

Board of Directors Part One

Agenda and papers

of a meeting to be held in public

2.00pm–3.30pm
Tuesday 25th February 2014

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

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 25th February 2014, 14.00 – 15.30,
Board Room, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES				
1.	Chair's Opening Remarks Ms Angela Greatley, Trust Chair		Verbal	
2.	Apologies for absence and declarations of interest Ms Angela Greatley, Trust Chair	To note	Verbal	
3.	Minutes of the previous meeting Ms Angela Greatley, Trust Chair	To approve	Enc.	p.1
3a.	Outstanding Actions Ms Angela Greatley, Trust Chair	To note	Enc.	p.7
4.	Matters arising Ms Angela Greatley, Trust Chair	To note	Verbal	
REPORTS & FINANCE				
5.	Trust Chair's and NED Report Non-Executive Directors as appropriate	To note	Verbal	
6.	Acting Chief Executive's Report Mr Simon Young, Acting Chief Executive	To note	Enc.	p.8
7.	Finance & Performance Report Mr Carl Doherty, Deputy Director of Finance	To note	Enc.	p.16
STRATEGY				
8.	Education and Training Report Mr Malcolm Allen, Dean	To approve	Enc.	p.25
QUALITY & GOVERNANCE				
9.	CQSG Report for Quarter 3 Dr Rob Senior, Medical Director	To note	Enc.	p.28
CONCLUSION				
16.	Any Other Business		Verbal	
17.	Notice of Future Meetings <ul style="list-style-type: none"> Wednesday 5th March 2014: Directors Conference, 1pm-5pm, Lecture Theatre, Tavistock Centre Wednesday 19th March 2014: Joint Board Meeting, 2pm-5pm, Lecture Theatre, Tavistock Centre Tuesday 25th March 2014: Board of Directors, 2pm-5pm, Board Room, Tavistock Centre 		Verbal	

Board of Directors

Meeting Minutes (Part One) Tuesday 28th January 2014, 2.00 – 4.00pm

Present:			
Ms Angela Greatley Trust Chair	Mr Malcolm Allen Dean	Mr Martin Bostock Non- Executive Director (Senior Independent Director)	Dr Rita Harris CAMHS Director (non-voting)
Mr David Holt Non-Executive Director	Ms Lis Jones Director of Nursing (non-voting)	Dr Ian McPherson Non-Executive Director	Ms Joyce Moseley Non-Executive Director
Ms Caroline Rivett Non-Executive Director	Dr Rob Senior Medical Director	Mr Simon Young Acting Chief Executive	Ms Louise Lyon Trust Director
Attendees:			
Mr Gervase Campbell Trust Secretary (minutes)	Mr Carl Doherty Deputy Director of Finance	Mr Anthony Levy Governor	Ms Pat Key Director of CGF
Dr Justine McCarthy Woods Quality Standards Lead	Ms Julia Smith Commercial Director	Mr Paul Jenkins	
Apologies:			
Ms Fiona Fernandes Assistant Trust Secretary			

Actions

AP	Item	Action to be taken	Resp	By
1	3	Mr Campbell to amend the minutes of the previous meeting	GC	Immed
2	7	Tavistock Consulting business plan to come to the board for review	LL	Mar/Apr
3	7	Mr Doherty to report on outstanding debts to the audit committee	CD	Feb
4	13	To follow up on finding a NED to overview the Quality Reports	GC	Feb

1. Trust Chair's Opening Remarks

Ms Greatley welcomed all to the meeting.

2. Apologies for Absence and declarations of interest

Apologies as above.

No declarations of interest were made on items on the agenda.

AP1

3. Minutes of the Previous Meeting

The minutes were agreed subject to minor amendments.

4. Matters Arising

- Action point 2 had not yet been completed however the other action points had been completed or were on schedule.
- Of the Outstanding Action schedule the board agreed item 4, the equalities report, should come off the list, and that item 2 had been addressed by the pre-board lunch seminar.

- Ms Lyon reported that the Gender Identity steering group had been set up.
- Ms Greatley explained that Mr Paul Jenkins would be joining the meeting at a later stage.

Ms Greatley asked Board members if there were any other issues they wished to raise, which were not on the agenda. No other issues were raised.

5. Trust Chair and NED's Report

Ms Greatley reported that she had attended the graduation ceremony, and found that it was excellently organised, a moving occasion as ever, and thanked the Dean. She reminded the board that the joint meeting had been moved to the 19th March so that Mr Jenkins would be able to attend, and informed the board that a NED recruitment committee was being organised as Ms Moseley and Mr Bostock would be leaving the Trust this year.

Mr McPherson reported that he had attended the launch of a report by the Centre for Mental Health called Building Better Futures where positive reference had been made to the FNP service.

Mr Bostock reported that he had been working with Ms Emma Heath in Communications on the inquest, and had been impressed at the great work she had done on such a sensitive issue.

Mr Holt reported that Ms Moseley had attended her first audit committee meeting, and that having the CQSG representative present had been extremely helpful.

The Board **noted** the reports.

6. Acting Chief Executive's Report

Mr Young introduced his report and highlighted:

- There was no funding associated with the 'Closing the Gap' policy document, but it was recognised nationally that this was a problem. Mr Nick Clegg's visit to the Trust had been in connection with the document's launch, and had been handled very well by Dr Harris and Dr Hodges.
- The date of TW's tragic death was incorrect in his report, it had been in October not December 2012. He noted that the Trust had given good support to the clinicians involved, but the inquest had been demanding.
- The Declaration of Sustainability the Trust would be required to make in the strategic plan was rigorous, but the management team would aim to give the Board the information they required to be able to give the assurance.
- There had been changes to the planning schedule, which might lead to some tight schedules around the May bank holiday meeting, but this was unavoidable.

- A 0.3% allowance had been made to targets for acute Trusts to allow for costs of implementing the Francis and Keogh recommendations, but it seemed unrealistic that these costs would only apply to acute Trusts.

The Board **noted** the report.

7. Finance & Performance Report

Mr Doherty introduced the report and highlighted:

- The surplus had risen and now stood at £1.6 million, but would be £1.0 million by the end of the year, because of timing of expenditure in some services and because non-recurrent projects were being planned.
- The cash situation was good.
- The first draft budget would be completed by next week, and would identify the remaining gap to be bridged.

Ms Greatley asked how the commissioners felt about the surplus. Mr Young said that were they to ask he would point to the deficit of the last two years. Dr Harris added that one of the big sources of the surplus was FNP, and was due in part to delays in new teams being commissioned through NHS England, and that these had been recognised and they were being allowed to carry the funding over as a result. Ms Lyon commented that in GIDS they were changing the tariff to charge less for group treatment which has now been introduced for some patients.

Mr Holt asked whether there were any capital projects that could be invested in now to provide savings in subsequent years, for example energy efficiency. It was agreed that this was an important option to consider and would be followed up outside the meeting.

AP2

Mr McPherson noted that there was significant income shortfall in Tavistock Consulting, and asked whether their plans needed to be discussed or reviewed. Ms Lyon commented that it was important to think about how the resource was being used, and it was agreed that they would bring the business plan to the board for review in March or April.

AP3

Mr Holt noted in the balance sheet the receivables had increased and asked whether this was due to bad debts. Mr Doherty commented that there was one bill for one million pounds for FNP that was still outstanding, due to a mix up, and was being chased. It was agreed that Mr Doherty would report on this to the Audit Committee.

The Board **noted** the report.

7a. Q3 Governance Statement.

Mr Young summarised that the Trust is fully compliant and should be so for the next twelve months.

The Board **approved** the statement for submission.

8. Significant Transactions

Mr Young explained the history behind the procedure being submitted for consideration by the Board. The procedure had also been submitted to the working group and would need to go the Council of Governors for approval. He highlighted that a 10% threshold had been chosen to define a significant transaction as this was the lower of two thresholds at which Monitor would also review proposals, and that section 6 attempted to make the procedure flexible enough to work even with the tight timescales that sometimes accompanied bids.

The Board made a number of suggestions:

- Paragraph 1.5, concerning Governors represented stakeholders, should be duplicated in the duties and responsibilities section of the procedure.
- The review date for the policy should be made earlier as use of the procedure would undoubtedly suggest improvements that should be made to it.
- In section 6.1 it should be made clear that it was necessary to have enough information available for an informed decision to be made before Governors were consulted.
- In section 6.6 it was important to clarify whether a majority of all Governors, or those present, was required.
- The introduction should make clear that the process was intended to be collaborative with learning to be shared.
- It should be checked that the financial limit at which the Board must be consulted was lower than the 10% suggested for the Governors.

The Board **approved** the procedure go forward to the Council of Governors with the changes suggested.

9. Trust Sealings

Two uses of the Trust seal were reported to the Board for approval:

- On the 2nd December 2013 an undertaking to indemnify the Secretary of State for pension contributions at the Day Unit.
- A proposed contract between the Trust and the L.B. Barnet for the continued provision of a Young People's Drug and Alcohol Service.

The Board **approved** both uses of the Trust Seal.

10 Update on the Digital Strategy

Ms Lyon explained that the Trust was separating out the clinical and Education and Training strategies, and that for the scoping work on the clinical side Sally Hodges was leading for CAMHS, and Richard Graham for SAAMHS. As well as looking internally they were examining what work other organisations were doing in this field, and looking for areas in which

we could collaborate. Ms Lyon noted that in a recent straw poll of patients held in the Trust 73% of respondents had said they would be interested in receiving therapy by Skype or some similar media. Dr Senior added that it was important to solve the governance issues around using Skype, or similar, in clinical provision, as there was a great demand for it in the nationally commissioned services. Ms Lyon also noted that as well as looking at delivering our services digitally it was important to recognise the importance of the digital realm in everyday life, and to incorporate that knowledge in all of our clinical work.

Dr Harris added that they were trialling an app called 'Brain in Hand', aimed at assisting those on the autism scale, and might become the main training site for it too. In addition they were in talks with Google about a website for young people, and that Andy Wiener and Emiliós Lemoniatis were looking at doing training for other providers of digital services. In addition Caroline McKenna holds a workshop on digital awareness and risk, and is looking at relevant questions to include on the Initial Assessment Form.

Mr McPherson commented that he was involved with a number of organisations in this area, including the e-Health Alliance which was looking to become an umbrella organisation in this field, and that he and Caroline Rivett, who also had experience relevant to this area, would both like to contribute. He added that it was encouraging to see the issue being discussed at Board level here, as not many organisations, and hoped something could be included at the Trust's E-Mental Health event with the International Initiative in Mental Health Leadership (IIMHL) in June.

The Board **noted** the report.

11 Care Quality Commission (CQC) Inspection Update

Ms Key introduced the update and highlighted that it was encouraging that Mental Health specialists would be involved in inspections, that the five key questions seemed eminently sensible, but it would be interesting to see how they were implemented and rated, and that we should not expect to be inspected until 2015.

Mr McPherson commented that the inspections would be more robust in the future, as he was aware of an organisation being inspected now where 40 inspectors would be onsite for a week. Ms Greatley added that she had been asked to Chair one of these 40 person inspection teams at the end of February. She felt it was encouraging that Paul Lelliott had been named as the deputy of Mental Health inspections, and he had previously been involved with accreditation schemes at the Royal College.

The Board **noted** the update.

12 Quarter 3 Quality Report

Dr McCarthy Woods introduced the report and summarised that the situation is positive, and the Trust is on track with the new KPIs. She noted that the DNA rates are always higher in Q2 and then reduce in Q3, but despite this we are on track to meet the targets. She explained this rise by noting that Q2 includes the summer holidays and a lot of patients get distracted, despite our efforts, such as text messaging, to address this. Dr Senior added that we have started following up on DNAs and found that this has made subsequent appointments are better attended, especially with hard to reach populations. Mr Holt wondered what the cost of a DNA was, and whether knowing this might help guide how much time and cost was justified in trying to reduce their rate.

Mr McPherson commented that we should be very proud of that 90% of children and 99% of young people reported satisfaction with the service, especially given that it had not been their choice to attend.

Mr Bostock asked what the difficulties mentioned in connection to the low rate of returns in CAMHS of Goal Based Measure outcome monitoring forms were. Dr McCarthy Woods explained that she was looking into this, and would report on it to the CQSG, and bring it back to the board if it was not resolved.

Mr Holt noted that the Child Safeguarding Training figures did not include new starters, and enquired what period of grace these staff were given. Dr McCarthy Woods explained that the expectation was that new staff would attend the first available training, and that most did, and the trainings ran 4 or 5 times a year.

The Board **noted** the report.

13 Update on Draft Annual Quality Report

Dr McCarthy Woods explained that she had brought the update to give an opportunity for feedback, and to ask whether a NED would be available to provide an overview to the team in preparing the full report. It was agreed Mr Campbell would email the NEDs after the meeting to seek a volunteer.

The Board **noted** the timetable and the plan.

14 Any Other Business

No other business was discussed.

15 Notice of Future Meetings

The Board noted its future meetings.

Part 1 of the meeting concluded at 4.15pm

AP4

Outstanding Action Part 1

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
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	
7	Nov-13	8. Charitable Funds Annual Report	Mr Young to circulate briefing on the two charitable funds.	Simon Young	Mar-14	
8	Nov-13	8. Charitable Funds Annual Report	Mr Young and Ms Moseley to arrange a briefing on social enterprise models for a future lunch session	Simon Young/ Joyce Moseley	Mar-14	Schedule for July BoD lunch session.
9	Nov-13	9. CQSG Report	Improve colour coding and make clearer which indicators have been achieved, and include an action plan with dates for those that have not	Rob Senior	Feb-14	
10	Jan-13	7. Finance and Performance Report	Tavistock Consulting Business Plan to come to Board for review.	Louise Lyon	Apr-14	Service Line Report scheduled for May BoD Meeting

Board of Directors : February 2014

Item : 6

Title : Acting Chief Executive's report

Summary :

Our new Chief Executive is joining the Trust the day before this Board meeting.

The Trust, in common with all providers, is engaged with CCGs, local authorities and NHS England as they plan for changes in the delivery of NHS services, to deliver better outcomes and greater efficiency.

The Centre for Mental Health evaluation of our innovative City and Hackney Primary Care service will be published in March. It was featured in a recent article in HSJ.

Ofsted inspected the Gloucester House Day Unit from 11 to 13 February.

The full business case for the Trust's new care record system is due to be presented to the Board next month.

A workshop to continue work on the brief for our future facilities is being held on 19 February.

For : Discussion

From : Acting Chief Executive

Acting Chief Executive's report

1. Paul Jenkins

- 1.1 As members are aware, we are welcoming Paul as our Chief Executive on 24 February, the day before the Board meeting. This is therefore my last report in role as Acting Chief Executive

2. Commissioner Events and Planning

- 2.1 The Medical Director and I took part in a workshop on Value-based commissioning organised by the North London CCGs on 12 February. The draft statement of the CCG Chairs' Intent is attached as Appendix 1 to this report. Appendix 2, which was also circulated for the meeting, summarises the current strategic commissioning intent of each of the 5 North London CCGs and of NHS England.
- 2.2 We are continuing to work with commissioners and other providers in the sector, contributing to developing the Integrated Practice Units which these policy documents seek.
- 2.3 A key factor will be the introduction of the Better Care Fund in 2015/16. This was announced in the 2013 Spending Review as a 'pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people.'
- 2.4 CCGs will be contributing significantly to creating the Better Care Fund. The allocations published by NHS England in December show that in 2015/16, CCGs will in total receive an additional £1,100m¹ and will then transfer £3,460m to the BCF. The net transfer of £2,360m represents 3.6% of their baseline 'programme budget allocation.' The figures for Camden CCG, for example, are £5.9m and £18.2m with a net transfer of £12.3m to the BCF. In the discussion on 12 February, commissioners were clear that they expect to recover this contribution through reduced acute hospital activity levels.
- 2.5 Plans for utilising the BCF have to be signed off by Health and Wellbeing Boards. Commissioners were due to submit their draft plans to NHS England by 14 February.
- 2.6 Following the commissioners and providers event in Hackney on 15 January, the Trust will also be taking part in the launch on 4 March of "One Hackney," where the City and Hackney CCG will be setting out their strategy for integrated care and the use of the Better Care Fund, and inviting the provider organisations to discuss this.

¹ This £1,100m 'reflects monies that in 2014/15 will be passed directly from NHS England to Local Authorities to support integration of health and social care.'

3. Primary Care Psychotherapy Consultation Service, City and Hackney

- 3.1 The Centre for Mental Health report on their evaluation of our innovative City and Hackney service is now being completed, and a launch is being planned in March.
- 3.2 In advance of this, the service evaluation is the subject of a feature article in Health Service Journal: "As physical healthcare shifts from the hospital to the community, so liaison psychiatry should too." (14 February, pages 24 and 25). The article reports a positive outcome on health outcomes; and evidence of high levels of GP satisfaction with the responsiveness of the service to local needs and primary care requirements, and with its focus on difficult to engage patients.

4. Ofsted

- 4.1 Ofsted inspectors visited the Gloucester House Day Unit from 11 to 13 February. Their report will be published in 30 days, and we cannot make formal statements about it until then.

5. Integrated Digital Care Record 2015

- 5.1 The evaluation of the tenders and demonstrations is now being completed. As previously reported, we plan to present a recommendation and the Full Business Case to the Board in March, so that the contract for Lot 1 (the application software) can then be awarded.
- 5.2 The Full Business Case will include an update on the timetable for preparation, configuration and implementation. During this period of around a year, we will be building on the valuable level of staff engagement already achieved during the selection process.

6. Building Brief

- 6.1 As part of the programme agreed by the Board for developing options for the Trust's future facilities, a workshop is being held on 19 February. The Management Committee subgroup, with David Holt, will be working with external advisers on healthcare planning and workplace trends, to review the brief for our future accommodation.

7. Conclusion

- 7.1 I am very grateful for the support and hard work of colleagues over this period of four months while I have been Acting Chief Executive, so that we have been able to make significant progress in several key areas for the Trust.

Simon Young
Acting Chief Executive
18 February 2014

Appendix 1: Draft North London CCGs Chairs' Intent

As CCG Chairs, we recognize that CCGs, authorised since 1st April this year, commence at a time of increased public scrutiny, expectation and health challenges which are set within a background of financial and resource constraint. Despite the inherent difficulties, we believe there is a unique opportunity, through clinically-led commissioning, to drive improvement in the delivery of high quality, evidence-based and compassionate services, defined and measured by outcomes not process, to the population of north-central London. By acting now, the intention is to protect the efficacy of and to maintain confidence in our local NHS services over the next 10 years.

The founding principles of the NHS, that care is free to all at the point of delivery, remains as relevant today as it was during its first inception. However, the model of health care and the delivery have remained largely unchanged. This system now needs to evolve more closely reflecting current patient need, population expectation and new technology/medical advances to maximise 'value' (health outcomes per pound spent). NHS England has defined an outcomes framework that provides strategic direction. It is our role to take this guidance and ensure that this strategy is understood, owned and delivered locally.

Across NCL there are a number of key challenges:

- Inequalities in health outcomes due to a range of demographic, socio-economic, cultural and access issues
- A plethora of individually high quality providers (across health and social care) but working within organisational boundaries that result in often fragmented and disjointed care
- An increasing demand on services from an aging population
- Very high levels of serious mental health illness
- High levels of childhood obesity and vulnerable children
- Commissioning that has not always focussed on quality or been clinically driven
- Significant current and future financial pressures.

Our intent is to transform services through clinically-led, innovative service re-design in order to deliver the CCGs' visions. This will focus on developing an integrated model of care, planned and co-ordinated around the needs of patients and their families.

It will also include:

- Developing a systematic approach to preventing disease
- Diagnosing disease earlier to reduce complications
- Empowering patients to improve the quality of life of those living with disease
- Reducing inequalities in health outcomes by targeting vulnerable groups in new ways

This will be achieved through working in closer partnership across the local health and social care system to:

- Engage and involve the local population so that they can work with commissioners to define outcomes that are important and meaningful to them.
- Engage with Public health and the Health and Well-Being Boards on innovative prevention and health promotion schemes in our schools, environment and work places
- Empower CCGs' member practices that now play a key role in defining local priorities and commissioning intentions, working to improve primary care quality and access and to monitor the quality and effectiveness of all our providers.
- Continue to collaborate with all providers and partners across Health, Local Authority, Social Care and Voluntary Sectors who have already demonstrated commitment to developing the integration of the system to work across organisational boundaries.
- Employ technological advances around sharing IT and information to improve communications across the whole system.
- Ensure commissioning is outcome-focussed rather than process driven with governance arrangements that see responsibility for delivering population outcomes across pathways of care not within individual organisations.
- Ensure the outcomes of providers are accessible to patients to enable and inform choice
- Extend existing links with local academic institutions, across CCGs and with NHS England with whom we will have a co-commissioning role across specialist commissioning and primary care and an assurance partnership to assist in delivering the CCG's priorities.

There should be no illusions about the challenges ahead; working collaboratively is easy in theory but more difficult in reality and breaking down the barriers across organisations to ensure the patient is at the heart of what we do will not be easy culturally or contractually. Finding the shared incentives to drive this will be key. Patients and clinicians will need to feel confident of both the evidence-base and quality and safety of delivering services in new ways and settings. These challenges will need to be met with determination and steadfastness. Our collective success in delivering improved outcomes depends on sharing, throughout the local health system a mutual understanding and respect for each other's roles and skills and a sense of collective responsibility for the effective use of limited resources; it also relies on developing and utilizing the skills of those within the wider CCGs.

We are convinced that core to making this happen is personal leadership, responsibility and accountability at all levels; within the member practices, in our Governing Bodies, across our local health economies and wider afield. We have already started this journey within our CCGs and recognize how colleagues across CCGs and partner organisations have already risen to the challenge. We look forward to collectively delivering this strategic intent.

Appendix 2: Individual Commissioners' Current Strategic Intent

Barnet CCG

- Currently has underdeveloped community services which needs to be addressed
- Developing a range of care closer to home services
- Work is being done to integrate service; with an initial focus on chronic disease management and corresponding pathway re-design
- Trying to improve the quality of and access to general practice so as to improve patient care and experience
- Shifting appropriate mental health secondary care into the community
- Reducing over reliance on secondary care services and trying to make Barnet in line with national benchmarking for secondary care use
- Strategic review of CCG finances; including focus on community hospital provision

Camden CCG

- Camden CCG's strategic intent is given in Appendix 1
- In summary it concentrates on a focus on delivering improved outcomes for patients, looking closely at the cost and value of services
- There is a desire to have system wide integrated services that are outcome focused
- Delivery of services via Integrated Practice Units
- Developing new contractual models with providers to support the outcomes focused strategy
- Initial focus of outcomes focused work – frail elderly, long term conditions (diabetes/cancer), mental health transition (people aged 18-25 years old focusing on both their mental health and physical health in a holistic way)

Enfield CCG

- A focus on improving quality in primary care, secondary care and mental health services
- Delivering a plan that takes the CCG into financial balance
- Reduction of health inequalities and a need to close the gap
- The need to reduce over use of secondary care
- Taking forward the integration of primary care, secondary care and mental health services
- A focus on prevention of ill health and early interventions that reduce morbidity and promote well being
- A re-procurement of local community health services to drive up the quality of provision
- Priority areas the CCG is focusing on include older people and diabetes

Haringey CCG

- There is a strategic and corresponding focus on improving prevention of ill health and promotion of well being
- The CCG is trying to integrate services so as to improve patient outcomes across primary care, secondary care and community services
- Trying to deliver more services out of hospital and closer to home
- Integration of the urgent care pathway and services
- Focus on improvement of the physical and mental health needs of Learning Disabled people
- Improving health and well being outcomes for all young people
- Focus on improving patient experience of all health services
- Reducing health inequalities
- Improving the CCGs budget position

Islington CCG

Integrated Care

- Plans to reduce health inequalities
- Greater focus on prevention of ill health and promotion of well being
- Reducing the prevalence gap of long term conditions
- A focus on intensive users of health services and improving their experience of them
- Promotion of self care and getting more people involved in their own care

Primary Care

- Development of defined networks of GPs as commissioners in localities
- GP practices providing wrap around services outside the hospital in the community

Urgent Care

- Major review of urgent care to create a more integrated pathway and associated services. Will involve a re-procurement

Planned care

- Reduction on use of secondary care services
- Reduction in use of consultant led services and alternative models

CCG and NHS E collaboration

- Delivering the North London CCGs value based commissioning programme; including devising new contractual models to support this work and replacement of PbR
- Using data to inform commissioning decisions and promoting interoperability of to support commissioning and delivery of care

NHS England

Primary care

- Managing the potential instability in general practice of the national equalisation programme in GMS contracts (and PMS)
- Reducing the variation in the quality and access that practices offer patients
- Working to devising measureable outcomes for primary care services
- Trying to achieve transformation in primary care in the absence of a clear investment fund
- Clarifying a national versus local agenda and implications for transformation of services
- *Primary Care commissioning intentions to be issued nationally by NHS E week beginning 11th November 2013*

Specialist commissioning

- Requirement to make savings and transform services
- More focus on patient centred care
- Separation of specialist and non-specialist services in long term conditions i.e. cancer, HIV
- Complexity of working with both stable and non-stable organisations and trying to achieve transformational change
- Need to improve patient access (i.e. radiotherapy)
- Possible requirement to de-commission some services in London (where there is perceived over provision to pay for services out of London (that are under provided)
- Programme of specialist commissioning service reviews
- Need for NHS E to work closely in commissioning of services with CCGs and Local Authorities
- Development of clinical networks (e.g. for HIV in-patient care)
- Need to drive improved value – could include more use of commercial sector
- Need to move some tertiary services to secondary care

Other

- Need for close work with Public Health on ensuring the efficacy of screening programmes
- Need to work with local I partners to put national plans into local action

Board of Directors: February 2014

Item : 7

Title : Finance and Performance Report

Summary:

After ten months a surplus of £1,736k is reported before restructuring, £1,469k above the revised budget surplus of £267k. Income has fallen below expectations, but this has been offset by underspends across most services mainly due to vacancies.

The current forecast for the year is a surplus of £839k.

The service line report is provided in Appendix C.

The cash balance at 31 January was £5,335k which is above plan due to the size of the surplus. Cash balances are expected to be lower by the end of the financial year yet still above plan.

This report has been reviewed by the Management Committee on 13 February 2014.

For : Information.

From : Deputy Director of Finance

1. External Assessments

1.1 Monitor

1.1.1 The CoSRR was 4 both cumulatively and year to date at the end of December. The quarter 4 forecast is to maintain the total cumulative rating of 4. As the surplus is forecast to reduce, the Debt Service Cover metric for quarter 4 is expected to be lower; but our rating is based on the cumulative metrics.

2. Finance

2.1 Income and Expenditure 2013/14

2.1.1 After January the trust is reporting a surplus of £1,736k before restructuring costs, £1,469k above budget. Income is £344k below budget, and expenditure £1,834k below budget.

2.1.2 The main issues behind the cumulative income shortfall of £344k are low activity for TC Consultancy which is now £274k below target, CAMHS Clinical is £262k below target largely due to the Day Unit and SAAMHS Training is £141k below target due to E Learning. These main income sources and their variances are discussed in sections 3, 4 and 5.

2.1.3 Appendices A and B show that significant savings have been achieved by month 10, exceeding the target, though some of these may be non-recurrent.

2.1.4 For an externally funded Finance project, the £5k under spend to date (within the Finance line) is matched by a £5k adverse variance on other income, since the funding is released in line with costs.

2.1.5 The key financial priorities remain to achieve income budgets; and to identify and implement the additional savings required for future years.

2.2 Forecast Outturn

2.2.1 The forecast surplus before restructuring of £839k is £689k above budget. FNP is £510k under spent after January but expect to utilise £145k of this by the end of the financial year, GIDU also expect to use the majority of their under spend. The CAMHS and SAAMHS management teams have implemented a number of non-recurrent projects which also increase expenditure in the final quarter. The Day Unit building project capital costs of £225k have been included in the revenue forecast as the project is no longer going ahead.

The Clinical income forecast is £138k above budget mainly due to the GIDU over performance of £400k which is offset by Day Unit in CAMHS (forecast £240k below target). The majority of the Consultancy forecast shortfall of £228k is due to TC, although they do expect to have an improved performance against target in the final quarter of the year.

The Training income forecast is £248k below plan due to lower than planned recruitment for academic year 2013-14 and the deferral of LCPD and FNP income to 2014-15.

The forecast allows for the remaining investment reserve of £73k to be fully utilised (which was allocated in August); and also for the remaining contingency reserve of £31k to be needed.

2.3 Cash Flow (Appendix D)

2.3.1 The actual cash balance at 31 January was £5,335k which is an increase of £2,521k in month and is £1,795k above plan. The increase is due to the payment in advance of the Training Contract and the receipt of the outstanding FNP contract invoice. Salaries are lower than plan due to vacancies across the trust and the under spend on non-pay has reduced expected payments to suppliers. Capital expenditure is below plan following the decision to defer the Day Unit project. The year-to-date receipts and payments will be summarised in the Board Report.

		Cash Flow year-to-date		
		Actual	Plan	Variance
		£000	£000	£000
Opening cash balance		3,176	3,176	0
Operational income received				
	NHS (excl SHA)	13,917	12,800	1,117
	General debtors (incl LAs)	5,953	7,034	(1,081)
	SHA for Training	11,965	10,933	1,032
	Students and sponsors	1,869	2,825	(956)
	Other	547	180	367
		34,251	33,772	479
Operational expenditure payments				
	Salaries (net)	(12,812)	(13,796)	984
	Tax, NI and Pension	(9,692)	(9,760)	68
	Suppliers	(8,436)	(9,025)	589
		(30,940)	(32,581)	1,641
Capital Expenditure		(589)	(1,042)	453
Interest Income		8	4	4
Payments from provisions		0	(11)	11
PDC Dividend Payments		(571)	(578)	7
Closing cash balance		5,335	2,740	2,595

2.4 Better Payment Practice Code

2.4.1 The Trust has a target of 95% of invoices to be paid within the terms. During December we achieved 79% (by number) for all invoices and the cumulative total for the year was also 88%.

3. Training

3.1 Academic Year performance

3.1.1 Academic year 2013-14 fee income is £209k below Plan: SAAMHS £189k adverse to Plan, TC £25k adverse to Plan and CAMHS £5k above Plan. The favourable variances for academic year 2012-13 means the financial year fee income forecast is now £20k below the financial year Plan.

3.2 Financial Year to date Income

3.2.1 The high in month income variance for DET arises from the release of HENCEL funding to match expenditure arising from HEA and Agresso consultancy, and the bursary income received for Educational Psychology trainees offset by the same expenditure. The January variance for CAMHS is as a result of income being higher than budget for FNP (£61k) and the correction to an under-accrual for Educational Psychology fee income last month (£28k). This month visiting lecturer payments are higher than anticipated as we expect claims from tutors who have now started to work on the portfolio review.

3.3 Financial Year to date Expenditure

3.3.1 YTD contract income is £28k below Plan and is planned to improve slightly by the end of the financial year.

3.3.2 YTD non-contract academic and fee income is £25k below Plan. This includes the adverse variance to date on E-learning income of £119k offset by HENCEL funding not budgeted and fees and short course income above budget by £21k and £43k respectively.

Patient Services

3.4 **Activity and Income**

3.4.1 Total contracted income for the year is expected to be in line with budget, subject to meeting a significant part of our CQUIN[†] targets agreed with commissioners; achievement of these is reviewed on a quarterly basis.

3.4.2 Variances in other elements of clinical income, both positive and negative, are shown in the table below.

3.4.3 The income budget for named patient agreements (NPAs) was reduced this year from £205k to £196k. £64k of the total budget is to replace the contract with Waltham Forest. After January actual income is £2k above budget and the forecast is expected to be £6k above budget.

3.4.4 Court report income (which is budgeted at £113k for the year, of which £50k is for the Portman) has delivered just £17k up to January. The fall in demand is unlikely to recover and as a result the target for 2014/15 will have to be greatly reduced or removed altogether. An alternative source of income must be sought or costs reduced to mitigate the loss.

[†] Commissioning for Quality and Innovation

3.4.5 Day Unit was £209k below target after month 10. There are currently down to 7 pupils and the budget was set at 11. The service is currently reviewing potential alternatives which would be more appealing to commissioners.

3.4.6 Project income is forecast to be £78k above target for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	10,232	10,241	0.1%	11	-30	GIDU credit note
Cost and vol variances	217	551	153.6%	399	400	GIDU Over perf
NPAs	163	165	1.2%	2	6	
Projects and other	1,318	1,089		-	89	Income matched to costs, so variance is largely offset.
Day Unit	710	501	-29.4%	-253	-256	
FDAC 2nd phas	432	468	8.2%	42	28	Income matched to costs, so variance is largely offset.
Court report	94	17	-82.4%	-93	-88	
Total	13,167	13,032		108	149	

4. **Consultancy**

4.1 TC income was £66k in January and is £594k cumulatively, significantly down compared to last year's £798k at this stage, and £274k below budget. However, the expenditure budget is currently £79k under spent, reflecting the staffing model. TC have also earned some of the CPPD income included in Education and Training which is £42k below target. As noted above, TC are forecasting an improvement in the second half of the year and expect to reduce the shortfall to £250k.

4.2 Departmental consultancy is £45k above budget after ten months. The majority of the favourable variance is within SAMHS which is £49 above plan due to the BUPA Project. There has been a related increase in Complex Needs expenditure.

Carl Doherty
Deputy Director of Finance
12 February 2014

774	
-----	--

THE TAVISTOCK AND PORTMAN NHS TRUST											APPENDIX B
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2013-14											
All figures £000											
Jan-14			CUMULATIVE			FULL YEAR 2013-14					
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	OPENING BUDGET	REVISED BUDGET	FORECAST	REVISED BUDGET VARIANCE	
INCOME											
1 CENTRAL CLINICAL INCOME	610	694	84	5,911	6,005	94	6,247	7,131	7,381	250	
2 CAMHS CLINICAL INCOME	347	221	(126)	3,426	3,163	(262)	4,033	4,121	3,789	(332)	
3 SAAMHS CLINICAL INCOME	378	328	(50)	3,829	3,863	34	4,358	4,586	4,806	220	
4 NHS LONDON TRAINING CONTRACT	605	605	(0)	6,045	6,045	0	7,254	7,254	7,254	0	
5 CHILD PSYCHOTHERAPY TRAINEES	179	175	(4)	1,790	1,730	(61)	2,188	2,148	2,097	(51)	
6 JUNIOR MEDICAL STAFF	94	103	9	938	947	9	1,130	1,126	1,137	11	
7 POSTGRADUATE MED & DENT'L EDUC	7	11	4	70	94	24	76	84	112	29	
8 DET TRAINING FEES & ACADEMIC INCOME	54	135	81	1,937	2,052	115	1,324	2,201	2,273	72	
9 CAMHS TRAINING FEES & ACADEMIC INCOME	541	642	101	5,424	5,467	43	7,541	6,506	6,428	(78)	
10 SAAMHS TRAINING FEES & ACADEMIC INCOME	138	99	(39)	1,308	1,167	(141)	1,426	1,584	1,402	(183)	
11 TC TRAINING FEES & ACADEMIC INCOME	21	18	(3)	251	209	(42)	293	293	246	(47)	
12 TC INCOME	87	66	(21)	868	594	(274)	1,004	1,042	792	(250)	
13 CONSULTANCY INCOME CAMHS	7	4	(3)	93	89	(4)	107	107	101	(6)	
14 CONSULTANCY INCOME SAAMHS	28	66	38	360	409	49	337	416	470	54	
15 R&D	12	18	6	133	208	76	128	211	236	25	
16 OTHER INCOME	64	81	18	936	933	(3)	964	1,063	1,065	2	
TOTAL INCOME	3,171	3,266	95	33,319	32,976	(344)	38,411	39,873	39,588	(285)	
EXPENDITURE											
17 COMPLEX NEEDS	279	284	(5)	2,941	2,908	33	3,432	3,513	3,574	(62)	
18 PORTMAN CLINIC	127	101	26	1,273	979	294	1,527	1,527	1,239	288	
19 GENDER IDENTITY	96	104	(8)	959	815	144	1,115	1,151	1,078	73	
20 BIG WHITE WALL & DEV PSYCHOTHERAPY UNIT	18	15	3	185	192	(7)	247	221	230	(10)	
21 NON CAMDEN CAMHS	354	372	(18)	3,443	3,346	98	4,023	4,147	4,157	(10)	
22 CAMDEN CAMHS	399	369	30	3,798	3,547	251	3,684	4,596	4,450	147	
23 CHILD & FAMILY GENERAL	43	44	(1)	363	312	50	449	449	411	38	
24 FAMILY NURSE PARTNERSHIP	287	306	(19)	2,871	2,361	510	0	3,446	3,205	241	
25 JUNIOR MEDICAL STAFF	84	63	21	839	784	54	1,052	1,006	911	96	
26 NHS LONDON FUNDED CP TRAINEES	179	169	10	1,790	1,738	52	2,189	2,148	2,085	63	
27 TAVISTOCK SESSIONAL CP TRAINEES	3	3	0	28	25	3	34	34	30	4	
28 FLEXIBLE TRAINEE DOCTORS & PGMDE	32	22	10	324	303	21	388	389	363	26	
29 EDUCATION & TRAINING	204	194	10	3,245	3,210	35	4,042	3,779	3,797	(17)	
30 VISITING LECTURER FEES	135	192	(58)	1,100	1,032	68	1,179	1,369	1,257	112	
31 CAMHS EDUCATION & TRAINING	123	118	4	1,225	1,239	(14)	4,868	1,471	1,495	(24)	
32 SAAMHS EDUCATION & TRAINING	78	78	(1)	777	778	(1)	843	933	930	3	
33 TC EDUCATION & TRAINING	0	(2)	2	0	2	(2)	0	0	4	(4)	
34 TC	78	64	14	776	697	79	893	931	856	75	
35 R&D	15	11	4	139	118	22	183	169	159	10	
36 ESTATES DEPT	174	221	(47)	1,823	1,848	(25)	2,053	2,171	2,217	(46)	
37 FINANCE, ICT & INFOMATICS	192	148	44	2,008	1,942	65	1,944	2,350	2,394	(44)	
38 TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	83	102	(19)	822	764	58	977	989	917	72	
39 COMMERCIAL DIRECTORATE	68	44	24	636	556	80	646	772	667	105	
40 HUMAN RESOURCES	52	54	(2)	567	540	26	622	670	653	17	
41 CLINICAL GOVERNANCE	41	48	(7)	409	428	(19)	451	490	521	(30)	
42 PROJECTS CONTRIBUTION	(6)	(10)	4	(57)	(50)	(8)	(69)	(69)	(60)	(9)	
43 DEPRECIATION & AMORTISATION	46	48	(2)	458	485	(27)	550	550	582	(32)	
44 IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	0	0	0	0	0	0	
45 PRODUCTIVITY SAVINGS	0	0	0	0	0	0	0	0	0	0	
46 INVESTMENT RESERVE	(6)	0	(6)	(62)	0	(62)	170	73	73	0	
47 CENTRAL RESERVES	3	0	3	26	0	26	350	31	31	0	
TOTAL EXPENDITURE	3,177	3,162	15	32,706	30,898	1,808	37,845	39,307	38,227	1,081	
OPERATING SURPLUS/(DEFICIT)	(6)	104	111	614	2,078	1,464	566	566	1,361	795	
48 INTEREST RECEIVABLE	0	1	0	4	9	5	5	5	10	5	
49 DIVIDEND ON PDC	(35)	(35)	0	(351)	(351)	0	(421)	(421)	(421)	(0)	
SURPLUS/(DEFICIT)	(41)	70	111	267	1,736	1,469	150	150	951	801	
50 RESTRUCTURING COSTS	0	0	0	0	30	(30)		0	30	(30)	
SURPLUS/(DEFICIT) AFTER RESTRUCTURING	(41)	70	111	267	1,706	1,439		150	921	831	

Page 23 of 49

APPENDIX D													
2013/14 Plan													
	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	3,176	3,901	3,061	1,627	2,940	1,844	1,585	3,408	2,134	1,133	3,540	2,648	3,176
Operational income received													
NHS (excl SHA)	315	1,942	1,380	1,421	1,314	1,283	1,273	1,315	1,283	1,274	1,314	1,283	15,397
General debtors (incl LAs)	1,073	403	556	562	459	1,618	571	483	480	829	565	482	8,081
SHA for Training	2,567	142	79	2,567	143	79	2,567	142	79	2,567	143	79	11,156
Students and sponsors	325	150	150	100	0	200	800	250	100	750	100	100	3,025
Other	18	18	18	18	18	18	18	18	18	18	18	18	216
	4,298	2,655	2,183	4,668	1,934	3,198	5,229	2,208	1,960	5,438	2,140	1,962	37,875
Operational expenditure payments													
Salaries (net)	(1,427)	(1,527)	(1,453)	(1,427)	(1,327)	(1,327)	(1,327)	(1,327)	(1,327)	(1,327)	(1,327)	(1,327)	(16,450)
Tax, NI and Pension	(932)	(981)	(981)	(981)	(981)	(981)	(980)	(981)	(981)	(981)	(981)	(981)	(11,722)
Suppliers	(847)	(988)	(1,074)	(874)	(723)	(799)	(1,099)	(1,174)	(724)	(723)	(725)	(723)	(10,473)
	(3,206)	(3,496)	(3,508)	(3,282)	(3,031)	(3,107)	(3,406)	(3,482)	(3,032)	(3,031)	(3,033)	(3,031)	(38,645)
Capital Expenditure	0	0	(100)	(72)	0	(340)	0	0	(530)	0	0	(1,275)	(2,317)
Loan	0	0	0	0	0	200	0	0	600	0	0	900	1,700
Interest Income	0	1	0	1	0	1	0	0	1	0	1	0	5
Payments from provisions	0	0	(9)	(2)	0	0	0	0	0	0	0	0	(11)
PDC Dividend Payments	(367)	0	0	0	0	(211)	0	0	0	0	0	(210)	(788)
Closing cash balance	3,901	3,061	1,627	2,940	1,844	1,585	3,408	2,134	1,133	3,540	2,648	995	995
2013/14 Actual/Forecast													
	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	3,176	3,786	2,141	1,291	3,871	4,707	3,357	6,906	4,789	2,814	5,335	4,143	3,176
Operational income received													
NHS (excl SHA)	572	1,065	1,296	2,227	2,639	965	1,289	939	865	2,060	1,314	1,283	16,514
General debtors (incl LAs)	861	433	274	393	741	293	1,768	357	217	616	565	482	7,000
SHA for Training	2,465	17	199	2,669	154	105	3,588	72	16	2,680	143	79	12,188
Students and sponsors	291	108	86	134	90	344	304	57	122	333	100	100	2,069
Other	39	30	54	50	65	77	37	51	76	68	18	18	583
	4,228	1,653	1,909	5,473	3,689	1,784	6,986	1,476	1,296	5,757	2,140	1,962	38,354
Operational expenditure payments													
Salaries (net)	(1,329)	(1,308)	(1,274)	(1,296)	(1,218)	(1,212)	(1,295)	(1,299)	(1,275)	(1,306)	(1,327)	(1,327)	(15,466)
Tax, NI and Pension	(932)	(998)	(981)	(953)	(976)	(931)	(940)	(995)	(989)	(997)	(981)	(981)	(11,654)
Suppliers	(968)	(962)	(463)	(570)	(618)	(678)	(1,131)	(1,181)	(996)	(869)	(1,025)	(1,023)	(10,484)
	(3,229)	(3,268)	(2,718)	(2,819)	(2,812)	(2,821)	(3,366)	(3,475)	(3,260)	(3,172)	(3,333)	(3,331)	(37,604)
Capital Expenditure	(24)	(31)	(42)	(74)	(42)	(109)	(71)	(119)	(12)	(65)	0	(175)	(764)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	1	1	1	0	1	1	0	1	1	1	1	0	9
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	(366)	0	0	0	0	(205)	0	0	0	0	0	(210)	(781)
Closing cash balance	3,786	2,141	1,291	3,871	4,707	3,357	6,906	4,789	2,814	5,335	4,143	2,390	2,390

Board of Directors : February 2014

Item : 8

Title: Education and Training Report

Purpose:

To propose an appropriate cycle and structure of reporting for education and training

This report has been reviewed by the following Committees:

- Management Committee, 13th February 2013

This report focuses on the following areas:

- Quality
- Risk

For : Approval

From : Malcolm Allen, Dean of Postgraduate Studies

Education and Training Report

February 2014

1. Reporting cycle and structure

- 1.1 In January 2013 the Board approved a proposal for an annual cycle of three major reports from education and training:
- March special attention to CAMHS
 - July special attention to SAAMHS
 - November general.
- 1.2 However, a recent report from Baker Tilly, our internal auditors, made this recommendation: *"The Education and Training Reports produced for the Trust Board should reflect training activities with the CAMHS and the SAMHS service lines and submitted to the Board on a quarterly basis. In addition, once the Key Performance Indicators have been developed by the Department of Education and Training they should be included within the Education and Training Reports. This will make senior management and Board members aware of progress made by the Department of Education and Training compared to the previous reporting period."*
- 1.3 The creation of a KPI-based system of reporting is clearly desirable and the Education & Training Executive has been working on a schedule of appropriate KPIs. However, the proposal for *quarterly reports* does not fit with the real-world cycle of education and training activity. The most significant indicators that measure our economic success occur once at the beginning of the academic year when we have analysed our admissions figures (although there may be some subsequent variation between October and June insofar as we experience drop-out for various reasons). Similarly, quality will be measured usually from a number of annually reported phenomena, including importantly the student feedback questionnaire.
- 1.4 Therefore, the following annual reporting cycle is proposed:
- KPI-based annual report on recruitment and admissions presented to the November Board meeting, including numbers of applications and enrolments, progression and retention figures, results against targets, etc.
 - KPI-based annual report on quality presented to the February Board, with KPIs based on student feedback exercise, external examiner reports, completion rates, Review & Enhancement Process report
 - Annual report containing a review of the past year and a preview of the forthcoming year, referencing our KPIs, and including a summary of business development, presented to the Board in June or July.

- 1.5 All three reports will also contain updates on the process of strategic transformation, business development and normal reporting of relevant developments. All reports will also have CAMHS and SAAMHS service lines dimensions as well as an integrated dimension. The annual report will also contain a summary of business development, though this will also be reported on throughout the year as it occurs.
- 1.6 The Management Committee considered a draft paper with more detail around these proposals but wished for more time to consider some of the issues raised. It is proposed to bring this paper to the April Board meeting, with the complete schedule of recommended KPIs and a substantive reporting on most of them (as would have been received in November 2013 and February 2014).
- 1.7 The Board is requested to approve this cycle of reporting as appropriate to education and training.

Malcolm Allen
Dean of Postgraduate Studies

Board of Directors : February 2014

Item : 9

Title : CQSG Report, Q3, 2013/14

Purpose:

The purpose of this report is to give an overview of performance of clinical quality, safety, and governance matters in the opinion of members of the CQSG. 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:

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

The assurance to these committees was based on evidence scrutinised by the work stream leads and the Management Committee. Presentation of the RAG ratings have been fine tuned in line with feedback from the Board.

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, Q3, 2013/14

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 an amplification of red and amber rated elements.

2. Findings

- 2.1 Appendix 1 sets out the detail by reporting line, the expected rating in column on the right of the table may change over that reporting period.
- 2.2 Having considered and discussed the reports, the committee set the level of assurance as demonstrated; this is recorded below.

2.3 Corporate Governance and Risk

2.3.1 Substantial assurance was demonstrated

- 2.3.2 All areas green
- 2.3.3 The committee welcomed the CQC's focus on 5 areas and looked to the Trust to adapt local systems in due course
- 2.3.4 The committee pleased to note Trust responses to tenders are to be aligned to the CQC's 5 areas of interest

2.4 Clinical Outcomes

2.4.1 Adequate assurance was demonstrated

- 2.4.2 CAMHS systems are fully functional; SAAMHS systems are under development
- 2.4.3 Clinical engagement is an issue that is being tackled on a number of fronts; the committee directed that sanctions apply to non-compliers as with mandatory training but this has not yet been implemented
- 2.4.4 The SAAMHS Director is addressing low clinical engagement levels in SAMHS, especially at the Portman; the Clinical Governance Office and Informatics team are providing data reports to support clinical practice

2.4.5 The committee noted a patient portal is being developed

2.5 Clinical Audit

2.5.1 *Adequate assurance was demonstrated*

2.5.2 The committee noted that audit work was being undertaken but that resources were yet to be identified to ensure potential improvements identified in reports were implemented at clinical team level

2.6 Patient Safety and Clinical Risk

2.6.1 *Substantial assurance was demonstrated*

2.6.2 A process to eliminate discrepancies on child protection arrangement records in different record systems has been implemented

2.6.3 One SUI was closed; two more have been opened and are being investigated

2.6.4 The Clinical Governance Office has completed the medical revalidation process

2.7 Quality Reports

2.7.1 *Substantial assurance was demonstrated*

2.7.2 The setting of 2013/14 KPIs was complete at the end of this quarter for reasons beyond the Trust's control; operationally this was unhelpful

2.7.3 Work to produce the 2013/14 report is well underway

2.8 Patient and public involvement

2.8.1 *Substantial assurance was demonstrated*

2.8.2 The Quality Stakeholder Group had provided a useful forum for patients to engage with commissioners

2.8.3 The launch of the new website is anticipated

2.9 Information Governance

2.9.1 *Adequate assurance was demonstrated*

2.9.2 Overall improvements were noted; a small number of long-standing issues remained outstanding but reassurance was given that these would be completed by the end of Q4

- 2.9.3 The table in this report shows predicted Q4 position of Red for two areas and Amber for one other. However, the actions agreed now will ensure that the Trust meets the required standard (level 2) for these tasks as well as for all the others. The MC will monitor progress towards completion

3. Conclusion

- 3.1 This report gives a comprehensive overview and summary of the level of assurance in the opinion of members of the CQSG.

Appendix 1

Corporate Governance and Risk Work stream						
Task	Q4	Q1	Q2	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 significant concern.	
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	G	G	G	G	All training targets achieved or exceeded. Additional health and safety training had been provided for staff using ladders.	
Estates and Facilities infrastructure improvements and CQC and NHSLA compliance	A	G	G	G	All estates projects were completed on schedule. A project to increase records storage capacity was commenced. Redecoration at the Tavistock Centre had been well received by stakeholders.	

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	The NHSLA assessment system has been changed; this reporting line will be amended to show the incorporation of useful elements of this work into the CQC compliance report from the Q4 report.	
Non-clinical incident reports	G	G	G	G	Monitoring via work streams working well.	
Specific case reports (serious incidents / SUIs)	A	G	G	G	No issues to report.	
Central alert broadcast advice	G	G	G	G	No issues to report.	
Operational Risk Register	G	G	G	G	No issues to report.	
Relocation of Day Unit	G	G			This is on hold pending further consideration by the Board of Directors of the options for the Tavistock site and of the revised day unit business case	
CGR IG compliance	G	G	G	G	Targets met.	

Clinical Outcomes Work Stream						
Task	Q4	Q1	Q2	Q3	Action plan for amber and red risks	Predicted position for end of Q4
Implementation of OM project plan	A	A	A	A	CAMHS is working well, SAAMHS is working through problems in implementation.	
Local ownership of outcome monitoring	A	A	A	A	Take-up by clinicians in CAMHS and SAAMHS is being monitored fortnightly with a view to increasing the proportion of users from a low baseline to 100%.	
OM tracking system pilot training	G				Reporting line discontinued	
Processes for data collection are robust.	A	A	A	A	Clinical Governance and Informatics Managers have systems in place to examine data quality and will report from Q4.	
CQUIN targets CAMHS and SAAMHS				A	Targets were missed in Q3 and a plan is in place to improve performance.	

Clinical Audit work stream						
Task	Q4	Q1	Q2	Q3	Action plan for amber and red risks	Predicted position for end of Q4
NICE compliance	G	A	A	A	A gap analysis to have been produced in Q3 following publication of national guidance has been planned for Q4.	
Confidential inquiries	G				Reporting line discontinued	
CA IG compliance	A				Reporting line transferred to IG report	
National audit requirements	G	G	G		Reporting line discontinued	
Compliance with plan	A	A	A	G	No issues to report.	
Audit tracking	G	G	G	A		
NICE quality standards	A				Reporting line discontinued	
Implementing improvements recommended in audit reports				G	A plan is in place to address this from Q4.	

Patient Safety and Clinical Risk Work stream						
Task	Q4	Q1	Q2	Q3	Action plan for amber and red risks	Predicted position for end of Q4
Clinical incidents	G	G	G	A	A suicide of a former patient is being investigated. A suicide of a patient of another trust where this Trust was contributing is being investigated	
Specific case reports (serious incidents / SUIs)	A	G	G	G	A final report into a suicide previously reported will be produced in Q4.	
Hospital acquired infection	G	G	G	G	'flu vaccination rates for staff have improved	
New Clinical claims	G	G	G	G	None.	
Complaints responses	G	G	G	G	1 clinical complaint was made in Q3; all open cases were resolved by the end of the quarter.	
PSCR NHSLA compliance	G	G	G	G	See entry in CGR report.	
PSCR CQC compliance	G	G	G	G	No areas of concern noted.	

Central Alert Broadcast advice	G	G	G	G	
Supervision of clinicians	G	G	A	A	Procedure reviewed and awaited re-formatting [now done].
Revalidation	G	G	G	G	The Clinical Governance team were thanked for their work to deliver this requirement.
PSCR risk review	G	G	G	G	There are no 9+ risks
Safeguarding children	A	A	A	A	A plan is in place to address an identified processing error.
Safeguarding adults	G	G	G	G	

Quality reports work stream						
Task	Q4	Q1	Q2	Q3	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				Reporting line discontinued	
Arrangements to deliver CQUIN are fit for purpose	A				Reporting line discontinued	
That data to be collected has been agreed	G				Reporting line discontinued	
That data quality procedure is implemented	G				Reporting line discontinued	
That QR components of the AR are submitted on time and in the correct format	G				Reporting line discontinued	
That QR requirements of IG9 are completed	G				Reporting line transferred to IG	

CQUINS and KPI targets are agreed for 2013/14	A	A	G	Trust's smoking cessation target was agreed. Plan to improve data flows in place. Plan to improve data flows in place. This is an area of ongoing development with the lead CCG. Work ongoing	
Arrangements in place to report on CQUINS and KPIs for SAAMHS	A	A	A		
Arrangements in place to report on CQUINS and KPIs for CAMHS	A	A	A		
Meeting Quality Priorities listed below at **	G	G	G		
Meeting quality reporting requirements of CCG	G	G	G		
Quality report Recommendations from 2012-13	A	A	A		
Preparation for Quality Report 2013-14	-	-	G		

PPI work stream						
Task	Q4	Q1	Q2	Q3	Action plan for amber and red risks	Predicted position for end of Q4
CQC compliance	G	G	G	G	Liaison activity is on-going; no gaps in delivery of work apparent.	
Providing assurance that the Trust adheres to all PPI related policies and procedures	G	G	G	G	Departmental PPI leads promote procedures to teams	
Discussing PPI issues arising from PALS, complaints or other forms of PPI input and making recommendations	G	G	G	G	See comments book next to straw poll box for latest comments from users.	
Discussing the findings of the experience of service questionnaire and ensure	G	G	G	G	Findings and action plans considered quarterly.	

delivery of action plans									
Ensuring the involvement of patients in service improvement	G							Reporting line discontinued	
To improve the patient experience of diverse groups	G							Reporting line discontinued	
To ensure 3 issues identified at stakeholder meetings were addressed by March 2014	G	G	G	G	G				
To hold 3 patient forums	G	G	G	G	G			Scheduled	
To audit accessibility of modality leaflets		G	G	G	G				
To produce 3 further leaflets on modalities	G							Reporting line discontinued	
To produce further 4 leaflets		G						Reporting line discontinued	

on modalities							
That PPI IG requirements are completed	G					Reporting line transferred to IG report [see 203]; PPI to propose plan and report thereon from Q1 2014/15.	
Ensure that quality is continually improved through the development of patients centred services and within the organisation's culture [with QR lead and others]	G	G	G	G	G	Five public constituency members help oversee this work.	

Information Governance Work Stream : Q3 2013/14

Task	Q4	Q1	Q2	Q3	Action plan for amber and red risks	Predicted position for end of Q4, 2014
101 Governance Overview	G	G	G	G	A strong area for the Trust.	G
105 Policy overview	G	R	R	R	IT Manager to complete Mobile Device Procedure review by end Jan.	R
110 Contractor compliance	G	A	R	G	All known contracts comply.	G
111 Employee contract compliance	G	G	G	G	The use of national terms and conditions saves the Trust from the expense of developing its own compliance regime.	G
112 IG training	G	A	A	A	Over two thirds of staff have been trained; staff who did not complete by the deadline will be told that they face sanctions if they do not complete. Directorates continue to monitor and report progress.	G

Task	Q4	Q1	Q2	Q3	Action plan for amber and red risks	Predicted position for end of Q4, 2014
200 Caldicott functionality/ Data Protection	G	A	R	R	<p>DET and IT Manager need to provide secure storage for student research data. Action to be completed and operational by 6 March. This risk remains on the register at a high level.</p> <p>The Commercial Directorate has now provided a list of contracts, indicating the gaps in compliance. The largest contracts are now compliant. Others are not yet: this is due mainly to the delays and difficulties experienced by all providers this year in getting all contracts finalised and signed, rather than specific issues on the IG clauses. An action plan is in place to get this work complete, possibly with exceptions for some very small contracts, before 31 March.</p>	R
201 Confidentiality compliance	G	A	A	A	A revised Code of Confidentiality is awaited from the Caldicott Guardian.	G
202 & 203 Consent compliance	G	A	A	R	The procedure relating to this is overdue for renewal; approval is awaited from the PPI lead	G
205 Access request compliance	G	G	G	G	The Trust receives few requests.	G
206 Confidentiality audit compliance	G	A		R	The audit has since been scheduled for Q4; additional temporary resource has been found to support this work.	A

Task	Q4	Q1	Q2	Q3	Action plan for amber and red risks	Predicted position for end of Q4, 2014
207 Sharing protocol compliance	G	G	A	G	This is covered in contracts; though as most partners are NHS the Trust can be assured we are all working to the same high standards unlike the private sector. However, more work to ensure good contract management is indicated (see also 210).	G
209 processing outside UK	G	A	A	G	The EU Commission has expressed serious concerns about the failure of US firms to protect EU citizens' data. Until this has been resolved to the satisfaction of the Commission, US based storage systems for data storage are not recommended for use when procuring new systems. The Trust does not plan to use any US based storage systems.	G
210 New systems compliance	G	R	R	R	For systems related to new services (from tenders or other developments), Commercial Directorate has drawn up a procedure setting out how IG compliance will be incorporated into due diligence and implementation processes. After current consultation with Risk and Governance colleagues, this will be finalised by 6 March. Meanwhile, the process to procure a new patient records system is addressing the pertinent issues as part of a wider collaboration across directorates and functions and this is being well managed.	G
300 Information security skills compliance	G	G	A	G	The 2013 audit was completed and no areas of concern were identified	G
301 Risk assessment of Information Assets	G	A	A	G	There has been a delay in completing the annual review due to a change in staff; the task is in hand completion is expected in Q4.	G

Task	Q4	Q1	Q2	Q3	Action plan for amber and red risks	Predicted position for end of Q4, 2014
302 Incident Reports	G	G	G	G	Reporting is monitored at the IG work stream; no concerns apparent.	G
303 Registration Authority compliance	G	G	G	G	An audit indicated good compliance.	G
304 RA monitoring compliance	G	G	G	G	An audit indicated good compliance.	G
305 access control compliance	G	G	G	G	Access to Trust systems is multi-layered.	G
307 Risk management	G	R	R	G	New risks were added to the register in Q3	G
308 Data mapping	G	A	G	G	All known assets have been mapped.	G
309 Business continuity assurance	G	A	A	G	This is addressed as part of the risk assessment process; no concerns apparent.	G
310 Disruption preparation assurance	G	A	A	G	This is addressed as part of the risk assessment process; no concerns apparent.	G

Task	Q4	Q1	Q2	Q3	Action plan for amber and red risks	Predicted position for end of Q4, 2014
311 Protection of IAs	G	A	A	G	This is addressed as part of the risk assessment process; no concerns apparent.	G
313 Network assurance	G	G	G	G	Access controls to Trust systems are multi-layered.	G
314 Teleworking assurance	G	G	G	G	Access controls to Trust systems are multi-layered.	G
323 Protection of IA assurance	G	G	G	G	A comprehensive programme of assessment is monitored and reported to the IG work stream.	G
324 Pseudonymisation assurance	G	G	G	G	This is monitored and reported to the IG work stream.	G
400 IG quality, skills and experience assurance	G	G	G	G	A review of an external archive is underway. A reorganisation of the Trust's basement archive was completed. Extra capacity is needed to cope with more and thicker patient files.	G
401 NHS number assurance	G	G	G	G	This is rather obsolete as 'RiO' only functions with NHS numbers, the Trust is therefore compliant.	G
402 Accuracy of data input	G	A	R	A	New arrangements are due to report evidence of compliance with this requirement from February.	G
404 Audit assurance	G	A	G	G	This complements 206 and is managed by the Governance and Risk Adviser with support from the Clinical Governance Office and Governance Manager.	G

Task	Q4	Q1	Q2	Q3	Action plan for amber and red risks	Predicted position for end of Q4, 2014
406 Monitoring paper records assurance	G	G	G	G	Tracking records is well managed; spot checks have been introduced.	G
501 Data definitions compliance assurance	G	G	G	G	This is rather obsolete as 'RiO' only functions with national definitions; nevertheless the task to 'prove' compliance exists!	G
502 External data feedback reports	G	A	A	A	New arrangements are due to report evidence of compliance with this requirement from February.	G
504 Benchmark reports	G	A	A	A	New arrangements are due to report evidence of compliance with this requirement from February.	G
506 Service user data accuracy validation	G	A	A	A	New arrangements are due to report evidence of compliance with this requirement from February.	G
507 Data completeness validation	G	A	A	A	New arrangements are due to report evidence of compliance with this requirement from February.	G
508 Clinical data input validation	G	G	G	G	This is limited as the question is not tailored to the Trust.	G
514 Clinical coding audit validation			A	A	The Informatics Manager needs to provide evidence of compliance.	G

Task	Q4	Q1	Q2	Q3	Action plan for amber and red risks	Predicted position for end of Q4, 2014
516 Clinical coding training programme assurance			A	A	The Quality Reports Lead needs to provide evidence of compliance.	G
601 Corporate record management assurance	G	A	G	G	The Trust is undertaking a small project to ensure compliance with the Public Records Act 1958.	G
603 FOI compliance assurance	G	G	A	G	This responsibility is being transferred to the Governance Assistant and training is being provided.	G
604 Records lifecycle management assurance	G	A	G	G	The Trust is undertaking a small project to ensure compliance with the Public Records Act 1958. A small investment in extra storage space will alleviate pressure on the patient records archive.	G

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 25th February 2014, 14.00 – 15.30,
Board Room, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES				
1.	Chair's Opening Remarks Ms Angela Greatley, Trust Chair		Verbal	
2.	Apologies for absence and declarations of interest Ms Angela Greatley, Trust Chair	To note	Verbal	
3.	Minutes of the previous meeting Ms Angela Greatley, Trust Chair	To approve	Enc.	p.1
3a.	Outstanding Actions Ms Angela Greatley, Trust Chair	To note	Enc.	p.7
4.	Matters arising Ms Angela Greatley, Trust Chair	To note	Verbal	
REPORTS & FINANCE				
5.	Trust Chair's and NED Report Non-Executive Directors as appropriate	To note	Verbal	
6.	Acting Chief Executive's Report Mr Simon Young, Acting Chief Executive	To note	Enc.	p.8
7.	Finance & Performance Report Mr Carl Doherty, Deputy Director of Finance	To note	Enc.	p.16
STRATEGY				
8.	Education and Training Report Mr Malcolm Allen, Dean	To approve	Enc.	p.25
QUALITY & GOVERNANCE				
9.	CQSG Report for Quarter 3 Dr Rob Senior, Medical Director	To note	Enc.	p.28
CONCLUSION				
16.	Any Other Business		Verbal	
17.	Notice of Future Meetings <ul style="list-style-type: none">Wednesday 5th March 2014: Directors Conference, 1pm-5pm, Lecture Theatre, Tavistock CentreWednesday 19th March 2014: Joint Board Meeting, 2pm-5pm, Lecture Theatre, Tavistock CentreTuesday 25th March 2014: Board of Directors, 2pm-5pm, Board Room, Tavistock Centre		Verbal	

