the mechanism.
that non-clinical risks are effectively identified, assessed and managed and that the risk register is kept up to date with information about the management of these risks	A quarterly report was received and findings discussed where appropriate.
that non-clinical incidents are being managed effectively and in line with the Trust's procedures, and that all 9+	A quarterly report was received and findings discussed where appropriate, in addition, IG incidents were discussed in detail



incidents are appropriately investigated, through receipt of a quarterly report	by the IG work stream.
that Health and Safety matters affecting staff are effectively managed as confirmed by receipt of notes from the Health and Safety Committee	Notes of the Health & Safety Committee were reviewed; no areas of concern were noted. The timing of the H&S Committee was changed to allow timely quarterly reports to the work stream
that the operational risk register continues to provide board level information, which will contribute to a risk-enabled board culture.	This operational risk register was discussed at each meeting, and the Board receive the full risk register annually. The risk register was reported to the Board, via the MC, if required. The Board reviewed its approach to governance in some depth and recommendations were made.
that HR submissions of compliance with mandatory regulations are fit for purpose	A quarterly report was received and findings discussed where appropriate. Significant improvements were noted over the year and data confidence was enhanced.
that reports on responding to the recommendations made by external bodies following reviews and inspections are made on time and that the risk register is updated where appropriate	A quarterly report was received and findings discussed where appropriate; no deadlines were missed.

### Recommendations

1. That the reference to prospective submissions to Monitor is amended to show that the Trust complied with the requirement to submit and that, should action plans be required, that they are put in place and monitored by the Management Committee.

## Clinical Outcome Monitoring Work Stream Annual Review 2012/13

This paper is a review of performance against the terms of reference set by the CQSG: the duties are set out in the table below in the left hand column, and on the right the work stream lead has summarised the performance over the year. In addition, the work stream lead has set out highlights, risks, and recommendations for consideration by the CQSG.

### Highlights for 2013

Duty	Review of performance
The lead's primary duty is monitoring the Trust's management of clinical outcomes and to provide assurances to the CQSG that regulatory and other external requirements in relation to outcome monitoring are being met, and that the Trust adheres to its approved process for responding to lessons learned from clinical audit in practice.	The work stream lead together with the clinical governance team, manage the Trust's OM programme. Regulatory and other external requirements are being met e.g. OM CQUIN targets for CAMHS 2012/13 were fully met
The Lead shall seek assurance on :	
that outcome monitoring methods in use in the trust reflect best practice for our patient population	Assurance can be given, for example, CAMHS is CORC ( CAMHS Outcome Research Consortium) compliant
that adequacy of outcome measures reflect corporate planning and the needs of external assessors and commissioners	Compliant

that there is local monitoring in place on the levels of outcome monitoring and that action is taken at Directorate / Speciality level when levels of monitoring do not reach agreed target levels	Yes – at team level and service level. Action plans in place to achieve target levels and these are continuously reviewed.
that there are improvements in outcome monitoring over the long term	Partial assurance can be given. Planned roll out of outcome monitoring tracker system to all clinicians May – July 2013 will support longer term monitoring

### Key risks

- Clinician acceptance of direct entry of outcomes to tracker database
- Impact of roll out of CYIAPT Oct 2013.

### Recommendations for 2013/14

- Continue to make OM integral part of clinical practice

## Clinical Audit Work Stream Annual Review 2012/13

This paper is a review of performance against the terms of reference set by the CQSG: the duties are set out in the table below in the left hand column, and on the right the work stream lead has summarised the performance over the year. In addition, the work stream lead has set out highlights, risks, and recommendations for consideration by the CQSG.

Duty	Review of performance
The lead will ensure that assurance is provided to the CQSG showing that regulatory, and other external requirements in relation to clinical audit, are being met, and that any recommendations from audit exercises are implemented in practice where appropriate.	Achieved The work stream lead together with the Governance and Risk Adviser maintained a clinical audit register through the year and followed up on completed audits, we received evidence of cooperation with one national audit we were involved in during 12-13
The lead shall seek assurance on the areas of practice listed below and will provide a summary report to the CQSGC of assurance received and any areas of concern/ breaches in practice that need further action outside the scope of the work stream:	
compliance with the procedure for clinical audit	through close support of those involved in clinical audit there were no breaches of procedure in the year, all audit reports were produced on the Trust template
compliance with annual audit programme (including follow up of lessons learned)	The annual programme continued and lessons were fed back to Directorates

that the annual programme complements organisational priorities	the programme was set to reflect organisational priorities
that audits and reviews are commissioned as required	achieved
that clinical staff are engaged in audit of their practice	this is occurring to an increasing extend, all are involved in changing practice when feedback indicates this is required
that the trust follows its procedures for responding to, and following guidance relevant to, practice; including NICE, and other external guidance.	requirements met during the year
that the implementation of recommendations made as a consequence of audit exercises lead to improvements in patient care	some improvements in care have resulted as a direct result of audit in 2012-13 eg digital life awareness, consent procedure, record keeping for group notes

### Key risks

- Clinical audit is not an integral part of practice and we are not able to show that all clinicians are actively involved in audit

### Recommendations for 2013/14

- That CAMHS and SAAMHS identify an audit champion to work with the Governance and risk Adviser and the Work stream lead to coordinate and promote audit practice in each Directorate/team

## PSCR Work Stream Annual Review 2012/13

This paper is a review of performance against the terms of reference set by the CQSG: the duties are set out in the table below in the left hand column, and on the right the work stream lead has summarised the performance over the year. In addition, the work stream lead has set out highlights, risks, and recommendations for consideration by the CQSG.

### Highlights for 2012-13

- The Patient Safety work stream has continues to review patient risk issues through the year. Unusually for the Trust we did have one SUI in the year, but found that the SUI policy and procedure worked well in practice. The work stream received a detailed report and action plan which was approved by the Board. During the year a very low number of reportable incidents occurred, which continues to be the pattern due to the nature of the services that we run. In year the on-going risk that has been identified relates to the identification of children with a child protection plan, via our Rio data base. Work continues to address this.

Duty	Review of performance
The trust follows its processes on managing clinical incidents, complaints and claims	All clinical incidents and complaints are being handled correctly. There were no clinician claims in the last year.
The trust learns lessons arising from clinical incidents, complaints and claims	An action plan from lessons arising from the SUI is being implemented. Due to the slight increase in complaint numbers both Directorates are holding focused sessions to explore lessons from complaints  One formal complaint resulted in training on GP letter writing and another prompted training on consent to treatment; both training

	sessions were well received.
In the event of an SUI the trust follows its investigation procedure in relation to investigation, whilst being open with patients and relatives, and supports staff directory involved	The Trust had 1 SUI in year. The SUI procedure was followed and a RCA report submitted to the Board and relevant external stakeholders. Our Being Open procedure was followed and the findings of the report have been provided to the family.
The trust follows any agreed action plan arising from the investigation of an SUI	Action plan from SUI approved in Q4, implementation will be via work stream in 2013-14
The trust effectively supervises all clinical practitioners	No specific audit of supervision took place in 2012-13; a targeted re-audit of the 2011-12 audit is scheduled for 2013-14. No evidence of lack of supervision received, and indeed the CQC were very impressed at our arrangements for supervision at their inspection visit in February 2013
The trust follows robust record keeping practises (the audit lead will monitor progress of annual records audit plans)	Guidelines for record keeping practises remain robust. Rolling audit of record keeping took place during the year with local feedback, focused change to record keeping for groups in one department resulted from the audit progress.
Safeguarding arrangements for children and adults are effective and in line with the trust procedure and pan-London procedures	Safeguarding children: Joint Ofsted/CQC audit of Camden Looked after children included the Tavi in 2012-13, feedback did not raise significant concerns. Safeguarding adults' arrangements effective.
Clinical risks are adequately assessed and reviewed	Clinical risks on risk register reviewed quarterly by lead.
The Trust responds in an appropriate and timely fashion to all relevant clinical safety alerts	No clinical safety alerts relevant to the Trust were received in 2012-13 The National reporting and learning system (NRLS) did not issued any

	alerts relevant to the Trust's clinical practice in 2012-13
Clinicians' revalidation records are accurate	Revalidation arrangements remain on track to meet all external requirements. Revalidation appraisal training took place in the year.
Reviews comply with the Health Act 2006 on reducing HCAs are undertaken and any recommendations are considered and implemented where appropriate	No incident reports relating to infection control were received in the year. Hand washing techniques and management of body fluid contamination injuries were covered at all induction and INSET days during the year.

### Key risks

- Identification of children with a CP plan on Rio: this remains on the risk register graded 9

### Recommendations for 2013/14

- Clinical record audit programme for 2013-14 is targeted by Directorate to address local identified issues (e.g. for CAMHS this will include evidence of record keeping arising from team meeting discussion)



## Quality reports work stream annual review 2012/13

This paper is a review of performance against the terms of reference set by the CQSG: the duties are set out in the table below in the left hand column, and on the right the work stream lead has summarised the performance over the year. In addition, the work stream lead has set out highlights, risks, and recommendations for consideration by the CQSG.

Duty	Review of recommendations
<p>The Lead shall seek assurance that prospective submissions to:</p> <ul style="list-style-type: none"> <li>• CQC (including evidence in support of continued compliance with standards pending an inspection)</li> <li>• NHSLA</li> <li>• Monitor</li> <li>• Connecting for Health</li> </ul> <p>are fit for purpose, and where there are short falls in performance that action plans are drawn up and then monitored</p>	<p>All submissions were made on time and showed satisfactory outcomes.</p> <p>Where interim submissions were made, and where assurance was not received plans were always submitted and proved satisfactory.</p>
<p>The Lead's primary duty is monitoring the Trust's management of quality across all clinical areas of the Trust and to provide assurances to the CQSG that regulatory and other external requirements in relation to quality are being met, and that the Trust adheres to its approved process for responding to quality issues that arise in practice.</p>	<p>The lead provides quarterly reports to the CQSG confirming external requirements have been met. The Data Quality Strategy and Policy has been devised to ensure the Trust adheres to its approved processes for responding to quality issues that arise in practice.</p>

<p>The Lead shall seek assurance on the areas of practice listed below and will provide a report to the CQSG with a summary of assurance received and any areas of concern/breaches in practice that need further action.</p>	<p>All aspects are covered in the quarterly CQSG report.</p>
<p>The Lead shall seek assurance that :</p> <ul style="list-style-type: none"> <li>• Quality accounts are produced to a high standard</li> <li>• Arrangements to deliver CQUIN are fit for purpose</li> <li>• That data quality is improving</li> <li>• That data to be collected has been agreed</li> <li>• That guidelines on the nature of data are satisfactory</li> </ul>	<p>The 2011/12 Quality accounts/Report was completed and submitted on time.</p> <p>The 2011/12 Quality report was assessed by external auditors and found to be satisfactory.</p> <p>Data collection agreed with commissioners for CQUINs.</p> <p>The establishment of a Framework for Data Quality and Procedures has been a key area of development for improving data validation.</p> <p>A service remodeling has created two main service areas; Specialist Mental Health and Child and Adolescent Mental Health and effective communication is assured via regular meetings.</p>
<p>The lead will liaise with other work stream leads to ensure effective use of resource and collaboration where possible so that duplication of effort can be avoided.</p>	<p>Monthly SAAMHS Clinical Governance meetings ensure best use of resources and collaboration.</p>

The lead will report to the CQSGC via the Management Committee on a quarterly basis. The report may be supplemented with other reports or documents in support of assurance. The report should identify any gaps in assurance and note any action to be taken to address gaps.	The quarterly reports to the CQSG ensure that any gaps are identified in assurance and action plans put in place.
<p>The Lead shall seek assurance that prospective submissions to:</p> <ul style="list-style-type: none"> <li>• CQC (including evidence in support of continued compliance with standards pending an inspection)</li> <li>• NHSLA</li> <li>• Monitor</li> <li>• Connecting for Health</li> </ul> <p>are fit for purpose, and where there are short falls in performance that action plans are drawn up and then monitored</p>	<p>All submissions were made on time and showed satisfactory outcomes.</p> <p>Where interim submissions were made, and where assurance was not received plans were always submitted and proved satisfactory.</p>
The Lead's primary duty is monitoring the Trust's management of quality across all clinical areas of the Trust and to provide assurances to the CQSG that regulatory and other external requirements in relation to quality are being met, and that the Trust adheres to its approved process for responding to quality issues that arise in practice.	The lead provides quarterly reports to the CQSG confirming external requirements have been met. The Data Quality Strategy and Policy has been devised to ensure the Trust adheres to its approved processes for responding to quality issues that arise in practice.
The Lead shall seek assurance on the areas of practice listed below and will provide a report to the CQSG with a summary of assurance received and any areas of concern/breaches in practice that need further action.	All aspects are covered in the quarterly CQSG report.
The Lead shall seek assurance that :	

<ul style="list-style-type: none"> <li>• Quality accounts are produced to a high standard</li> <li>• Arrangements to deliver CQUIN are fit for purpose</li> <li>• That data quality is improving</li> <li>• That data to be collected has been agreed</li> <li>• That guidelines on the nature of data are satisfactory</li> </ul>	<p>The 2011/12 Quality accounts/Report was completed and submitted on time.</p> <p>The 2011/12 Quality report was assessed by external auditors and found to be satisfactory.</p> <p>Data collection agreed with commissioners for CQUINs.</p> <p>The establishment of a Framework for Data Quality and Procedures has been a key area of development for improving data validation.</p> <p>A service remodeling has created two main service areas; Specialist Mental Health and Child and Adolescent Mental Health and effective communication is assured via regular meetings.</p>
The lead will liaise with other work stream leads to ensure effective use of resource and collaboration where possible so that duplication of effort can be avoided.	Monthly SAAMHS Clinical Governance meetings ensure best use of resources and collaboration.
The lead will report to the CQSGC via the Management Committee on a quarterly basis. The report may be supplemented with other reports or documents in support of assurance. The report should identify any gaps in assurance and note any action to be taken to address gaps.	The quarterly reports to the CQSG ensure that any gaps are identified in assurance and action plans put in place.
The Lead shall seek assurance that prospective submissions to:	All submissions were made on time and showed satisfactory outcomes.

<ul style="list-style-type: none"> <li>• CQC (including evidence in support of continued compliance with standards pending an inspection)</li> <li>• NHSLA</li> <li>• Monitor</li> <li>• Connecting for Health</li> </ul> <p>are fit for purpose, and where there are short falls in performance that action plans are drawn up and then monitored</p>	<p>Where interim submissions were made, and where assurance was not received plans were always submitted and proved satisfactory.</p>
<p>The Lead's primary duty is monitoring the Trust's management of quality across all clinical areas of the Trust and to provide assurances to the CQSG that regulatory and other external requirements in relation to quality are being met, and that the Trust adheres to its approved process for responding to quality issues that arise in practice.</p>	<p>The lead provides quarterly reports to the CQSG confirming external requirements have been met. The Data Quality Strategy and Policy has been devised to ensure the Trust adheres to its approved processes for responding to quality issues that arise in practice.</p>

## Patient and public involvement work stream annual review 2012/13

This paper is a review of performance against the terms of reference set by the CQSG: the duties are set out in the table below in the left hand column, and on the right the work stream lead has summarised the performance over the year. In addition, the work stream lead has set out highlights, risks, and recommendations for consideration by the CQSG.

### Highlights for 2013

- This is the first year that we have published quarterly reports on the qualitative and quantitative feedback from the ESQ (experience of service questionnaire) data. This data has provided us with more accurate and valid data on patient satisfaction than previous patient surveys, and we are now more able to be confident in the trends in feedback from patients.
- We have had several 'mystery shopper' evaluations over the year, and one of these involved young people. This feedback gives us the possibility of evaluating patients' experience of our services from a range of different perspectives, and allows for 'triangulation' of the data we receive.
- Owing to patient feedback we have focused on improving our published information for patients, with an emphasis on improving patients' capacity to understand and consent to treatment. This has resulted in the development of a range of information leaflets.

Duty	Review of performance
The Committee's primary duty is to oversee the Trust's management of patient and public involvement activity and to provide assurances to the CQSGC that regulatory and other external requirements in relation to patient and public involvement are being met, and that the Trust adheres to its	<p>This has been achieved through a range of mechanisms:</p> <ul style="list-style-type: none"> <li>• The PPI committee</li> <li>• The quality stakeholders group</li> <li>• ESQ data</li> <li>• Audits</li> </ul>

approved process for responding to PPI issues that arise in practice.	<ul style="list-style-type: none"> <li>• Surveys</li> <li>• Mystery shoppers</li> <li>• Visual straw polls</li> <li>• Strategy</li> <li>• Staff training</li> </ul>
The Committee shall:	
develop and raise the profile of Patient and Public Involvement work across the Trust	Achieved through committee meetings, department leads, posters around the Trust, articles in the Membership Newsletter and on the Trust website, and inset/induction day presentations.
ensure that PPI activities are coordinated across the Trust and that forums for departmental PPI work are available	This is achieved through the PPI committee, which includes representatives from CAMHS and SAMHS who coordinate PPI activities within their departments and fed back these activities to the PPI Committee.
support the PPI work of the Patient Advice and Liaison Service	The PALS officer is part of the PPI team and attends all relevant meetings.
review patient information material to ensure the patient perspective is considered	The PPI Committee and Quality stakeholders meetings undertake this task. During the year the patient information leaflets have been reviewed and three new modality leaflets developed.
liaise with groups and stakeholders to ensure that consistent	This is achieved through the PPI lead being a member of the

good quality information is made available to members, patients, stakeholders and relevant public groups about treatment options available at the Trust to support patients making informed decisions about their treatment	CAMHS and SAAMHS executive committees, as well as through regular audits and reviews of information. The PPI Committee and quality stakeholders meetings review the relevant information.
receive feedback from the Experience of Service Questionnaire on a quarterly basis. The Committee will advise the Trust on the PPI aspects of the feedback received via the annual PPI report	This is achieved through the PPI committee and quality stakeholders meetings.
ensure action plans based on the findings reports on patient feedback and other PPI work result in improved patient care, the patient environment and the patient experience	The PPI team lead on actions plans, and where appropriate, alert the relevant directors to the need for a plan.
provide details on how public members' views influence strategic planning	We have a dedicated space on the PPI committee for a public member, as well as for three governors. Members' views have led to the development of a visual straw poll and the decision to involve service users on staff interviews panels.
provide support to membership activity, particularly the recruitment and retention of members	The PPI team are involved with recruitment at all relevant events eg members/tavi talks/AGM. The PPI team has increased the number of Membership Newsletter articles written by members.

### Key risks

- That information about PPI work is not communicated through the staff group



- That PPI work is 'owned' and localised by teams
- That PPI work is under resourced

#### **Recommendations for 2013/14**

- That PPI work is increasingly localised, with the PPI team acting as a resource to enable and support this work
- That staff continue to make use of the rich data collected through the ESQ's and other sources to develop and improve services
- That directors ensure that communication about PPI findings and recommendations are disseminated effectively through the trust

## Information Governance work stream annual review 2012/13

This paper is a review of performance against the terms of reference set by the CQSG: the duties are set out in the table below in the left hand column, and on the right the work stream lead has summarised the performance over the year. In addition, the work stream lead has set out highlights, risks, and recommendations for consideration by the CQSG.

### Highlights for 2013

The Trust achieved level 3 (top) on 28\* of the elements of the IG toolkit; and level 2 on the remaining 17. (\* this includes three which do not apply to us).

Task	Outcome
prospective submissions to the CfH/DH (or successor body) are fit for purpose, and where there are short falls in performance that action plans are drawn up and then monitored	The submissions/plans for each requirement were reported to the IG Lead, who reviewed each before uploading it as evidence. The evidence submission was scrutinised at each IG group meeting. Internal Audit also reviewed the process and progress. The SIRO reviewed the final submission and approved it prior to submission.
that the Trust maintains an effective IG strategy and associated procedures that are fit for purpose,	This is set out in the IG framework and is up to date.
that IG risks are effectively identified, assessed and managed and that the risk register is kept up to date with information about the management of these risks	The IG group reviewed its risks, and risks of interest, at each meeting. Changes were made as necessary.

that IG incidents are being managed effectively and in line with the Trust's procedures, and that all 9+ incidents are appropriately investigated, out outcomes documented in a quarterly report	Risks were managed according to the Trust's procedure with support from the Risk Adviser.
that information security matters are effectively managed as confirmed by receipt of notes from the IT Manager	Evidence of compliance was logged as part of the toolkit exercise.
that information assets are managed in accordance with the respective procedures	Overall performance summaries were noted on the Information Asset Register.
that external information governance submissions are accurate	See above
that reports on responding to the recommendations made by external bodies following reviews and inspections are made on time and that the risk register is updated where appropriate	na
that all requests for information made under the Freedom of Information Act were responded to by the statutory deadline and that any trends are explored	A quarterly report is received and reviewed by the work stream meeting.
A comprehensive IG training programme has been delivered by the Governance Manager.	Evidence of compliance was logged as part of the toolkit exercise.

## Key risks

- As usual, we start the new year with no information on when the revised IG toolkit for 2013/14 will be published. For the purpose of the first declaration, due on 31 July, we are assuming no significant changes, and prioritising our actions accordingly.

## Recommendations for 2013/14

- The 2013/14 IG action plan, currently in draft, will be finalised when we have the final report of the Information Commissioner's Office audit carried out in February.
- This will include some improvements to office security and further training and development for Information Asset Owners and Administrators. Work is already in hand on some points.
- The Caldicott Guardian's IG Action Plan is also to be agreed in the first quarter.

## Board of Directors : May 2013

**Item :** 10

**Title :** Constitutional Amendments

**Summary:**

The Constitution needs to be updated to reflect the relevant provisions in the Health and Social Care Act 2012 which came into force in April 2013. Constitutional changes need to be approved by the Board of Directors, the Council of Governors and by the members at the Annual General Meeting. Monitor no longer has a role in approving foundation trusts' constitutions.

The Act introduces new powers for governors to approve "significant transactions" and the Trust needs to decide whether it is going to include a description of a "significant transaction" in its Constitution and if it is, how it is going to define a "significant transaction."

**For :** Approval

**From :** Trust Secretary

## Constitutional Amendments

### 1. Introduction

1.1 The Health and Social Care Act 2012 received Royal Assent on 27<sup>th</sup> March 2012. The majority of the provisions relating to foundation trusts came into effect in April 2013. Set out in the attached Appendix is the proposed wording of the constitutional amendments which are needed to reflect the relevant provisions in the Health and Social Care Act. The wording is based on Monitor's Model Core Constitution.

1.2 Amendments to the Constitution need to be approved by the Board of Directors, the Council of Governors and at the Annual General Meeting. Monitor no longer has a role in approving foundation trusts' constitutions although trusts are still required to forward a copy of their amended constitutions to Monitor for publishing on Monitor's website.

### 2. Merger, Acquisition, Separation, Dissolution and Significant Transactions

2.1 The Health and Social Care Act 2012 introduces new powers for governors to approve mergers, acquisitions, dissolutions and significant transactions.

2.2 To reflect this change, the wording in Monitor's Model Constitution is:

The Trust may make an application to Monitor for a merger, acquisition, separation or dissolution only with the approval of more than half of the members of the Council of Governors present and voting;

a) The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust present and voting approve entering into the transaction.

2.3 Trusts have the option of either including:

- A description of what is meant by the term "significant transaction"; or
- Not defining the term "significant transaction." In this case, the Constitution must include the following statement: *"The constitution does not contain any descriptions of the term 'significant transaction' for the purposes of section 51A of the 2006 Act (Significant Transactions).*

### 3. Definition of a Significant Transaction

- 3.1 Although the Trust is not obliged to provide a definition of “a significant transaction” in the Constitution, for the avoidance of doubt, it would seem prudent to include a definition.
- 3.2 It is proposed to use Monitor’s definition of a “significant transaction” in the Constitution as set out in Appendix F of the Compliance Framework (set out below). Transactions which meet the criteria as set out below will require the approval of the Council of Governors. For other matters which do not meet the definition of a “significant transaction”, the Trust will continue to discuss its future plans with the Council of Governors and to seek their views.

**Extract from Monitor’s Compliance Framework (Appendix F) - Transactions**

Ratio	Description	Significant
Assets	The gross assets or capital (total of fixed assets and current assets) subject to the transaction divided by the gross assets of the foundation trust.	>25%
Income	The income attributable to: <ul style="list-style-type: none"> <li>• The assets; or</li> <li>• The contract</li> </ul> associated with the transaction, divided by the income of the foundation trust.	>25%
Consideration to total NHS foundation trust capital	The gross capital <sup>1</sup> of the company or business being acquired/divested, divided by the total capital <sup>2</sup> of the foundation trust following completion, or the effects of total capital of the foundation trust resulting from a transaction.	>25%

- 3.3 The Board is requested to approve the proposed constitutional changes as set in the Appendix and to agree the definition of a “significant transaction”. The proposed constitutional changes will be presented to the June meeting of the Council of Governors and the Annual General Meeting for approval.

Ms Julie Hill  
Trust Secretary  
20<sup>th</sup> May 2013

<sup>1</sup> Gross capital equals the market value of the target’s shares and debt securities, plus the excess of current liabilities over current assets.

<sup>2</sup> Total capital of the foundation trust equals taxpayers’ equity

## Appendix 1

### Constitutional Amendments

The wording of the proposed constitutional amendments is shown in italics.

#### **4. Amendments to Main Constitution**

##### **2.1 Annual General Meeting**

Paragraph 4.4.1 to add at the end:

*"The Annual General Meeting shall be open to members of the public."*

##### **2.2 Council of Governors – Duties to Governors**

A new Paragraph to be inserted after paragraph 12 to read:

*"The general duties of the Council of Governors are:*

- *to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and*
- *to represent the interests of the members of the Trust as a whole and the interests of the public.*

*The Trust shall take steps to ensure that the governors are equipped with the skills and knowledge they require in their capacity as such."*

##### **2.3 Council of Governors – Meetings of Governors**

To add an additional sub-paragraph to Paragraph 13 to read:

*"For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting".*

##### **2.4 Council of Governors – referral to the Panel**

To add a new paragraph after paragraph 13 to read:

*"In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the Trust has or is failing:-*



- *To act in accordance with its constitution, or*
- *To act in accordance with the provision made by or under Chapter 5 of the 2006 Act.*

*A governor may refer a question to the Panel, only if more than half of the members of the Council of Governors voting approve the referral."*

## **2.5 Board of Directors – General Duty**

New paragraph after paragraph 17 to read:

*"The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public."*

## **2.6 Board of Directors – Meetings**

New paragraph to be added after paragraph 23 to read:

*"Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.*

*Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors."*

## **2.7 Board of Directors – Conflict of Interests of Directors**

Paragraph 25 to be deleted and replaced with:

*"The duties that a director of the trust has by virtue of being a director include in particular –*

- *A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust.*
- *A duty not to accept a benefit from a third party<sup>3</sup> by reason of being a director or doing (or not doing) anything in that capacity.*

*The duty referred to above is not infringed if –*

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<sup>3</sup> third party" means a person other than The trust, or a person acting on its behalf.

- *The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or*
- *The matter has been authorised in accordance with the constitution.*

*The duty referred to in sub-paragraph above (paragraph number to be inserted) in is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.*

*If a director of the trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the trust, the director must declare the nature and extent of that interest to the other directors.*

*If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.*

*Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.*

*This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.*

*A director need not declare an interest –*

- *If it cannot reasonably be regarded as likely to give rise to a conflict of interest;*
- *If, or to the extent that, the directors are already aware of it;*
- *If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered –*
  - *By a meeting of the Board of Directors, or*
  - *By a committee of the directors appointed for the purpose under the constitution.*

## **2.8 Documents available for public inspection**

Paragraph 30 to be deleted and replaced with the following:

*"The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:*

- *a copy of the current Constitution;*
- *a copy of the latest annual accounts and of any report of the Auditor on them;*

- a copy of the latest Annual Report;

*The Trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:*

- *a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.*
- *a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.*
- *a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.*
- *a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.*
- *a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.*
- *a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.*
- *a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.*
- *a copy of any final report published under section 65I (administrator's final report).*
- *a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.*
- *a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.*

## 2.9 Amendments to the Constitution

Paragraph 37 to be replaced with the following:

*“The Trust may make amendments to this Constitution With the approval of the Board of Directors, Council of Governors and Members”.*

## 2.10 Mergers, Acquisition, Separation, Dissolution and Significant Transactions

New Paragraph to be inserted after paragraph 37 to read:

- b) *“The Trust may make an application to Monitor for a merger, acquisition, separation or dissolution only with the approval of more than half of the members of the Council of Governors, present and voting;*
- c) *The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust present and voting approve entering into the transaction.*

*“Significant transaction” means a transaction:*

- Assets: Where the gross assets or capital (total of fixed assets and current assets) subject to the transaction divided by the gross assets of the foundation trust are 25% or greater, or*
- Income: Where the annual income attributable to the assets or the contract associated with the transaction divided by the income of the foundation trust is 25% or greater, or*
- Capital Where the gross capital<sup>4</sup> of the company or business being acquired/divested, divided by the total capital<sup>5</sup> of the foundation trust following completion, or the effects of total capital of the foundation trust resulting from a transaction is greater than 25%.*

## Annex 1 of the Constitution – Composition of the Council of Governors

Paragraph 2 – Appointed Governors to read:

### 1. Appointed Governors

	Governor Seats
<b>Primary Care Trusts</b>	
Camden CCG	2

<sup>4</sup> Gross capital equals the market value of the target’s shares and debt securities, plus the excess of current liabilities over current assets

<sup>5</sup> Total capital of the foundation trust equals taxpayers’ equity

<b><i>Local Authorities</i></b>	
London Borough of Camden	1
<b><i>Partnership Organisations</i></b>	
Voluntary Action Camden	1
University of Essex	1
University of East London	1
<b><i>Total</i></b>	<b>6</b>

Julie Hill  
Trust Secretary  
May 2013

## Board of Directors: May 2013

**Item :** 11

**Title :** Corporate Governance Board Statement

**Summary:**

Monitor's Corporate Governance Board Statement will form part of the Trust's Annual Strategic Plan, due to be submitted to Monitor by 9.00am on 3 June 2013.

The Board of Directors is invited to approve the statement, which is attached.

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

*(delete where not applicable)*

- Quality
- Risk
- Finance

**For :** Approval

**From :** Director of Finance and Deputy Chief Executive

## Corporate Governance Board Statement

### 1. Introduction

- 1.1 As part of the Trust's Annual Strategic Plan submission to Monitor, the Board of Directors is required to consider 19 statements covering quality, finance and governance matters; and having had regard to the views of the governors, to confirm or not confirm each of the statements.
- 1.2 The Compliance Framework requires Trusts to identify any risk to any of these statements; and mitigating actions (if necessary). However, no supporting details are required if compliance is confirmed.
- 1.3 Appendix 1 of the report sets out the text of each of the 19 statements. The Board of Directors is invited to confirm all 19 statements, on the basis of:
  - Regular reports on quality, performance, finance and governance received throughout the year, including the quarterly declarations.
  - The annual quality report and annual accounts presented to this meeting, together with the reports of the external auditors on both of them.
  - The annual plan also being presented to this meeting.
- 1.4 Statement 16 does not apply to this Trust's membership of an AHSC: see Appendix 2.
- 1.5 Statements 18 and 19 are not listed in the Compliance Framework, but they are on the template we have been sent; so they are included here for approval.
- 1.6 In approving the statements, we can confirm that we have taken the views of the governors into account. The Board has consulted the Council of Governors during the development of the 2013 annual plan. The Council of Governors also receives reports on the matters covered by these statements; and representative members of the Council take part in the governance processes of the Trust.

Simon Young  
Director of Finance and Deputy Chief Executive  
20 May 2013

## Appendix 1

### Statement from the Board of the Tavistock and Portman NHS FT

*The board are required to respond "Confirmed" or "Not Confirmed" to the following statements (see notes below)*

#### For quality that:

#### Board Response

1. The board is satisfied that, to the best of its knowledge and using its own processes and having assessed against 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.
2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.
3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

Confirmed

Confirmed

Confirmed

#### For finance that:

4. The board anticipates that the trust will continue to maintain a financial risk rating of at least 3, as [currently] defined in Monitor's Compliance Framework, over the next 12 months
5. The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.

Confirmed

Confirmed



**For governance, that:**

- |     |  |           |
|-----|--|-----------|
| 6.  | The board will ensure that the trust remains at all times compliant with its licence and has regard to the NHS Constitution  | Confirmed |
| 7.  | All current key risks to compliance with the trust's licence have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.   | Confirmed |
| 8.  | The board has considered all likely future risks to compliance with its licence and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.  | Confirmed |
| 9.  | The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.   | Confirmed |
| 10. | An Annual Governance Statement is in place pursuant to the requirements of the NHS Foundation Trust Annual Reporting Manual, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury ( <a href="http://www.hm-treasury.gov.uk">www.hm-treasury.gov.uk</a> ). | Confirmed |
| 11. | The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix B; and a commitment to comply with all known targets going forwards.  | Confirmed |
| 12. | The board is satisfied that its NHS foundation trust can operate in an economic, efficient and effective manner.   | Confirmed |
| 13. | The board will ensure that the trust will at all times operate effectively within its constitution. This includes: maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; that all board positions are filled, or plans are in place to fill any vacancies; and that all elections to the board of            | Confirmed |

governors are held in accordance with the election rules.

- |     |   |           |
|-----|---|-----------|
| 14. | The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience, skills and training to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.                  | Confirmed |
| 15. | The board is satisfied that: the management team has the capacity, capability, training and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.  | Confirmed |
| 16. | For an NHS foundation trust engaging in a major Joint Venture, or Academic Health Science Centre (AHSC), the board is satisfied that the trust has fulfilled, or continues to fulfil, the criteria in Appendix C4. <i>[Internal Note: see Appendix 2 of this paper]</i>   | Confirmed |
| 17. | The board is satisfied that plans are in place to ensure that the trust will at all times comply with all applicable legal requirements.  | Confirmed |
| 18. | The board is satisfied that during 2013 the Trust has provided the necessary training to its governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.  | Confirmed |
| 19. | <b>EITHER:</b><br>After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. | Confirmed |

Or

After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or

paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services

Or

In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature

Signature

**Name**

**Name**

**Capacity**

**Capacity**

**Date**

**Date**

*In the event than an NHS foundation trust is unable to fully self certify, it should NOT select 'Confirmed' in the relevant box. It must provide commentary (using the section provided at the end of this declaration) explaining the reasons for the absence of a full self certification and the action it proposes to take to address it. Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.*

*Where boards are unable to self-certify, they should make an alternative declaration by amending the self-certification as necessary, and including any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance*

## Appendix 2

Statements 1 to 17 in Appendix 1 are listed in the 2013/14 Compliance Framework (Appendix C3).

The Compliance Framework sets out (in appendix F, pages 72 to 73) the criteria under which statement 16 is required: see below. These do not apply to this Trust.

### Joint ventures

.....

The relevant triggers are:

- 'Control' i.e.: where a separate decision making body has influence over the development and/or delivery of an NHS foundation trust's strategy. Where the separate decision-making body is a legal entity, influence would normally be defined as at least 20% ownership.
- 'Financial conditions': where an NHS foundation trust's:
  - assets within the vehicle are greater than 10% of its total assets (per the most recent quarterly monitoring submission); or
  - share of income or expenditure from the partnership exceeds 10% of the foundation trust's total income or expenditure respectively in any full financial year.
- Legal arrangement – for 'accredited' AHSCs only, where an NHS foundation trust enters into a legal agreement establishing the legal arrangement of the partnership.

## Board of Directors : May 2013

**Item : 12**

**Title :** Staff Survey 2012 - Summary Results, Findings and Action Plan

**Summary:**

The purpose of this report is to provide the Board with a summary and analysis of the annual staff survey results, highlighting important areas and to provide assurance that the views expressed by staff in the survey are being addressed. Summary discussion of the Trust's survey results from 2012

- Findings: In particular, areas where the Trust needs to improve
- Other important areas such as Equalities , demographic groupings and specific work areas
- Any other areas of concern and
- Action plans to ensure improvements

This report has been reviewed by the following Committees:

- Management Committee

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

*(delete where not applicable)*

- Quality
- Equality
- Communications

**For :** Discussion and Approval of the Action Plan

**From :** Ms Susan Thomas, Director of Human Resources

# 2012 Annual Staff Survey

## Summary Results, Findings and Action Plan

May 2013

**2012 Annual Staff Survey**  
**Summary Results, Findings and Action Plan**

## Contents

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3. Findings and Action Plans (2012 Survey)	88
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## Introduction

1.1 This document summarises the results from the **2012** NHS annual staff survey. This national survey is commissioned annually by the Care Quality Commission (CQC) for NHS staff and takes place between October and December, with results published in February.

1.2 The results from this year's survey (2012) are good, with the Trust having high scores in a number of key survey areas, including staff engagement. Out of a total of 28 key findings this year, the Trust is rated as being in the highest/best category in 10 areas and rated as 'better than average' in 7 areas. The Trust has been rated as average in 3 areas and below average in 8 areas. The Trust also has the highest score of all mental health trusts in 6 of the areas where it is rated as being in the highest/best category.

1.3 An important achievement to highlight this year as mentioned is that the Trust's score for staff engagement has been rated as being in the highest best category, with a high proportion of staff stating that they would recommend the Trust as a place to work and receive treatment. Some of the other areas where the Trust had the highest scores include staff stating that there is good communication between management and staff, that they can contribute towards work improvements and that they feel motivated and are satisfied with their jobs. These positive results show that the Trust is still one of the best employers in its sector.

1.4 There has however been a slight decrease in the number of staff taking part in the survey. The Trust's response rate this year is 45% (207 staff), compared with a response rate of 52% in 2011 and 51% in 2010. This 2012 response rate is below the national response rate of 50%, though the national response has also decreased from a response rate of 55% in 2011 to 52% this year. The Trust's lower response rate is probably attributable to the fact that the Trust's efficiency and productivity programme came to an end at the time the survey took place, with the Trust going through a significant amount of change during that period.

1.5 The first section of this report focuses on the areas identified as requiring improvement from the 2011 survey. These 2011 survey results are then compared with the 2012 survey outcomes, to assess whether actions taken over the past year have secured the desired improvements. The second section summarises the results from this year's survey, highlighting key findings. Action plans are proposed for areas where improvements are required, including timescales for completion.



1.6 This year, some changes have been made to improve and shorten the survey. There are only 28 key findings this year, compared to 38 in 2011. Due to this, some key areas may not have direct comparisons with equivalents in previous years. As in previous years, the Tavistock is classified as a mental health/learning disability (MHLD) Trust, and is therefore compared with other MHLD Trusts across the country. The Trust scores this year are also weighted based on the numbers of staff in each occupational group e.g. Nursing. This report contains the weighted scores. Unweighted scores are shown in **Appendix 1** for information.

## 2. Key Areas of concern from the 2011 Survey

The Trust's scores in 2011 were very good, however there were a number of areas identified as requiring improvement in that year. These include -

1. The number of staff stating that they were working extra hours
2. The number of staff receiving health and safety training in the past 12 months
3. The number of staff stating that they had well-structured appraisals
4. The number of staff reporting errors, near misses or incidents witnessed in the last month
5. The numbers of staff stating that they feel motivated at work
6. Poorer outcomes for disabled and BME staff than other groups for a number of areas

In this section, these six major areas are compared with the 2012 survey outcomes to see where improvements have been achieved.

### 2.1 Areas showing Improvements

The three main areas that have shown improvements when compared with the 2012 results, are discussed below.

#### 2.1.1 The number of staff stating that they feel motivated at work

In the 2011 survey, on a scale of 1-5, the Trust's score for staff motivation was 3.78. This year (2012), the Trust's score is 3.87 for this category, with the national average being 3.84. In 2011, the trust was rated as being in the lowest worst category for this area, however this year the Trust has been rated as being in the highest best category. This is a good improvement especially considering that in the past year the Trust has gone through a number of organisational changes in line with the productivity and efficiency agenda. Such changes would normally be expected to have an adverse impact on staff motivation; however this does not seem to have been the case.

Measures proposed to deal with the trust's poor outcomes for staff motivation in the last year have included, seeking ways to improve morale through team based activities, away days and other organisation wide initiatives. While some of these have taken place across the trust and in teams, it does seem though that the fact that staff have been able to discuss the structural changes that took place and have had a greater involvement in discussions and decision making, has helped to ensure that staff morale hasn't declined and in turn helped keep staff motivation high.

### **2.1.2 The number of staff having well-structured appraisals**

In the 2011 survey, 40% of staff stated that they had received a well-structured appraisal in the last 12 months and the Trust was rated as average in this area, when compared with other Trusts. This year, the number having well-structured appraisals has increased to 45%. This score is also much higher than the mental health average of 41%. Measures taken to improve on these results in the past year have included streamlining the appraisal system, reducing the numbers of forms and improving the job planning processes. Work continues to take place to improve the appraisal system even further, which should secure further improvements in this area.

### **2.1.3 Outcomes for disabled and BME staff**

Poorer outcomes for disabled and BME staff were noticed in a number of areas in the 2011 survey. However, due to low numbers of respondents in the disabled category, it was acknowledged that results for that group may not have been statistically significant, though it was still necessary to consider interventions to secure improvements. Areas where poorer outcomes were noticed include the low numbers of BME and disabled staff stating -

- That there were good opportunities to develop
- That they were having job relevant training and
- that they were having well-structured appraisals

Additionally, the 2011 results showed a higher number of BME staff experiencing bullying and harassment in comparison with non-BME staff and a lower number believing that the Trust provided equal opportunities for career progression. The numbers of BME staff attending equalities training was also low in comparison with other groups.

A number of measures were taken during the year, to secure improvements in these areas, such as increased bullying and harassment training sessions, further equalities initiatives highlighted at Trust INSET

day as well as through regular equalities briefing sessions, statements provided highlighting the Trust's commitment to equalities etc.

In this year's survey (2012) there were seventeen (17) respondents in the disabled category compared to nineteen (19) in the 2011 survey. The BME respondents had also decreased from forty-three (43) in 2011 to thirty-four (34) this year. Some slight Improvements have however been noticed in the outcomes for BME and disabled staff in a number of areas in this survey. For example a higher proportion of BME and disabled staff when compared with other staff groups, stated that they are being appraised. In addition a higher proportion of BME staff in comparison with other groups, indicated they are having well-structured appraisals. The scores for the other areas mentioned above for BME staff have also improved significantly with 81% stating that there is equal opportunities in career progression compared with 67% in 2011. 16% of BME staff also stated that they have experienced bullying and harassment from other staff in 2012 compared to 23% in 2011. However, there still remain a number of areas where outcomes haven't improved, especially for disabled staff and these are discussed later in the report.

## **2.2 Area/s showing no improvement**

Three areas out of the six haven't improved in comparison with previous years. These are discussed below–

### **2.2.1 The number of staff stating that they were working extra hours**

In the 2011 survey 70% of staff stated that they worked extra hours in order to meet work commitments. In 2012 the number has increased to 80% of staff stating this. Measures taken over the past year include improvements in Job planning, provision of stress and time management briefings sessions, updating the Trust's flexible working policies and e-mail notifications to staff covering time management and workload management. These interventions however do not seem to have secured the desired improvements. The Trust's recent efficiency and productivity exercise and new working arrangements arising from this may have some part to play in this. However, a high number of staff stating that they are working additional hours is a regular feature in the Trust's survey outcome and has been so for a number of years.

### **2.2.2 The number of staff receiving health and safety training in the past 12 months**

There have been no discernible improvements in the number of staff receiving health and safety training, with this number actually reducing from 70% in 2011 to 66% in 2012. This reduction is despite measures taken to improve on this in the past year, which have included providing adhoc health and safety briefings and updates and applying sanctions for

non-attendance at mandatory training. It should be noted that staff are only required to attend Health and Safety training once every two years, as part of the Trust's INSET day and the annual attendance rate at this event is normally between 85% to 92%. The Trust's staff survey score for this question is therefore quite low and does not reflect the numbers actually attending INSET training, where Health and Safety topics are covered.

### **2.2.3 The number of staff reporting errors, near misses or incidents witnessed in the last month**

Regarding this area, the Trust's score of 85% in 2011, though high, was still lower than the mental health average of 97%, with the best score being 100% for that category. This year the Trust scored 76% compared to a national average of 93%. Measures taken in the past year which have included incident reporting training and e-mail notifications, have not secured improvements, with this area having deteriorated substantially. Further work is required and this is discussed in detail in subsequent sections of this report.

## **3. Findings and Action Plans (2012 survey)**

The staff survey this year (2012) once again has been structured around the four pledges contained in the NHS constitution with two additional themes. This means results can be easily compared with previous years. However, due to some changes made to the survey this year to shorten it, 7 key findings cannot be compared with 2011 data.

As a reminder, the four pledges and two additional themes from the survey are shown below:

**Pledge 1:** *clear roles and responsibilities and rewarding jobs*

**Pledge 2:** *personal development, access to appropriate training*

**Pledge 3:** *maintaining staff health, well-being and safety*

**Pledge 4:** *staff involvement and engagement*

### **Additional Themes**

**Theme 1:** *Staff Satisfaction*

**Theme 2:** *Equalities and Diversity*

The main findings from the 2012 survey are summarised below including significant demographic and occupational findings where relevant.

Graphical representations of some pledge findings including comparisons with the 2011 survey results (where available) are shown at the end of each section.

### **3.1 Pledge 1 – Clear roles, responsibilities and rewarding jobs**

In 2011 there were nine key findings for this pledge and the Trust did well in six out of those nine areas. This year (2012) this pledge has been reduced to five key findings. The Trust has done well in three out of these five key findings and has been rated as better than average for the three findings. While no areas of this pledge have gotten significantly worse than in 2011, two areas where the trust did not do so well this year, have been classed as being in the worst 20% category.

The findings for this pledge are discussed in more detail in the next section.

#### **3.1.1 Positive findings**

The Trust did well in the following key areas

- Staff feeling satisfied in the quality of work and patient care they deliver
- Work pressure felt by staff and
- Effective team working

Looking at the demographic responses, a few positive points to mention are that-

- A higher proportion of disabled staff in comparison with any other demographic staff group indicated that they feel that their roles make a difference to patients.
- The lowest proportion of staff indicating that they are working extra hours is in the BME staff category
- Work pressure felt by staff is also lowest for staff in management and administrative groups

#### **3.1.2 Negative Findings**

The negative findings for this pledge are in two areas, the number of staff working extra hours and the percentage of staff agreeing that their roles makes a difference to patients.

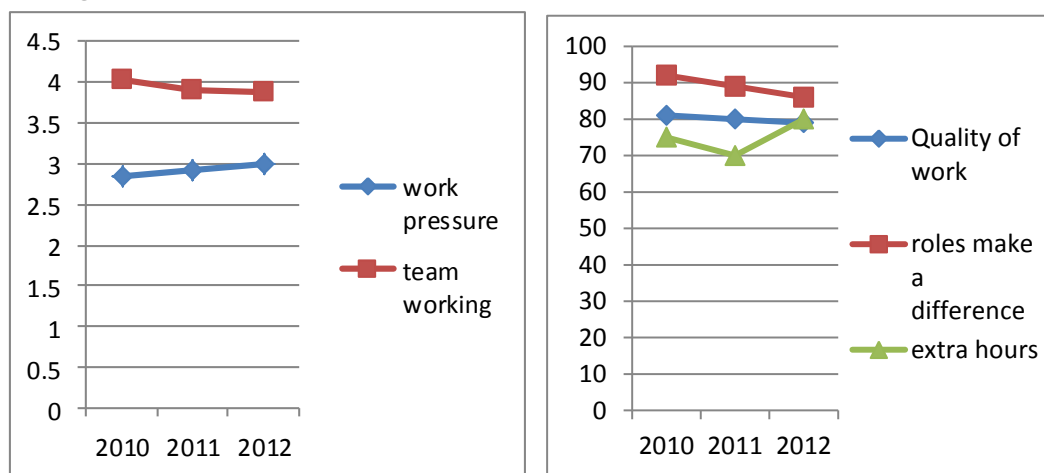
For a number of years the trust has had a higher than average score for the number of staff stating that they work extra hours in order to fulfil their roles. This has also always been particularly higher for clinical staff. This is the same this year with the Trust's score of 80% being higher than

the MHLA average of 70%. The Trust score as mentioned earlier, has also increased from 70% in 2011 to 80% this year. However when considering unweighted figures, the increase is not so much, with the Trust having an unweighted score of 80% this year compared with an unweighted score of 76% in 2011.

Another negative finding for this pledge is in 'staff agreeing their roles make a difference to patients'. The Trust was rated as average for this question in 2011, however this year; outcomes for this question have gotten worse with the trust rated as being in the lowest worst category for mental health Trusts. The Trust's score of 80% is below the MHLA average of 90%.

Other significant negative demographic findings for this pledge include a higher proportion of clinical staff than non-clinical staff experiencing pressure at work and a lower proportion of BME staff in comparison with other groups, stating that there is effective team working.

The two diagrams below show the trend for these five main areas and how they have mostly gotten worse over the past three years of reporting.



## Action

The findings from this year's survey show that the main issue of concern is still the number of staff working extra hours. It is important that improved job planning takes place this year especially as these issues are more prevalent with clinical staff. Additionally the clinical staff group seem to be experiencing the most work pressure so this will also need to be addressed. Further training events on managing pressure and time and workload management will be rolled and clinical staff in particular should be encouraged to attend these events.

The graphs above show that there is a downward trend in most areas of this pledge which will need to be looked into. The other areas of focus this year will need to be on increasing staff awareness of the impact that

all staff have in their specific roles on patient care and delivery. All staff must be encouraged to attend Trust events such as the INSET day, staff meetings, team meetings, scientific meetings, in order to get a better understanding of how their roles fit into the overall Trust strategy and in terms of patient care

***Responsibility for Action – Director of Human Resources, Chief Executive Officer***

***Completion Date – April 2014***

### **3.2 Pledge 2 – Personal development and access to training**

In 2011, the Trust had high scores in all six areas of this pledge, with only one area rated as average and four areas rated as having the highest best score. This year this pledge has been reduced to four key findings and the Trust has done well in three out of these four key areas. This is still a relatively good result.

These positive findings are discussed below:

#### **3.2.1 Positive findings**

Areas where the Trust showed positive results this year are in

- the number of staff being appraised in the last 12 months
- the number of staff having well-structured appraisals in the last 12 months
- the number of staff stating that they have support from their immediate managers

Of the three areas above, the number of staff having well-structured appraisals has shown the most increase, when compared with the Trust's 2011 result, from 40% in 2011 to 45% this year. This score is also higher than the MHLA average of 41%. This is a good outcome as this area was rated as average in 2011. The number of staff indicating that they feel supported by senior managers at 3.78 (scores range from 1-5) is also higher than the MHLA average of 3.77.

Other positive demographic and occupational findings include -

- A higher proportion of clinical staff being appraised and receiving job relevant training.
- A higher number of disabled and BME staff indicating that they have been appraised in the last 12 months.
- Also the highest proportion of staff having well-structured appraisals is in the BME staff group

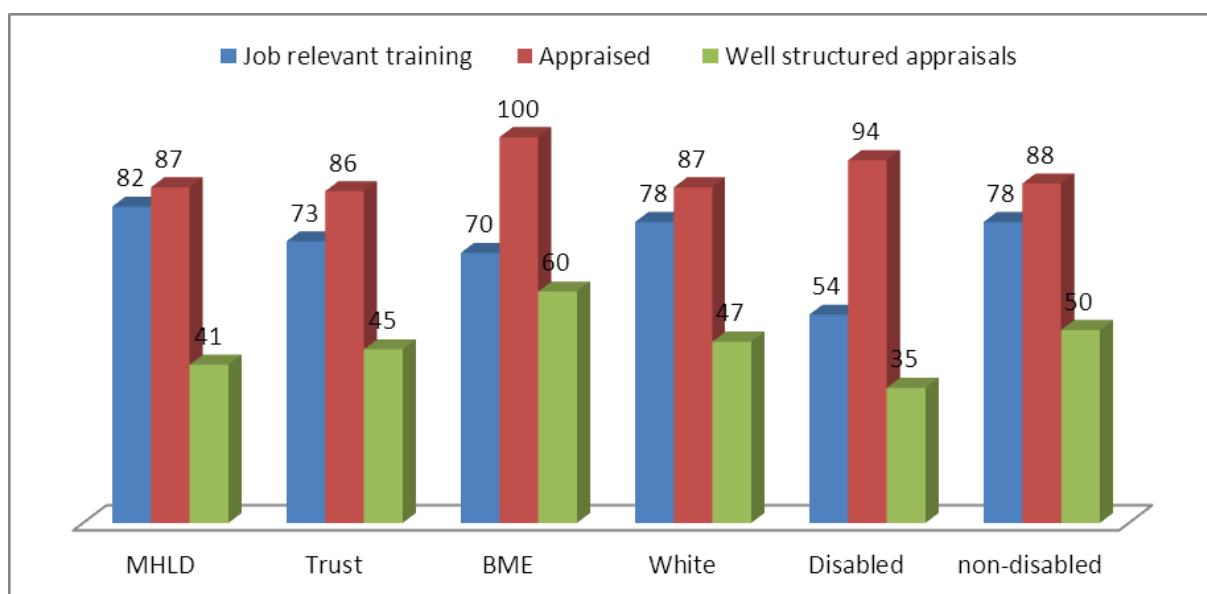


### 3.2.2 Negative Findings

The only area rated as not so good for this pledge is in relation to the number of staff receiving job relevant training in the last 12 months. The Trust's score of 73% is lower than the MHL D average of 82%. Further analysis of demographic data also shows that responses for disabled and BME staff are also the lowest for job-relevant training. In addition, disabled staff had the lowest outcomes of any staff group for having well-structured appraisals.

Data on occupational groups also show that administrative staff score lower than any other group for the areas of this pledge. Administrative staff are less likely to feel that there is support from immediate managers, less likely to have been appraised in the last 12 months and less likely to have had a well-structured appraisal.

Some of these main findings shown in the chart below -



### Action

The area of job relevant training needs to be addressed. It is evident that while training does take place, it seems some staff may not feel that this training is relevant to effectively support their development. Managers should be encouraged to discuss training needs with their staff at all times of the year, not just at appraisals. This will be useful in circumstances where development priorities change during the year. Financial support for training should continue to be provided and managers will be encouraged to bid for NHS London funds to support staff development. Particular attention should be provided to the development of administrative and support staff.



Some of the poorer outcomes for disabled and BME staff in terms of job relevant training should be explored further at the Equalities Committee where some targeted improvement plans can be identified.

***Responsibility for Action –Director of HR , Chair of Staff Training Committee and Chair of the Equalities Committee***

***Completion Date – April 2014***

### **3.3 Pledge 3 – Maintaining staff health and wellbeing**

In 2011, the Trust had good scores in twelve out of the fourteen areas for this pledge, similar to its result in the previous year (2010). This year, this pledge has been reduced to eleven key areas and the Trust has shown good scores in seven out of those areas. In addition, this year the Trust has been rated as having the highest best score of all Trusts in its category, in six out of those seven areas.

#### **3.3.1 Positive findings**

The areas where the Trust scored extremely well for this pledge and has been rated as having the highest best score are in areas such as the low numbers of staff witnessing errors and incidents and the low numbers experiencing harassment, bullying, violence etc. from staff, patients and members of the public. The Trust also scores highly in terms of the numbers of staff feeling pressure to attend work, with the Trust rated as having the highest best score in this area as well.

In terms of positive outcomes when considering demographic statistics, it is worth mentioning that a lower proportion of disabled and BME staff compared with all other staff groups stated that they had experienced physical violence from patients, public or staff.

#### **3.3.2 Negative Findings**

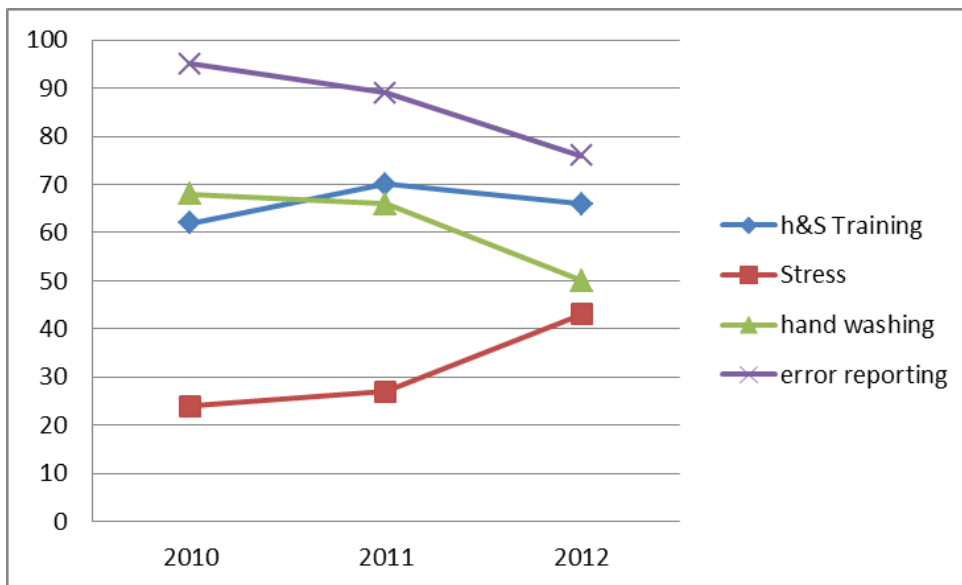
The four main areas where the Trust has not done so well are in relation to the numbers stating that they have undertaken health and safety training in the past year, the numbers suffering work related stress, the numbers stating hand washing materials are available and the numbers reporting errors, near misses or incidents. The Trust also had low scores for the percentage of staff reporting errors, near misses or incidents and those undertaking Health and Safety in 2011 as well as in 2010. These two areas have also been discussed in the earlier section of this report.

The Trust's score for availability of hand washing materials has reduced from 66% in 2011 to 50% this year, with the MHLA average this year

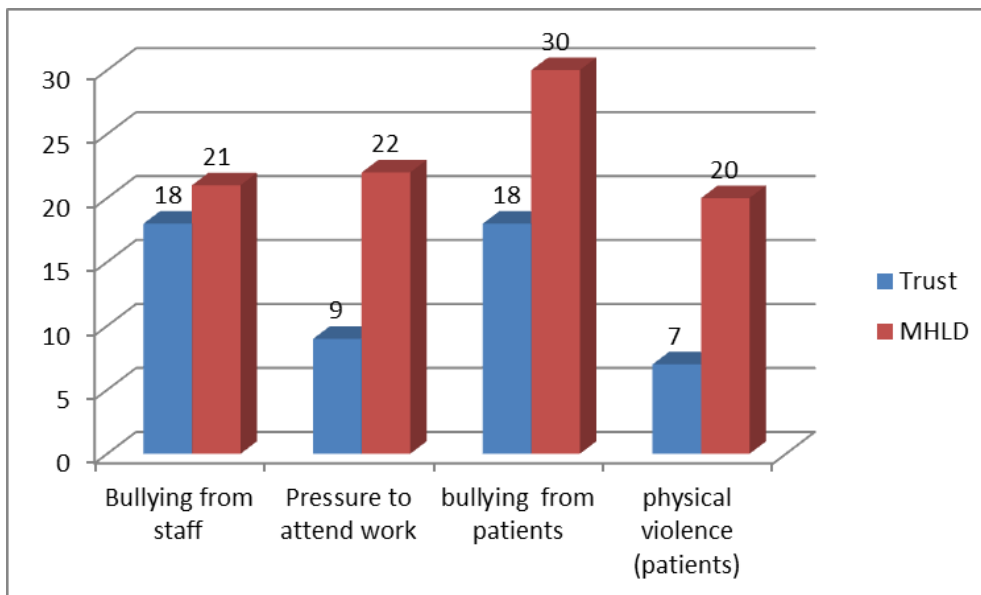
being 55%. Additionally the numbers suffering work related stress has also increased from 27% in 2011 to 43% this year, with the MHL D average being 41%, though the MHL D average has also increased from an average of 33% in 2011.

Other areas to consider include a higher proportion of disabled staff experiencing work related stress and indicating that they had not have health and safety training. A very high number of disabled staff also indicated that they felt pressure to attend work while unwell, 29% compared with 9% for non-disabled staff.

The trends over the past three years for the areas where the Trust did not do well are shown below-



The Trust's good scores compared with the 2012 MHL D average are also shown below



## Action

The four main areas to focus on should be in the areas shown as declining this year. The Trust should continue to provide additional health and safety training updates outside the normal INSET events. This should be through email alerts, briefing hand-outs, flyers and health and safety awareness sessions either in teams or at directorate meetings.

Incident reporting training should continue to be provided to all staff frequently throughout the year. E-mail notifications with details of incident reporting procedures and Q&As included as information briefings.

In addition to providing stress awareness briefings regularly, the issue of workload and job planning needs to be addressed properly as part of the overall staff job planning process as this also links into staff working additional hours to meet increasing workloads.

The trust will also need to consider whether the available hand washing materials need to be improved upon.

***Responsibility for Action – HR Director, Risk Management Lead, Health and Safety Manager***

***Completion Date – June 2014***

### 3.4 Pledge 4 – Staff involvement and engagement

This year once again and similar to the last two years, the Trust has been rated as being in the best 20% of MHL D Trusts, for the two areas of this pledge.

#### 3.4.1 Positive findings

The Trust's score of 51% (similar to its 2011 score), for the percentage of staff reporting good communication between senior management and staff, has been rated as the highest best score of all MHL D Trusts and much higher than the MHL D average score of 29%. The second finding for this category relates to the number of staff stating that they are able to contribute towards improvements at work. The Trust's score of 76% is higher than the MHL D average of 71% and higher than its score of 75% in 2011.

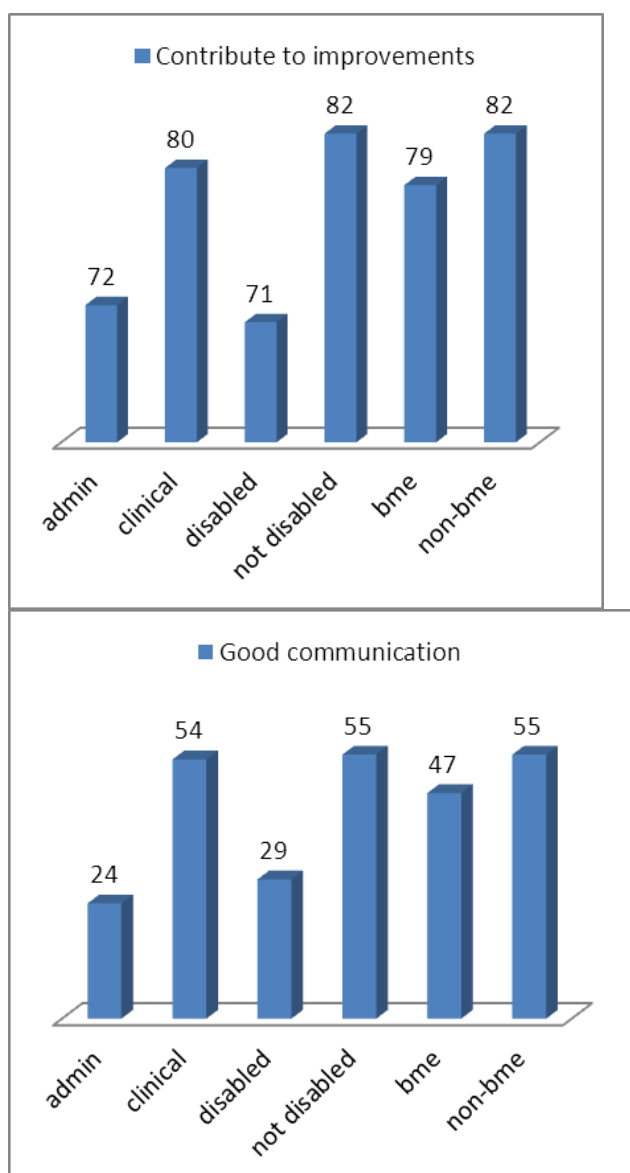
Looking at the demographic and occupational statistics for this area, a higher proportion of staff in corporate/central functions reported good communication with management compared with other non-managerial groups.

### 3.4.2 Negative findings

Some areas for further improvement relate to the slightly lower numbers of disabled staff reporting good communication with management in comparison with other groups. 29% of disabled staff indicated that there is good communication between management and staff, while 55% of non-disabled staff feel that communication is good. The figure for BME staff for this question at 47% is also lower than the figure of 55% for non-BME groups. Additionally the number of administrative staff indicating that there is good communication at 24% is quite low compared with 54% for clinical staff and 50% for medical staff.

Another area to note is that the numbers of disabled staff stating that they are able to contribute to work improvements at 71%, is lower than any other demographic group. The figure for non-disabled staff for this question is 82%.

The negative findings by demographic group is illustrated below-



## Action

While the Trust's overall results for this pledge are very good, they are not as good once drilled down to demographic and occupational data. It is therefore important that the Trust continues to work on improving its communication and staff involvement groups to ensure that they are much more inclusive and accessible and understood by all levels of staff. The best method of ensuring that all levels of staff feel engaged and are able to contribute to the Trust's work should be considered by the management committee, in conjunction with Human Resources and the Trust's communications department.

### 3.5 Additional Theme 1: Staff Satisfaction

The Trust's scores in 2011 for this area were in the highest best for three out of all four key findings for this theme, with one area rated as below average. This year, this theme has been reduced to three key findings and

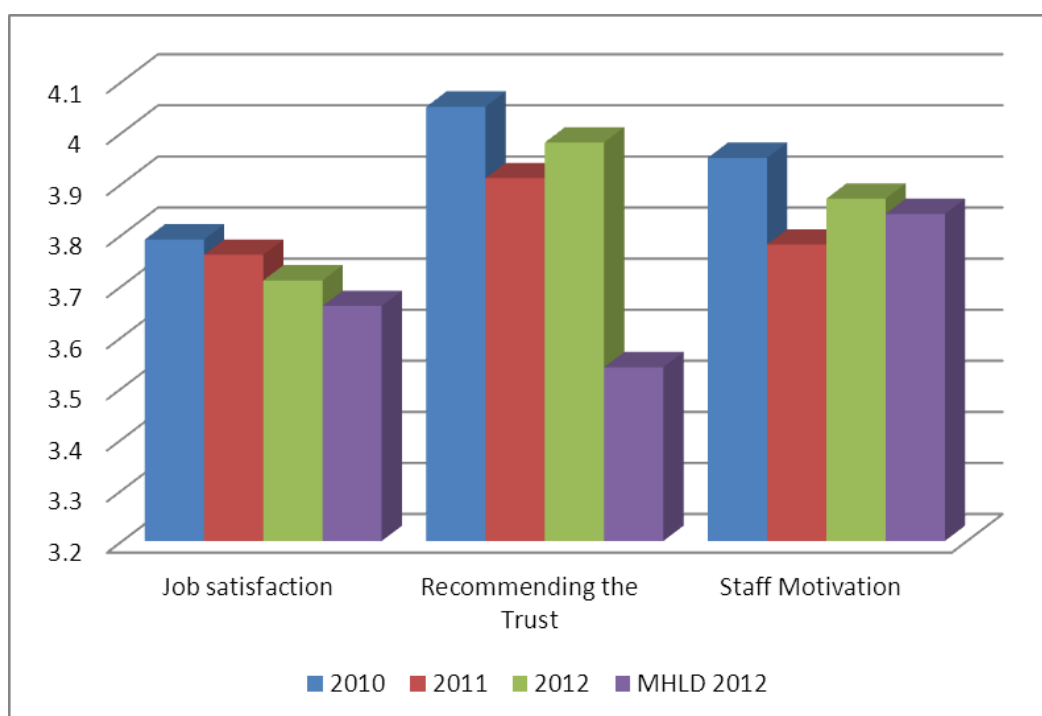
the Trusts results have improved, with the Trust rated as being in the highest best for one area and above average for two areas.

### 3.5.1 Positive findings

The Trust is ranked as being in the best category for staff recommending the Trust as a place to work and receive treatment and better than average for staff motivation at work and staff job satisfaction. The Trust's score for motivation which was 3.78 in 2011 (scale from 1-5), has increased to 3.87 this year, with the MHL D average being 3.84. As discussed in the earlier part of this report, this is a good improvement. The Trust's score for staff recommending the Trust as a place to work has also increased from 3.91 in 2011 to 3.98 this year, with the MHL D average being 3.54.

Demographic and occupational findings for this pledge are also quite good, such as a higher proportion of clinical staff reporting staff satisfaction and motivation, considering they are the group that also work the most additional hours. Staff in management and central service functions also have the highest proportion of staff satisfaction. Once again, the figures for disabled staff for all three areas of this pledge are slightly lower than for other groupings.

The Trust results are shown in the chart below



### 3.6 Additional Theme 2: Equalities and Diversity

In 2011, the Trust did well in all three areas of this pledge and was rated in highest best for all three categories. This year, the Trust's results have

declined with one area rated as being below average and the other two areas rated as average and better than average respectively.

### 3.6.1 Positive Findings

The two main areas where the Trust did well this year are in the number having equalities and diversity training in the last 12 months and the number experiencing discrimination at work in the last 12 months. The numbers having equalities training has improved slightly from a score of 60% in 2011 to 61% this year. This score is also above the MHLA average of 59%. This is a good result considering that this training is covered mainly at INSET events which staff are required to attend only once in every two years. The number of staff experiencing discrimination has increased slightly from 9% in 2011 to 10% this year; however this is still below the MHLA average of 13%.

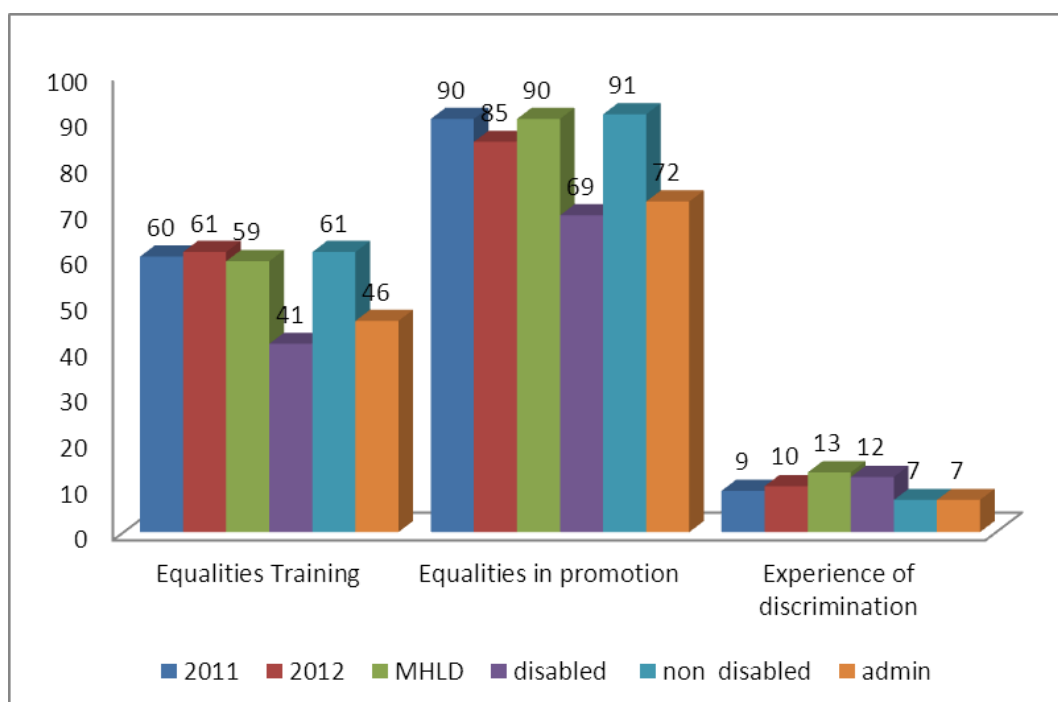
Some positive areas to mention in terms of demographic and occupational statistics are the improvements in BME staff outcomes this year for this theme. A higher proportion of BME staff indicated that they believe the Trust provides equal opportunities in career progression (67% in 2011 and 81% this year) and the number experiencing discrimination has also decreased from 16% in 2011 to 9% this year.

### 3.6.2 Negative Findings

The Trust has not done well in terms of the numbers believing the Trust provides equal opportunities for career progression or promotion. The Trust's score of 85% is a reduction on its score of 90% in 2011 and also below the MHLA average of 90%. The Trust was rated as average for this area in 2011 but this year is rated as below average.

As expected for this question, scores are also lower for staff in the administrative and clerical groups than in other groups. Additionally the outcomes for disabled staff are also poorer for this question.

These positive and negative findings are shown below



## Action

The numbers believing that the Trust provides equal opportunities in career progression needs to be addressed. Work was previously undertaken by the equalities committee in terms of analysing staff progression data across the trust. This work may need to be undertaken again, however further discussion is required in the first instance at the committee to consider these survey findings. Thought should be given to devising positive methods of providing career and progression support to specific groups of staff including minority and disabled staff.

**Responsibility for Action – HR Director, Trust Equalities Chair**

**Completion Date – June 2014**

## 4. Conclusion

This year's survey results are good. A number of areas noted as requiring improvements in the 2011 survey have shown improvements this year. As in previous years, there still remain number of areas that require further work such as the numbers of staff working extra hours, the numbers undertaking health and safety training and the numbers reporting incidents, errors and near misses. Additionally, the poorer outcomes for disabled staff for a number of key areas needs to be addressed.

The overall response rate in terms of the numbers completing the survey has also declined this year. This is probably due to the Trust's recent productivity exercise which took place around the same period that



questionnaires were sent out. It is important that work is undertaken in the next survey round to improve response rates.

This year, as in 2011, unadjusted (unweighted)\* scores have not been used in this report when making comparisons. From previous reports, using raw unadjusted scores to analyse this Trust's data has usually improved the Trust's outcomes for most questions. Notwithstanding this, our results this year, without unweighted scores, still show that the Trust continues to improve and outperform many other Trusts in its sector. It is also important to note that the Trust has been rated as being in the highest best category for overall staff engagement, when compared with Trusts of a similar type. This is an extremely good result.

Ms Susan Thomas  
Director of HR  
May 2013

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

## Appendix 1 – Unadjusted scores 2012 survey

Key Findings	MHLD weighted average	Trust Weighted score	Unweighted score
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	78	79	85
KF2. % agreeing that their role makes a difference to patients	90	86	90
<i>KF3. Work pressure felt by staff</i>	3.02	2.99	2.96
KF4. Effective team working	3.83	3.87	4.02
<i>KF5. % working extra hours</i>	70	80	80
KF6. % receiving job-relevant training, learning or development in last 12 mths	82	73	75
KF7. % appraised in last 12 mths	87	86	89
KF8. % having well structured appraisals in last 12 mths	41	45	49
KF9. Support from immediate managers	3.77	3.78	3.91
KF10. % receiving health and safety training in last 12 mths	73	66	60
<i>KF11. % suffering work-related stress in last 12 mths</i>	41	43	38
KF12. % saying hand washing materials are always available	55	50	59
<i>* KF13. % witnessing potentially harmful errors, near misses or incidents in last mth</i>	27	18	13
KF14. % reporting errors, near misses or incidents witnessed in the last mth	93	76	81
KF15. Fairness and effectiveness of incident reporting procedures	3.52	3.66	3.71
<i>* KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths</i>	20	7	5
<i>KF17. % experiencing</i>	4	1	0

<i>physical violence from staff in last 12 mths</i>			
<i>* KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths</i>	30	18	10

<b>Key Findings</b>	<b>MHLD weighted average</b>	<b>Trust Weighted score</b>	<b>Unweighted score</b>
<i>* KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths</i>	21	18	14
<i>* KF20. % feeling pressure in last 3 mths to attend work when feeling unwell</i>	22	9	11
KF21. % reporting good communication between senior management and staff	30	51	52
KF22. % able to contribute towards improvements at work	71	76	80
KF23. Staff job satisfaction	3.66	3.71	3.86
KF24. Staff recommendation of the trust as a place to work or receive treatment	3.54	3.98	4.04
KF25. Staff motivation at work	3.84	3.87	3.90
KF26. % having equality and diversity training in last 12 mths	59	61	60
KF27. % believing the trust provides equal opportunities for career progression or promotion	90	85	88
<i>KF28. % experiencing discrimination at work in last 12 ths</i>	13	10	7

# Board of Directors

2pm–4pm, Tuesday, 28<sup>th</sup> May 2013

## Agenda

### **Preliminaries**

**1. Chair's opening remarks**

*Ms Angela Greatley, Trust Chair*

**2. Apologies for absence**

**3. Minutes of the previous meeting**

(Minutes attached) p1  
For approval

**4. Matters arising**

### **Reports & Finance**

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

*Non-Executive Directors as appropriate*

For noting

**6. Chief Executive's Report**

*Dr Matthew Patrick, Chief Executive*

(Report attached) P8  
For discussion

**7. Finance & Performance Report**

*Mr Simon Young, Director of Finance & Deputy CEO*

(Report attached) P12  
For information

**8. CQSG Report Quarter 4 2012-3**

*Dr Rob Senior, Medical Director*

(Report attached) P18  
For discussion

**9. CQSG Annual Performance Review 2012/13**

*Dr Rob Senior, Medical Director*

(Report attached) P39  
For discussion

### **Corporate Governance**

**10. Constitutional Amendments**

*Ms Julie Hill, Trust Secretary*

(Report attached) P65  
For approval

**11. Corporate Governance Board Statement**

*Mr Simon Young, Director of Finance and Deputy CEO*

(Report attached) P74  
For approval

### **Quality & Development**

**12. Staff Survey 2012, Summary Results, Findings and Action Plan**

*Mr Namdi Ngoka, Deputy Director HR*

(Report attached) P81

For discussion and  
approval

**13. Annual Report and Accounts**

**a) Annual Report**

*Ms Julie Hill, Trust Secretary*

*(Report to follow  
For approval)*

**b) Annual Accounts**

*Mr Simon Young, Director of Finance and Deputy CEO*

*(Report to follow)  
For approval*

**c) Letters of Representation**

*Mr Simon Young, Director of Finance and Deputy CEO*

*(Report to follow)  
For approval*

**14. Quality Report 2012/13**

*Ms Louise Lyon, Trust Director*

*(Report to follow)  
For approval*

**15. Annual Plan**

*Mr Simon Young, Director of Finance and Deputy CEO*

*(Report to follow)  
For approval*

**Conclusion**

**16. Any other business**

**17. Notice of future meetings**

Wednesday, 12<sup>th</sup> June 2013: Directors' Conference, 12noon-5pm\*

Tuesday, 25<sup>th</sup> June 2013: Board of Directors

Thursday, 27<sup>th</sup> June 2013: Council of Governors

Tuesday, 23<sup>rd</sup> July 2013: Board of Directors

Wednesday, 11<sup>th</sup> September 2013: Directors' Conference, 12noon-5pm\*

Thursday, 12<sup>th</sup> September 2013: Council of Governors

Tuesday, 24<sup>th</sup> September 2013: Board of Directors

Tuesday, 29<sup>th</sup> October 2013: Board of Directors

Wednesday, 13<sup>th</sup> November 2013: Directors' Conference, 10am-5pm\*

Tuesday, 26<sup>th</sup> November 2013: Board of Directors

Thursday, 5<sup>th</sup> December 2013: Council of Governors

\*These are informal meetings and are not open to the public.

Meetings of the Board of Directors will be from 2pm until 5pm, and are held in the Board Room.  
Meetings of the Council of Governors are from 2pm until 5pm, and are held in the Lecture Theatre. Directors' Conferences are from 12 noon until 5pm, except where stated.