

## Board of Directors Part One

### **Agenda and papers**

of a meeting to be held in public

2.00pm–4.00pm  
Tuesday 29<sup>th</sup> April 2014

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



## BOARD OF DIRECTORS (PART 1)

**Meeting in public**  
**Tuesday 29<sup>th</sup> April 2014, 14.00 – 16.00**  
**Board Room, Tavistock Centre, 120 Belsize Lane, London NW3 5BA**

### AGENDA

PRELIMINARIES				
1.	<b>Chair's Opening Remarks</b> Ms Angela Greatley, Trust Chair		Verbal	
2.	<b>Apologies for absence and declarations of interest</b> Ms Angela Greatley, Trust Chair	To note	Verbal	
3.	<b>Minutes of the previous meeting</b> Ms Angela Greatley, Trust Chair	To approve	Enc.	p.1
3a.	<b>Outstanding Actions</b> Ms Angela Greatley, Trust Chair	To note	Enc.	p.9
4.	<b>Matters arising</b> Ms Angela Greatley, Trust Chair	To note	Verbal	
REPORTS & FINANCE				
5.	<b>Trust Chair's and NED Report</b> Non-Executive Directors as appropriate	To note	Verbal	-
6.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To note	Enc.	p.10
7.	<b>Finance &amp; Performance Report</b> Mr Carl Doherty, Deputy Director of Finance	To note	Enc.	p.13
8.	<b>Annual Complaints Report</b> Mr Paul Jenkins, Chief Executive	To note	Enc.	p.25
9.	<b>Camden CAMHS Service Report</b> Dr Andy Wiener, Associate Clinical Director	To note	Enc.	p.30
STRATEGY				
10.	<b>Time to Change Initiative</b> Mr Paul Jenkins, Chief Executive	To approve	Enc.	p.43
QUALITY & GOVERNANCE				
11.	<b>Corporate Governance – External Contacts List</b> Mr Gervase Campbell, Trust Secretary	To note	Enc.	p.54
12.	<b>Q4 Governance Statement</b> Mr Carl Doherty, Deputy Director of Finance	To approve	Enc.	p.82
13.	<b>Q4 Quality Report</b> Ms Louise Lyon, Trust Director	To approve	Enc.	p.88

<b>14.</b>	<b>Draft Annual Quality Report</b> Ms Justine McCarthy Woods, Quality Standards and Reports Lead	To approve	Enc.	p.104
<b>15.</b>	<b>CQC Inspection Report</b> Ms Jane Chapman, Governance and Risk Adviser	To note	Enc.	p.163
<b>CONCLUSION</b>				
<b>16.</b>	<b>Any Other Business</b>		Verbal	
<b>17.</b>	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"> <li>• Tuesday 27<sup>th</sup> May 2014: Board of Directors, 2pm-5pm, Board Room, Tavistock Centre</li> <li>• Tuesday 10<sup>th</sup> June 2014: Directors' Conference, 12pm-5pm, Lecture Theatre</li> <li>• Tuesday 24<sup>th</sup> June 2014: Board of Directors, 2pm-5pm, Board Room, Tavistock Centre</li> <li>• Thursday 26<sup>th</sup> June: Council of Governors, 2pm-5pm, Board Room, Tavistock Centre</li> </ul>		Verbal	

## Board of Directors

### Meeting Minutes (Part One) Tuesday 25<sup>th</sup> March 2014, 2.00 – 3.45pm

<b>Present:</b>			
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	Mr Paul Jenkins Chief Executive	Ms Lis Jones Director of Nursing (non-voting)	Ms Louise Lyon Trust Director
Dr Ian McPherson Non-Executive Director (Deputy Trust Chair)	Ms Caroline Rivett Non-Executive Director	Dr Rob Senior Medical Director (late)	Mr Simon Young Deputy Chief Executive & Director of Finance
<b>Attendees:</b>			
Mr Gervase Campbell Trust Secretary (minutes)	Mr Carl Doherty Deputy Director of Finance (items 7,9,10)	Dr Elena Rowland Governor	
<b>Apologies:</b>			
Ms Joyce Moseley Non-Executive Director			

#### Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to be made to minutes	GC	Immed
2	5	Check with Ms Thomas that whistle-blowing clause is included in Trust contracts	GC	April
3	5	Ms Jones to look at the culture of openness with Ms Thomas and report back to the Board	LJ	May
4	7	Finance FAQs to be circulated to the Board	CD	April
5	11	Dr Harris to circulate a note on the tiered model of CAMHS Service Delivery	RH	April

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

Ms Greatley opened the meeting and welcomed everyone.

#### 2. Apologies for Absence and declarations of interest

Apologies as above. Dr Senior was delayed but expected shortly.

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

- The minutes had been amended (AP1).
- The staff survey was booked for the April board (AP2)
- Mr Allen confirmed the auditors had been informed of the new reporting schedule
- Final outrun column included in budget (OAP3)
- Charitable funds briefing to be circulated in April (OAP7)
- TC report scheduled for May board (OAP10)

## 5. Trust Chair and NEDs' Report

Ms Greatley reported that she had attended a number of meetings in the last month, and the headline message at all of them was the sheer financial pressure the whole system, both local authorities and the NHS, was under. The current year-on-year savings and Nicholson challenge were hard but also likely to be insufficient and we can anticipate the targets being revised and made more challenging in the future.

Ms Greatley reported that she had attended an interesting conference at the King's Fund called 'One Year on From Francis', which questioned what the duty of candour really meant in terms of being transparent and open to challenge from service users, as well as how complaints and whistleblowing were dealt with. Mr Holt added that the conference had clarified for him that whilst we are regulated and set standards to report against, those are minimums and we should not be automatically congratulating ourselves on reaching them, but instead striving to go beyond them, and setting our own higher and improving standards where applicable.

Ms Greatley referred to the letters from the Secretary of State for Health which stress the need to operate with openness and transparency, and emphasise assisting whistleblowing. Ms Rivett commented that the letters make the issues appear straightforward, but in difficult situations they tend to be more nuanced and there was a question on how we could manage the clash between targets from above and an internal culture of openness that supports staff.

Dr McPherson asked whether our contracts had been amended to include the clause on whistleblowing. Ms Greatley agreed that we would ask Ms Susan Thomas, the Director of HR, to look at the policy and contracts, but that addressing the question of nuance and culture was more difficult. Ms Jones volunteered to work on this question and report back to the board.

Mr Holt asked how the board could get reassurance on this. Mr Jenkins commented that focussing on whistleblowing as an answer to the Francis concerns approaches the problem in the wrong way: people should know what is going on without having to rely on whistle-blowers for information on quality. In this Trust we were fortunate in that our size meant the NEDs were accessible, and having robust feedback data from patients regarding quality of care was a major source of assurance for the Board.

The Board **noted** the report.

AP2  
AP3

## 6. Chief Executive's Report

Mr Jenkins reported that he was grateful for the welcome he had received in the Trust, and that having seen more of the work that was done he felt even better about the Trust's potential.

Mr Jenkins introduced the 100 day consultation he would shortly be starting, and thought that of the three framework questions it was the first he felt most strongly about, as it was important strategically to concentrate our resources on areas with the best chance of success. He intended to bring the results back to the Board in the summer.

Commenting that the evaluation report on the Hackney PCPS was launching on the 27<sup>th</sup>, Mr Jenkins noted that it showed the positive impact a well organised scheme could have on the problems behind heavy use of physical health services, and whilst it would be hard to replicate it was good to have done it and got such good results. Hackney CCG has challenged providers to work together in advance of the Better Care Fund, and we would be facilitating early discussions on this, which would be a good opportunity to demonstrate the contribution we can make. Mr Bostock queried why we weren't able to play a larger role given that the work we had done fit the criteria of the Better Care Fund so well. Mr Jenkins explained that the present focus was on older people, which is a group we do not currently cover, though we are looking at this, and so our immediate opportunity is to consult and advise. Mr Young added that they could hope the positive results in Hackney would lead to work in other boroughs, though this might take time and others might replicate the idea instead.

Mr Jenkins introduced the Time to Change pledge, with which he had been involved in his previous role. He explained that the pledge is a public statement by an organisation to tackle stigma and he suggested focusing on our employment practices and involving people with lived experience of mental health problems more centrally in our decision making. Dr McPherson commented that the pledge was a good piece of work and fitted well with work being done in the equalities committee. The Board **supported** the adoption of the pledge.

Mr Jenkins reported that we had won an award in partnership with the Red Cross for our work with refugees in the Psychotherapies Services Project. Ms Greatley added we had received a clear accolade from the CQC following their recent visit, and expressed her thanks to those staff who had been involved. Mr Holt asked about the provisions for our offering our best staff to the CQC for the new inspection regime, Ms Greatley explained that the schemes were still being piloted but we can put staff forward and the CQC will reimburse us for their time. Mr Jenkins and Mr Holt agreed that it was important that we do submit our best staff both to give ourselves an insight into the process but also to learn about best practice elsewhere. Mr Young commented that we had already nominated some staff to the CQC,

including Dr Harris, following an invitation from the London Mental Health Network.

## 7. Finance & Performance Report

Mr Doherty introduced the written report by highlighting that the current underspend was £1.8M, which should reduce to £1.2M by the end of the year due to ongoing work around the Trust and the write off of £200K for Gloucester House the Day Unit expansion. The cash position was good, and this was an essential element in the capital budget for the following year.

In response to a question from Ms Rivett, Mr Young confirmed that we keep the surplus, and that it acts to recharge our reserve. Dr McPherson stressed that it was important to communicate this clearly to staff, and it was agreed that the FAQs which had been circulated round the Trust should be circulated to the Board as well.

AP4

The Board **noted** the report.

## 8. Portman Clinic Service Line Report

Mr Ruszczynski opened by referring to a tabled paper that showed the Portman's improving financial position over the past few years, which was now in the black. The emphasis within the clinic has moved from clinical towards more teaching and training, and the balance was now approximately 65:35; the clinic had long wanted to do more teaching, and in part had achieved this by appointing someone internally to work with DET. Part of the productivity savings had come from retirements and voluntary redundancies, where the clinic had lost almost 25% of its staff, and in the process the staffing profile had been altered towards lower grades.

Mr Ruszczynski explained that the clinic's professional development was well imbedded with the Criminal Justice system, with contracts both for training with the local probation service, and also to provide supervision to probation services across London, and in addition there was an NHS England funded project for anti-social disorder for men which was rolling out to 12 sites in England and Wales. Ms Greatley commented that this was a population who had been neglected so it was therapeutically very important to be able to work with them. Dr McPherson commented that the evidence base was important in convincing critics of the value of this work, and Mr Ruszczynski added that they hoped to get funding to do more research in the area.

Mr Ruszczynski explained that the future strategy aimed to consolidate their gains and then look to opportunities to work with more partners, such as prisons. He listed a number of concerns: the future funding both from mental health and the criminal justice system; that a lot of future opportunities were in teaching and consulting, and these required experienced and confident staff, so it was important not to go too far in



shifting the staff balance; and finally some worry amongst the staff about how things would develop once he stepped down in the summer.

*Dr Senior joined the meeting.*

Dr McPherson commented that the engagement and DNA figures for the Portman Clinic were exceptional given the client group, and showed that the service being offered was meeting their needs, and stressed that other developments were building out of the strength of the clinical services.

Mr Holt commented on the long periods some treatment lasted, and asked how reductions in funding would affect someone who was still a long way from finishing therapy. Mr Ruszczynski explained that whilst commissioners used to question the length of therapy they no longer did so, possibly because the clinic was good at demonstrating the value of their work, both in terms of outcomes and in keeping people out of worse situations, and because the next option is often prison, which is much more expensive.

Mr Bostock asked whether re-offending rates of ex-offenders were monitored and Mr Ruszczynski explained that they were for those in treatment, but not once they had left, as it was expensive and funding was not available.

Ms Lyon commented that this was Mr Ruszczynski's last report after nine years, and the Portman Clinic had been transformed in that time and was in a good place for his successor and providing a really good service to people who no one else wants to help. Ms Lyon and Board expressed their thanks.

The Board **noted** the report.

## 9. Income and Expenditure Budget, 2014/15

Mr Young introduced the budget by explaining that the Trust faced the usual efficiency savings, which were expressed by a tariff deflator of 1.7%, to be confirmed, combined with increased costs, and slightly tempered by the AfC pay announcement. In addition as Gloucester House the Day Unit was in transition, with a period of both low prices and low numbers, it would be able to offer less contribution this coming year.

Mr Young explained that Monitor has removed the requirement for Foundation Trusts to achieve a surplus and so for the coming year the target surplus has been reduced from £150K to £40K with a £315K contingency reserve.

Mr Young confirmed that all clinical contracts and training funds that could be expected to be secured at this point in the year had been – or the differences were small – so he believed it was an achievable budget, and asked the Board to approve it.

Mr Bostock pointed out that section 3.5 stated that a small surplus was required for Monitor. Mr Young explained that this was mis-worded, and the requirement was to avoid major fluctuations and remain close to break-even both throughout the year and at year end, i.e. to keep the Debt Service Ratio even, and that they expected to achieve this.

Dr McPherson commented that although the deflator looked to be about 1.7%, some CCGs were being more flexible on this and NHS England were not. Mr Young confirmed that there was some variation but we expect ours to be 1.7%, and whilst there could be no definitive answer the uncertainty was not enough to put this budget at risk.

Mr Holt noted that the income line was reducing year on year, and asked about how the potential new business was dealt with in the budget. Mr Young explained that the reduction was partly due to an artificial construct where we had in the past taken income for the consortium responsible for educational psychology training and then redistributed it to other parties, but were no longer the lead so £500K of this income and expenditure had both been removed. Regarding growth, the expectation was that no large services would be taken on in time to affect next year's budget, but margins due to smaller growth opportunities had been included.

Ms Rivett asked how solid the income estimates were. Mr Young replied that the growth estimates included some elements which were not solid, but these only formed a small percentage of the total, perhaps 2%; and that the consultancy income and student numbers were not secure but were based on prudent estimations and contingency plans existed to ensure them.

Dr Senior asked about non-recurrent money in the system, which entailed some risks in terms of short term staffing, but should still be actively pursued. Mr Young explained that the amounts were not large and some were already included in the budget. Furthermore the CEO and management committee would not look to allocate the investment reserve until a time when these ideas were clearer, but still early enough to ensure it can be spent within the year.

The Board **approved** the Income and Expenditure Budget for 2014/15.

## **10 Capital Budget, 2014/15**

Mr Doherty introduced the budget by explaining that it was a similar size as last year, but made up differently, and could be paid for from the cash reserve. He explained that the budget included £600k for the relocation programme, a slight reduction in the initial Estates proposal as less work would be done on the lifts, and funding for FNP and DET to invest in their IT management system and for FNP to improve their website.

Mr Holt asked whether the capital spend for FNP would be recovered in

future years. Mr Doherty explained it would be reclaimed via depreciation from the FNP budget.

Mr Holt asked whether the cash flow would cover planned works within next year's capital budget. Mr Young confirmed that they expected to have enough cash from the balance on the 31st March and depreciation. In the following years of the operational plan the cash position would get tighter but they would be watching to ensure there was enough to cover.

The Board **approved** the Capital Budget for 2014/15.

## 11 SUI Action Plan

Dr Harris confirmed that all the actions in the plan had been completed, with the exception of the prescribing audit which set up ready to be done and would be completed shortly.

Dr Harris then commented that since the inquest they had moved beyond the action plan to imbedding good practice within the Trust, with mandatory risk assessment workshops rolled out, the Digital Life team up and running and developing strategy for the coming year, and the risk assessment procedure and recording form being improved and included in clinical inductions.

Dr Senior added that the Camden Safeguarding Children Board have not yet officially heard from the Coroner, and when they do the will meet and may have lessons for involved parties. Already the British Transport Police have changed their practices, and we can expect national outcomes including roll out of digital awareness, with which the Trust would be involved.

Dr Senior went on to note that there appears to be an increase in self-harm, especially with adolescent girls in North London, and Medical Directors have discussed how the separate procurement of Tier 4 care has caused difficulty in getting those in need admitted. In speaking to colleagues they'd learnt of vulnerable adolescents who could no longer be kept in paediatric wards being cared for in the community or sent to adult services.

Dr McPherson commented that the system for young people was in flux and unlikely to get any better, and asked whether there was an opportunity to offer a better quality service. Mr Senior said that a couple of years ago when a Tier 4 pathway existed it would have been possible, but was more difficult now. Dr Harris added that the 3.5 model had been put in place before the changes and agreed to circulate a brief description of the tiered model of CAMHS service delivery.

The Board **noted** the report.

## 12 Any Other Business

AP5

No other business was discussed.

### **13 Notice of Future Meetings**

The Board noted its future meetings.

Part 1 of the meeting concluded at 3.45pm

No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
7	Nov-13	8. Charitable Funds Annual Report	Mr Young to circulate briefing on the two charitable funds.	Simon Young	Mar-14	



## Board of Directors : April 2014

**Item :** 6

**Title :** Chief Executive's Report

**Summary:**

This report provides a summary of my activities in the last month and key issues affecting the Trust.

**For :** Discussion

**From :** Chief Executive

## Chief Executive's Report

### 1. Induction

- 1.1 I have continued to have the opportunity to visit teams across the organisation. I have also had the chance to meet a number of Governors on a 1:1 basis and hope to arrange the opportunity to meet with others over the next couple of months.

### 2. Shaping our Future – 100 day consultation

- 2.1 I have now launched my 100 day consultation. I am aiming to seek views from staff, service users, members and governors and wider stakeholders. As part of this a series of consultation meetings have been organised. I will aim to bring back feedback and conclusions from the exercise to the June and July meetings of the Board.

### 3. Hackney

- 3.1 We had a successful launch on 27<sup>th</sup> March of the evaluation report on the Hackney Primary Care Psychotherapy Service. I will be keen, as part of my 100 day consultation, to develop thinking on how we can best develop this service and secure opportunities to be involved in similar initiatives in other parts of the country.
- 3.2 I have been chairing the Programme Board for the "One Hackney" project involving all the providers in City and Hackney CCG. The programme aims to develop a number of initiatives to better co-ordinate care for the most vulnerable patients, supported by £1.8m of non-recurrent funding from the CCG. The work has also been supported by Tavistock Consulting and may point to a wider area of work they could be involved in in facilitating models of integrated care.

### 4. 2014/5 Budget and submission to Monitor

- 4.1 We have submitted our 2 year forecasts to Monitor on the basis of the numbers we agreed at the March Board meeting and await their response. Simon Young and I have a routine call with them on 13<sup>th</sup> May. While we are confident that the forecasts are deliverable but it will be crucial that we recognise the scale of the challenge represented by the targets for both new business growth and savings. I have agreed with Simon Young that we will use the Productivity Programme Group as a focal point for senior



management oversight of progress against the targets. The Group will provide a regular report to the Board of Directors on progress.

## **5. CAMHS Development Strategy**

- 5.1 There are likely to be a significant number of opportunities in the coming year to expand our work in providing services for children and young people. While, in general, I believe we are well placed to respond to this I have agreed with Rita Harris that it would be helpful to undertake some work to refresh our thinking about our strategy for children and young people's services and how we might offer additional value in providing services across a number of different geographical locations. To kick this off we are holding a strategy day on 14<sup>th</sup> May.

## **6. Big White Wall**

- 6.1 I met with Jen Hyatt and Nicky Runeckles from Big White Wall to review our relationship. The meeting was constructive and highlighted a shared view of how we might develop our relationship in the future.

Paul Jenkins  
Chief Executive  
22<sup>nd</sup> April 2014



## Board of Directors : April 2014

**Item :** 7

**Title :** Finance and Performance Report

**Summary:**

The draft accounts will be submitted to Monitor and to the auditors on 23 April as required.

At the end of the financial year a surplus of £1,244k is reported before restructuring, £1,094k above the revised budget surplus of £150k.

As expected, there was a deterioration in month of £571k, due to mainly to the writing off of the Day Unit capital project, as well as short term projects across the organisation.

The cash balance at 31 March was £2,757k, well ahead of Plan due to the reduced deficit but also to a number of other temporary factors.

The two year plan was submitted to Monitor on 4 April, the quarter 4 return will be submitted on 30 April, and our financial continuity of service risk rating is expected to remain 4.

This position has been reviewed by the Management Committee on 17 April.

**For :** Information.

**From :** Carl Doherty, Deputy Director of Finance

## 1. External Assessments

### 1.1 Monitor

- 1.1.1 Monitor has confirmed that for quarter 3, the Trust has retained a green governance rating and the Continuity of Service Financial Risk Rating returned to 4, above Plan.
- 1.1.2 Based on the draft accounts for the year, it is expected that the Governance rating and the Financial Risk Rating will remain unchanged in quarter 4.

## 2. Finance

### 2.1 Income and Expenditure 2012/13 (Appendices A, B and D)

- 2.1.1 In the draft accounts for the year, the trust is reporting a surplus of £1,244k before restructuring costs, £1,094k above budget. Income is £365k above budget, and expenditure £729k below budget.
- 2.1.2 The favourable movement in month on income of £590k (compared to budget) includes variances of £516k on Training income which is mainly due to £272k for DET Training Fees and Academic income for the release of the HENCEL project funding and the associated costs are reflected in expenditure. Clinical income is £164k favourable in month and just under target cumulatively due to the inclusion of the backdated CQUIN and cost and volume elements for the month.
- 2.1.3 The expenditure budget was over spent in month by £1,061k. The Day Unit capital project write off of £233k is shown here as Depreciation, but will be identified separately as an Impairment in the Accounts. Education and Training were overspent by £216k in March using non-recurrent HENCEL funding mentioned in 2.1.2; Estates were £156k over budget following the completion of the non-recurrent environment improvement projects; Complex Needs were overspent £212k also on non-recurrent projects and GIDU was £85k overspent in month due to backdated prescribing costs. The annual leave provision was increased by £33k due to a rise in the cost of average annual leave carried forward by staff members.
- 2.1.4 There was a small cumulative budgeted deficit in clinical income of £20k. In CAMHS there was a deficit of £478k due to Day Unit under performance by £254k and CAMHS IAPT Project was also £140k below due to a deferral to 2014/15. These shortfalls were offset by SAAMHS Clinical £274k over budget due to GIDU over activity and Central Clinical Income was £183k favourable due to CQUIN and other cost and volume over performances. All the main income sources and their variances are discussed in sections 3, 4 and 5.
- 2.1.5 For an externally funded Finance project, the £5k underspend to date (within the Finance line) is matched by a £5k shortfall on other income, since the funding is only released in line with costs.

2.1.6 The analysis in Appendix D shows that for both CAMHS and SAAMHS, the savings, contribution and surplus (before restructuring) are well ahead of budget.

## 2.2 Cash Flow (Appendix C)

2.2.1 The cash balance at 31 March was £2,757k which is a decrease of £1,649k in month and is £1,762k above Plan. The in-month decrease is due to payments in advance of the national training contract. 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 are summarised below. The year-to-date receipts and payments are summarised in the table below.

2.2.2 Appendix C shows the cash outturn for the year and is summarised below:

		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)	15,551	15,397	154
	General debtors (incl LAs)	7,357	8,081	(724)
	SHA for Training	12,822	11,156	1,666
	Students and sponsors	2,175	3,025	(850)
	Other	637	216	421
		38,542	37,875	667
Operational expenditure payments				
	Salaries (net)	(15,475)	(16,450)	975
	Tax, NI and Pension	(11,690)	(11,722)	32
	Suppliers	(10,320)	(10,473)	153
		(37,485)	(38,645)	1,160
Capital Expenditure		(741)	(2,317)	1,576
Loan		0	1,700	(1,700)
Interest Income		9	5	4
Payments from provisions		0	(11)	11
PDC Dividend Payments		(744)	(788)	44
Closing cash balance		2,757	995	1,762

## 2.3 Better Payment Practice Code

2.3.1 The Trust has a target of 95% of invoices to be paid within the terms. During March we achieved 92% (by number) for all invoices. The cumulative total for the year was 88%.

## 2.4 Statement of Financial Position (aka Balance Sheet) and Capital Expenditure

- 2.4.1 Appendix E reports the SoFP at 31 March, compared to the Plan figures for the year.
- 2.4.2 Trade and other receivables are over plan due to the £1m 4<sup>th</sup> quarter FNP invoice being paid in early April, as well as a number of March CCG invoices which were raised late due to the agreement of volume and CQUIN payments. Cash is higher than plan due to the size of the surplus, as well as the effects of the factors above. Property, Plant and Equipment is £1.8m below plan and the £1.7m loan was not required as the Day Unit project was deferred.
- 2.4.3 Compared to Plan, Fixed Asset values are £1.8m lower due to the deferral of the Day Unit project. The revaluation reserve is also increased by £1.5m.
- 2.4.4 The balances on reserves are explained by the following table:

	Income and Expenditure Reserve £000	Revaluation Reserve £000
Opening balance, April 2013	985	8,979
Surplus for the year	1,105	
Transfer relating to depreciation	139	(139)
Closing balance, March 2014	<u>2,229</u>	<u>8,840</u>

- 2.4.5 The dividend payable to the Secretary of State for 2013/14 is based on the average of the opening and closing "net relevant assets." The closing figure includes the revaluation, but the dividend remains close to budget due to other factors.

## 2.5 Capital Expenditure

- 2.5.1 Up to 31 March, expenditure on capital projects was £741k. This included £223k on the Day Unit which was later written off.
- 2.5.2 The capital budget for the year was £2,317k in total, including £1,700k for the Day Unit project.

### 3. **Training**

3.1 Training income was £531k above budget for the year.

#### 3.2 Academic year

3.2.1 2013-14 fee income is £193k below Plan: SAAMHS £168k adverse to Plan, TC £25k adverse to Plan and CAMHS on Plan.

#### 3.3 Financial Year

3.3.1 In month 12 the release of the remaining HENCEL funding and Educational Psychology trainee bursaries and respective expenditure is reflected in DET fees and academic income. CAMHS also reflects a favourable in month variance on FNP. Academic and fee income is £207k below budget, against a forecast of £242k.

3.3.2 Year to date contract income is £54k above Plan due to the one-off payment from HENCEL. Cumulative non-contract academic and fee income is £476k above Plan. This is due to HENCEL funding of £385k, FNP £209k, Essex HEFCE settled at a higher rate than planned (£58k) and good performance in the year for CAMHS and SAAMHS short courses.

3.3.3 These favourable variances are offset by adverse variances to Plan on e-learning (£161k) due to low activity mainly planned for SAAMHS, fees (£27k) due to lower than target recruitment mainly in SAAMHS and LCPPD (£47k) due to activity being deferred into the next financial year. The reduction of planned e-learning activity and income is offset by other streams of income and also results in a projected underspend on visiting lecturers for development and backfill of £148k.

3.3.4 Expenditure ended the year with an adverse variance of £175k and includes £237k for expenditure against HENCEL funding and a saving on e-learning pay costs of £85k.

#### 4. Patient Services

##### 4.1 Activity and Income

4.1.1 Overall clinical income is £20k below the revised budget for the year due to a short fall on Day Unit offset by GIDU over performance.

	Budget £000	Actual £000	Variance %	Comments
Contracts - base values	12,328	12,429	0.8%	
Cost and vol variances	239	558	133.4%	GIDU Over perf
NPAs	196	169	-13.7%	
Projects and other	1,583	1,515		Income matched to costs, so variance is largely offset.
Day Unit	860	605	-29.7%	
FDAC 2nd phase	518	523	1.0%	Income matched to costs, so variance is largely offset.
Court report	113	18	-83.8%	
Total	15,838	15,818		

4.1.2 Total contracted income for the year is in line with budget. Part of the budgeted income for the year is dependent on meeting our CQUIN<sup>†</sup> targets agreed with commissioners and achievement is reviewed on a quarterly basis.

4.1.3 Cost and volume elements have mainly over-performed, with GID at £298k.

4.1.4 Income for named patient agreements (NPAs) was £27k below budget.

4.1.5 Court report income (which is budgeted at £113k for the year, of which £50k is for the Portman) has delivered just £18k for the year. The fall in demand is unlikely to recover and as a result the target and associated expenditure budget for 2014/15 has been greatly reduced or removed altogether.

4.1.6 Day Unit was £255k below target after month 12. They are currently down to 7 pupils and the budget was set at 11. The service has been reviewed and a revised business model will operate in 2014/15 which was discussed at the February 2014 Board.

4.1.7 Project income was £68k below budget for the year. When activity and costs

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



are slightly delayed, we defer the release of the income correspondingly.

## 5. **Family Nurse Partnership**

- 5.1 This was the first year in which the FNP national unit has been managed by the partnership of the Trust with SRU and Impetus-PEF, following its transfer from DH.
- 5.2 Continued growth of the service nationally is a key objective of the contract. At 31 March 2014, there are 13,150 places available in FNP services nationally, which is ahead of the required trajectory. The Government's revised target is 16,000 places by April 2015, and the FNP national team is in line to achieve the target, though there some risks to this. Funding from the Big Lottery will help set up some of the new services.
- 5.3 The Service Review is due to be completed at the end of July. Recommendations in some areas are already being tested and implemented.
- 5.4 Impetus-PEF have offered significant funding for posts in business development, finance and performance management and communications over the next two years. These posts are due to be finalised and recruited to shortly.

## 6. **Consultancy**

- 6.1 TC income was £66k in March and is £721k cumulatively, significantly down compared to last year's £877k at this stage, and £321k below budget. However, the expenditure budget is currently £94k under spent, reflecting the staffing model. TC have also earned some of the CPPD income included in Education and Training which is £52k below target.
- 6.2 Departmental consultancy is £56k above budget after twelve months. The majority of the favourable variance is within SAMHS which is £74k above plan due to the BUPA Project. There has been a related increase in Complex Needs expenditure.

Carl Doherty  
Deputy Director of Finance  
22 April 2014

[illegible]

THE TAVISTOCK AND PORTMAN NHS TRUST					APPENDIX B				
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2013-14									
All figures £000			Mar-14		CUMULATIVE			FULL YEAR 2013-14	
		BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	OPENING BUDGET	REVISED BUDGET
	INCOME								
1	CENTRAL CLINICAL INCOME	610	700	90	7,131	7,315	184	6,247	7,131
2	CAMHS CLINICAL INCOME	347	321	(27)	4,121	3,643	(478)	4,033	4,121
3	SAAMHS CLINICAL INCOME	379	479	100	4,586	4,861	274	4,358	4,586
4	NHS LONDON TRAINING CONTRACT	605	657	52	7,254	7,307	52	7,254	7,254
5	CHILD PSYCHOTHERAPY TRAINEES	179	287	108	2,148	2,149	0	2,188	2,148
6	JUNIOR MEDICAL STAFF	94	84	(10)	1,126	1,101	(25)	1,130	1,126
7	POSTGRADUATE MED & DENT'L EDUC	7	11	4	84	111	27	76	84
8	DET TRAINING FEES & ACADEMIC INCOME	54	326	272	2,201	2,535	334	1,324	2,201
9	CAMHS TRAINING FEES & ACADEMIC INCOME	541	647	106	6,506	6,895	389	7,541	6,506
10	SAAMHS TRAINING FEES & ACADEMIC INCOME	138	125	(13)	1,584	1,390	(195)	1,426	1,584
11	TC TRAINING FEES & ACADEMIC INCOME	21	18	(3)	293	241	(52)	293	293
12	TC INCOME	87	66	(21)	1,042	721	(321)	1,004	1,042
13	CONSULTANCY INCOME CAMHS	7	(5)	(12)	107	89	(18)	107	107
14	CONSULTANCY INCOME SAAMHS	28	47	19	416	490	74	337	416
15	R&D	67	35	(31)	211	261	50	128	211
16	OTHER INCOME	197	152	(45)	1,197	1,259	63	964	1,197
	TOTAL INCOME	3,360	3,950	590	40,007	40,366	359	38,411	40,007
	EXPENDITURE								
17	COMPLEX NEEDS	280	492	(212)	3,513	3,661	(148)	3,432	3,513
18	PORTMAN CLINIC	127	171	(44)	1,527	1,260	268	1,527	1,527
19	GENDER IDENTITY	96	181	(85)	1,151	1,153	(3)	1,115	1,151
20	BIG WHITE WALL & DEV PSYCHOTHERAPY UNIT	18	9	9	221	215	6	247	221
21	NON CAMDEN CAMHS	352	347	6	4,147	3,986	161	4,023	4,147
22	CAMDEN CAMHS	400	403	(3)	4,600	4,324	276	3,684	4,600
23	CHILD & FAMILY GENERAL	43	119	(76)	449	470	(21)	449	449
24	FAMILY NURSE PARTNERSHIP	287	403	(115)	3,446	3,122	324	0	3,446
25	JUNIOR MEDICAL STAFF	84	80	4	1,006	936	71	1,052	1,006
26	NHS LONDON FUNDED CP TRAINEES	179	173	6	2,148	2,062	86	2,189	2,148
27	TAVISTOCK SESSIONAL CP TRAINEES	3	3	0	34	30	4	34	34
28	FLEXIBLE TRAINEE DOCTORS & PGMDE	33	31	1	389	360	29	388	389
29	EDUCATION & TRAINING	189	405	(216)	3,779	3,899	(120)	4,042	3,779
30	VISITING LECTURER FEES	135	109	26	1,369	1,307	62	1,179	1,369
31	CAMHS EDUCATION & TRAINING	122	145	(23)	1,467	1,508	(41)	4,868	1,467
32	SAAMHS EDUCATION & TRAINING	78	97	(19)	933	949	(16)	843	933
33	TC EDUCATION & TRAINING	0	(4)	4	0	(2)	2	0	0
34	TC	78	91	(14)	931	836	94	893	931
35	R&D	15	38	(23)	169	173	(4)	183	169
36	ESTATES DEPT	174	330	(156)	2,171	2,431	(260)	2,053	2,171
37	FINANCE, ICT & INFOMATICS	305	338	(33)	2,484	2,474	10	1,944	2,484
38	TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	84	100	(16)	989	938	51	977	989
39	COMMERCIAL DIRECTORATE	68	71	(3)	772	717	55	646	772
40	HUMAN RESOURCES	52	65	(13)	670	666	5	622	670
41	CLINICAL GOVERNANCE	41	61	(20)	490	532	(41)	451	490
42	PROJECTS CONTRIBUTION	(6)	(6)	(0)	(69)	(61)	(8)	(69)	(69)
43	DEPRECIATION & AMORTISATION	46	282	(236)	550	815	(265)	550	550
44	IFRS HOLIDAY PAY PROV ADJ	0	33	(33)	0	33	(33)	0	0
45	PRODUCTIVITY SAVINGS	0	0	0	0	0	0	0	0
46	INVESTMENT RESERVE	141	0	141	73	0	73	170	73
47	CENTRAL RESERVES	3	0	3	31	0	31	350	31
	TOTAL EXPENDITURE	3,427	4,568	(1,141)	39,441	38,792	649	37,845	39,441
	OPERATING SURPLUS/(DEFICIT)	(67)	(618)	(552)	566	1,574	1,008	566	566
48	INTEREST RECEIVABLE	0	1	1	5	11	6	5	5
49	DIVIDEND ON PDC	(35)	45	80	(421)	(341)	80	(421)	(421)
	SURPLUS/(DEFICIT)	(101)	(572)	(471)	150	1,244	1,094	150	150
50	RESTRUCTURING COSTS	0	109	(109)	0	139	(139)	0	0
	SURPLUS/(DEFICIT) AFTER RESTRUCTURING	(101)	(681)	(580)	150	1,105	955	150	150

SLR Report M12 2013-14			Trust Total Budget M12 2013-14 £000	Actuals M12 2013-14 £000	SAMHS Budget M12 2013-14 £000	Actuals M12 2013-14 £000	CAMHS Budget M12 2013-14 £000	Actuals M12 2013-14 £000	Appendix C
Clinical Income			16,125	16,239	6,407	7,012	9,718	9,227	
Training course fees and other acad income			12,118	12,204	2,924	2,668	9,194	9,536	
National Training Contract			7,254	7,254	2,740	2,740	4,514	4,514	
Total Training Income			19,373	19,458	5,664	5,408	13,708	14,050	
Consultancy Income			1,357	905	1,337	894	20	11	
Research and Other Income (incl Interest)			214	316	83	119	131	197	
Total Income			<b>37,069</b>	<b>36,918</b>	<b>13,492</b>	<b>13,433</b>	<b>23,578</b>	<b>23,485</b>	
Clinical Directorates and Consultancy			22,212	21,248	8,136	7,888	14,076	13,361	
Other Training Costs (in DET budget)			4,906	4,665	1,415	1,262	3,491	3,403	
Research Costs			299	378	106	135	192	244	
Accommodation			2,598	3,020	1,238	1,439	1,360	1,581	
Total Direct Costs			<b>30,014</b>	<b>29,311</b>	<b>10,895</b>	<b>10,723</b>	<b>19,120</b>	<b>18,588</b>	
Contribution			7,055	7,607	2,597	2,710	4,458	4,897	
Central Overheads (excl Buildings)			9,783	9,883	3,531	3,557	6,252	6,326	
Central Income			2,878	3,520	980	1,202	1,898	2,318	
Surplus (deficit)			<b>150</b>	<b>1,244</b>	<b>46</b>	<b>355</b>	<b>104</b>	<b>890</b>	
SURPLUS as % of income			0.4%	3.4%	0.3%	2.6%	0.4%	3.8%	
CONTRIBUTION as % of income			19.0%	20.6%	19.2%	20.2%	18.9%	20.9%	

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	Total £000
Operating cash balance	3,176	3,901	3,061	1,627	2,940	1,844	1,585	3,408	2,134	1,133	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	15,397
General debtors (incl LAs)	1,073	403	556	562	459	1,618	571	483	480	829	8,081
SHA for Training	2,567	142	79	2,567	143	79	2,567	142	79	2,567	11,156
Students and sponsors	325	150	150	100	0	200	800	250	100	750	3,025
Other	18	18	18	18	18	18	18	18	18	18	216
Operational expenditure payments	4,298	2,655	2,183	4,668	1,934	3,198	5,229	2,208	1,960	5,438	37,875
Salaries (net)	(1,427)	(1,527)	(1,453)	(1,427)	(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)	(11,722)
Suppliers	(847)	(988)	(1,074)	(874)	(723)	(799)	(1,099)	(1,174)	(724)	(723)	(10,473)
Capital Expenditure	(3,206)	(3,496)	(3,508)	(3,282)	(3,031)	(3,107)	(3,406)	(3,482)	(3,032)	(3,031)	(38,645)
Loan	0	0	(100)	(72)	0	(340)	0	0	(530)	0	(2,317)
Interest Income	0	1	0	1	0	1	0	0	1	0	5
Payments from provisions	0	0	(9)	(2)	0	0	0	0	0	0	(11)
PDC Dividend Payments	(367)	0	0	0	0	(211)	0	0	0	0	(788)
Closing cash balance	3,901	3,061	1,627	2,940	1,844	1,585	3,408	2,134	1,133	3,540	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	Total £000
Operating cash balance	3,176	3,786	2,141	1,291	3,871	4,707	3,357	6,906	4,789	2,814	3,176
Operational income received											
NHS (excl SHA)	572	1,065	1,296	2,227	2,639	965	1,289	939	865	2,060	15,551
General debtors (incl LAs)	861	433	274	393	741	293	1,768	357	217	616	7,357
SHA for Training	2,465	17	199	2,669	154	105	3,588	72	16	2,680	12,822
Students and sponsors	291	108	86	134	90	344	304	57	122	333	2,175
Other	39	30	54	50	65	77	37	51	76	68	637
Operational expenditure payments	4,228	1,653	1,909	5,473	3,689	1,784	6,986	1,476	1,296	5,757	38,542
Salaries (net)	(1,329)	(1,308)	(1,274)	(1,296)	(1,218)	(1,212)	(1,295)	(1,299)	(1,275)	(1,306)	(15,475)
Tax, NI and Pension	(932)	(998)	(981)	(953)	(976)	(931)	(940)	(995)	(989)	(997)	(11,690)
Suppliers	(968)	(962)	(463)	(570)	(618)	(678)	(1,131)	(1,181)	(996)	(869)	(10,320)
Capital Expenditure	(3,229)	(3,268)	(2,718)	(2,819)	(2,812)	(2,821)	(3,366)	(3,475)	(3,260)	(3,172)	(37,485)
Loan	(24)	(31)	(42)	(74)	(42)	(109)	(71)	(119)	(12)	(65)	(741)
Interest Income	0	0	0	0	0	0	0	0	0	0	0
Payments from provisions	1	1	1	0	1	1	0	1	1	1	9
PDC Dividend Payments	(366)	0	0	0	0	(205)	0	0	0	0	(744)
Closing cash balance	3,786	2,141	1,291	3,871	4,707	3,357	6,906	4,789	2,814	5,335	2,757

Appendix E				
STATEMENT OF FINANCIAL POSITION	Plan	Actual	Variance	Actual
	31 March 2014	31 March 2014	31 March 2014	31 March 2013
	£000	£000	£000	£000
<b>Non-current assets</b>				
Intangible assets	97	101	4	97
Property, plant and equipment	15,833	13,980	(1,853)	14,066
<b>Total non-current assets</b>	<b>15,930</b>	<b>14,081</b>	<b>(1,849)</b>	<b>14,163</b>
<b>Current assets</b>				
Inventories				
Trade and other receivables	2,725	5,277	2,552	2,944
Cash and cash equivalents	995	2,756	1,761	3,176
<b>Total current assets</b>	<b>3,720</b>	<b>8,033</b>	<b>4,313</b>	<b>6,120</b>
<b>Current liabilities</b>				
Trade and other payables	(2,325)	(4,324)	(1,999)	(3,499)
Provisions	0	(6)	(6)	(11)
Tax payable	(598)	(619)	(21)	(589)
Other liabilities	(1,374)	(2,595)	(1,221)	(2,680)
<b>Total current liabilities</b>	<b>(4,297)</b>	<b>(7,544)</b>	<b>(3,247)</b>	<b>(6,779)</b>
<b>Total assets less current liabilities</b>	<b>15,353</b>	<b>14,570</b>	<b>(783)</b>	<b>13,504</b>
<b>Non-current liabilities</b>				
Loans	(1,700)	0	1,700	0
Provisions	(65)	(65)	0	(66)
<b>Total non-current liabilities</b>	<b>(1,765)</b>	<b>(65)</b>	<b>1,700</b>	<b>(66)</b>
<b>Total assets employed</b>	<b>13,588</b>	<b>14,505</b>	<b>917</b>	<b>13,438</b>
<b>Financed by (taxpayers' equity)</b>				
Public Dividend Capital	3,474	3,474	0	3,474
Revaluation reserve	8,979	8,849	(130)	8,979
Income and expenditure reserve	1,135	2,182	1,047	985
<b>Total taxpayers' equity</b>	<b>13,588</b>	<b>14,505</b>	<b>917</b>	<b>13,438</b>

## Board of Directors : April 2014

**Item :** 8

**Title :** Annual Complaints Report : Patient Services

**Purpose:**

The purpose of this report is to provide a summary of the formal complaints received by the Trust in 2013-14 and to identify any lessons learned from these complaints.

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, that complaints have been managed in line with NHS requirements.

This report has been reviewed by the following:

- Corporate Governance and Risk Workstream Committee
- Patient Safety Workstream Lead
- Management Committee

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

- Patient / User Experience

**For :** Noting

**From :** Chief Executive

## Annual Complaints Report

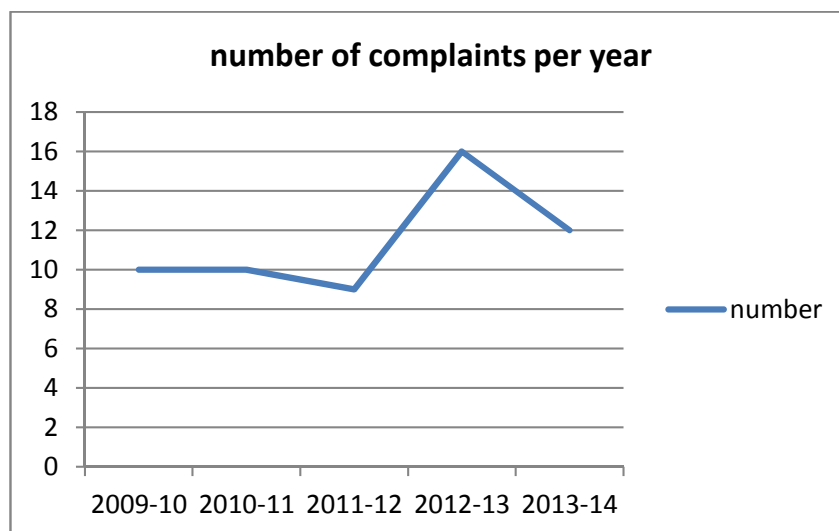
### 1. Introduction

The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. As in previous years the number of formal complaints received by the Trust in 2013-14 remains low at 12, this is a drop from 2012-16 when 16 formal complaints were received.

This short report summarises the complaints received in the year, and the lessons learned from this important form of patient feedback

### 2. Formal complaints received

Year	2009-10	2010-11	2011-12	2012-13	2013-14
No of formal complaints	10	10	9	16	12



During 2013-14 the Trust received 12 formal complaints. These were all investigated under the Trust's complaints procedure and a letter of response was sent by the Chief Executive to each complainant.

During 2013-14 patients referred a total of 0 complaints to HM Ombudsman compared to 7 in 2012-13 (see section 7 below).



### 3. Complaints by Directorate

Directorate	Number of complaints	
Year	2012-13	2013-14
CAMHS	7	3
SAMHS	9	9

### 4. Complaints Upheld

Upheld?	2012-13	2013-14
Upheld in full	0	0
Upheld in part	5	2
Not upheld	11	10
Under investigation at time of report	0	0
<b>Total complaints</b>	<b>16</b>	<b>12</b>

### 5. Topics of Complaints

See table for brief summary of topic of complaints, all related to clinical care. The Trust received no complaints about environment or facilities during 2013-14

Long wait for treatment.
Disagreed with diagnosis of child's condition
Difficulties with supervised contact arrangements between father and daughter at
Unhappy with contents of court report
Dissatisfied with lack of crisis provision in the Trust
'Prolonged' delays to treatment (GIDS)
Negative experience of group therapy (patient stopped attending after 6 months)
Negative experience of method of therapy
Complaint about missing report
Decision not to offer therapy
Patient challenging assessor's interpretation of his difficulties
Delay in starting medical therapy (GIDS)

## 6. Lessons learned

The elements of the complaints which were upheld are summarised in the table below together with actions taken/lessons learned if applicable.

Topic	What was upheld	Action/Lessons learned
Long wait for treatment. Lack of clarity about waiting list Failure in administrative procedures (delay in completion of paperwork)	Department accepted failure in administrative procedure. Apologised for the fact that that clinician was not fully familiar with procedures which resulted in mixed messages being given. However, no additional delay had occurred as a result of the error. Position about waiting list explained.	Clinician advised on correct procedures
Lack of response to referral from GP Complaint about missing report	NOT UPHELD Investigation found that GP had not made a referral to the Trust UPHELD Complaint about missing report upheld. Despite extensive search the report had not been located	Reminders to staff about the importance of filing reports when received

## 7. Parliamentary Health Service Ombudsman (PHSO) Investigations

At the start of 2013-14, 3 cases reported to PHSO in 2012-13 remained open.

During 2013-14, 2 of these two cases were closed with no further action required from the trust or being taken by PHSO.

One case (a complaint first presented in 2012-13) remained under investigation and the trust received a report from the PHSO which it disagreed. At March 2014 we were offered the opportunity to meet with the PHSO, which the Trust has accepted.

## 8. Next steps

At the end of 2012-13 the Management Committee asked the two Clinical Directors to see if any general lessons could be learned by in the increase in complaints to 16 and meetings to discuss complaints and their management took place in both CAMHS and SAAMHS

At the end of 2013-14 the complaints number has fallen to 12 (a drop of 25%) so no specific action has been identified at this time.

Report prepared by  
Jane Chapman  
Governance and Risk Adviser  
**April 2014**



## Board of Directors : April 2014

**Item : 9**

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

**Purpose:**

**Summary:**

This paper is written to provide the Board of Directors with assurance of achievements and progress towards meeting Directorate and Trust-wide objectives of the Camden CAMHS Service Line

This report has been reviewed by the following Committees:

- Management Committee, 17<sup>th</sup> April 2014

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

- 

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

- Quality
- Risk
- Finance

**For : Discussion**

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

## **Service Line Report – Camden CAMHS**

### Executive Summary

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

- 1.1 Completed the first year of the Children and Young People's IAPT (Improving Access to Psychological Treatments) Programme, and moving into the second (rollout) year.
- 1.2 Recruited to 15 new posts (8.3WTE, approx. 740K) across the Camden service as part of the new investment in complex needs, developmental concerns and parental mental health.
- 1.3 South Camden Team moved into a new community base in Amptill Medical Centre near Mornington Crescent NW1
- 1.4 An annual sum of 1 million pounds of new investment has been secured by the CCG commissioners for 5 years, to improve mental health services for 16 – 24 year olds. The commissioners were supported in their bid by the Tavistock and Portman FT, Camden and Islington Mental Health Trust the Brandon Centre and Anna Freud Centre. Most of the new services will go out to tender in the summer of 2014.

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

- 2.1 Roll out of outcome monitoring across the service needs to be actively managed to avoid low return rates.
- 2.2 Levels of clinical activity in the 2 generic CAMHS teams are increasing steadily year on year, and it is unclear how long this trend will continue or how activity levels can be managed effectively.
- 2.3 Admissions to specialist adolescent inpatient units have become very problematic since the change to national commissioning in April 2013. This is a national problem but affects us locally. Almost all units are full almost all of the time, and young people have to wait for up to 12 days on paediatric wards to get access to a bed, and when it is found it is usually a long way from home.

- 2.4 Completed suicide amongst adolescents may be on the increase due to an increase in lethal methods being adopted, but to date no national or local figures are available to corroborate this.

## **Main Report**

### **3. Overview of the Service**

- 3.1 A description of the Service was given in the report to the Board in November 2010, but this information has been updated repeated here, in Appendix 1.
- 3.2 **Update on issues raised in service line report from November 2011**
- 3.3 South Camden team moved into new premises in Amptill Square, off Eversholt Street in South Camden in the summer of 2013. There are now 6 clinical rooms rather than 3, and a larger open plan office area for staff to work.
- 3.4 **New staff recruited**
- 3.5 All the recruitment was completed by the spring of 2013 for the posts in the new investment which came on stream in the Autumn of 2012.
- 3.6 A small Complex Needs Outreach Team of 2.4 WTE CAMHS Staff + 0.5 Admin Staff has been established as an expert team to assist with the mental health aspects of cases that are of concern to the Camden Special Educational Needs (SEN) team, and to assist with the transition to Education Health and Care plans which replace Educational Statements in the Autumn of 2014. Some funding has been used to bring an educational psychologist into the team, seconded from SEN
- 3.7 The Young Parent Service was establishment, consisting of a small team of 1.5 WTE CAMHS Staff to offer specialist support for high need, vulnerable young parents. Unfortunately this service has gone out to tender with a 25% reduction in contact value. The Tavistock have put in a bid for the tender.

3.8 Additional CAMHS staff, alongside staff from many other agencies are now in post to support Special Emotional and Behavioural Needs Education Services (Robson House, and Camden Centre for Learning (CCfL) and the Moderate/Severe Learning Disability Educational Services (Swiss Cottage School). The aim was to create multiagency teams. This is proving to be a slow process due to the complexity of the different work cultures of the new staff, and lack of clarity about who they are accountable to.

3.9 Camden MALT have benefited from 2.4 WTE additional staff. An outreach CAMHS nurse has increased the offer for Looked After Children. 2 Adult Mental Health Staff have joined the team, which means that assessments for families can be more holistic.

#### **4. Developments**

4.1 A paper was presented to the board recently regarding progress with CYP IAPT. We are in a partnership with the Brandon Centre, MAC-UK and Camden Local Authority. Large strides have been made in the areas of service user participation, outcome measurement and evidence based treatments, which are detailed in that paper.

4.2 The roll out of outcome monitoring will not be without its challenges, as it requires culture change across the CAMHS service (not just in Camden CAMHS but across the directorate). An action plan has been developed which has a stepwise approach, bringing about culture change in a few teams before moving onto the others, and also, crucially, includes the development of staff to act as "outcome champions and supervisors", to disseminate practice within the teams.

#### **5. Clinical Quality and Outcome Monitoring**

5.1 Quarterly Reporting to CCG: This issue has been raised before, but it is important to remind the Board that the Camden Commissioners meet with each clinical team on a quarterly basis to review activity and outcomes and review the quality of the service. Reports of



compliance with targets in service specifications and of DBS checks, are also reported quarterly.

5.2 These conversations with commissioners, in transpires, are unusual in other CCG areas. The Camden Plan specifically requires commissioners and providers to cooperate in this way, but in other boroughs and counties, NHS Trusts specifically instruct their staff not to communicate with commissioners, but only to report on data that is requested. In Camden the delicate balance of cooperation and challenge is highly valued. This model is recognised as different, and London CYP IAPT Collaborative have invited the Associate Clinical Director (Andy Wiener) and the Camden CAMHS commissioner (Sarah Brown) to chair and contribute to a commissioning summit for CAMHS staff, commissioners and young people in May 2014.

5.3 The work in community settings continues to expand. About 30% of the work of North and South Camden Teams now takes place in primary or secondary schools or GP practice.

## **6. Pricing**

6.1 The commissioners are now explicit that they do not wish to have a cost and volume contract for Camden, but to continue with a block contract. However activity targets will remain in place, alongside targets for satisfaction and improvement on a range of outcome measures (to be baselined).

6.2 Prices are still needed however, for a range of purposes including working out the cost of services provided under EHC Plans. A price review is underway which will reduce the price of a first appointment to a more realistic level.

## **7. Financial Situation**

7.1 Below is a table showing the financial situation with the Camden Service Line.

Camden CAMHS Income and Expenditure				
	Budget 13/14	Actual 13/14	Budget 12/13	Actual 12/13
	£000	£000	£000	£000
Clinical Income	5,099	4,878	3,971	4,461
National Training Contract	627	627	408	408
Research and Other Income (incl Interest)	12	11	7	8
<b>Total Income</b>	<b>5,738</b>	<b>5,516</b>	<b>4,386</b>	<b>4,876</b>
Clinical Directorates and Consultancy	(4,840)	(4,529)	(3,863)	(3,810)
Accommodation	(524)	(609)	(289)	(280)
<b>Total Direct Costs</b>	<b>(5,364)</b>	<b>(5,138)</b>	<b>4,152</b>	<b>4,090</b>
<b>Contribution</b>	<b>374</b>	<b>379</b>	<b>234</b>	<b>786</b>
Central Overheads (excl Buildings)	(1,029)	(1,018)	(1,125)	(1,049)
Central Income	195	246	309	279
<b>Surplus/(deficit)</b>	<b>(460)</b>	<b>(393)</b>	<b>(581)</b>	<b>16</b>

### Clinical Activity

7.2 The statistics in the table below cover the last year 1<sup>st</sup> April 2013 to 31<sup>st</sup> August 2014 compared with 3 previous year-long samples.

7.3 The figure in **bold** is data for the period 1<sup>st</sup> April 13 – 31<sup>st</sup> March 14.

The three figures in brackets are data for the periods:

1<sup>st</sup> September 2011 to 31<sup>st</sup> August 2012 (top figure)

1<sup>st</sup> October 2010 to 30<sup>th</sup> September 2011 (middle),

1<sup>st</sup> January 2009 to 31<sup>st</sup> December 2009 (lowest figure).

	North Team	South Team	Other Trust Camden CAMHS	Total
	<b>340</b>	<b>265</b>	<b>42</b>	<b>647</b>
Initial Appointments	(280)	(241)	(99)	(620)
	(272)	(207)	(125)	(604)
	(231)	(189)	(97)	(517)

	<b>6872</b>	<b>3572</b>	<b>1200</b>	<b>11644</b>
Subsequent	(5486)	(2913)	(1659)	(10058)
Appointments	(4384)	(2909)	(2277)	(9570)
	(4288)	(2232)	(2564)	(9084)
	<b>463</b>	<b>412</b>	<b>85</b>	<b>960</b>
DNA	(728)	(518)	(240)	(1486)
As	(647)	(443)	(241)	(1331)
	(471)	(337)	(262)	(1070)
	<b>22</b>	<b>16</b>	<b>31</b>	
Ratio of 1 <sup>st</sup> Appts to	(20)	(12)	(16)	
follow-up (inc. DNA)	(18)	(16)	(20)	
	(21)	(15)	(30)	
	<b>6%</b>	<b>10%</b>	<b>6%</b>	
DNA rate	(11%)	(15%)	(12%)	
	(13%)	(9%)	(10%)	
	(9%)	(12%)	(9%)	

7.4 The clinical activity figures show that activity has continued to increased year on year.

7.5 Consultation and Resource Clinics (CaR Clinics) were brought in 18 months ago, to have a senior member of staff doing an initial assessment to ensure the correct treatment plan is in place. This practice is continuing but only for complex cases, and cases where there is a question about CAMHS being a suitable service.

7.6 Review systems are now developed to ensure that work on cases is always purposeful. The volume of cases that need to be reviewed is very high, so teams are having to put aside half days, every few months, to ensure all cases are discussed. The commissioners have asked that all cases open longer than 2 years, are explicitly reviewed, and that they are informed of the reasons for cases remaining open for longer than this period of time.

7.7 The overall DNA rate is falling as a result of better admin systems being in place.

7.8 "Appointment by clinician" reports keeps track of how busy clinicians are (aiming at an average of 2 clinical appointments per half day for clinic based work) and how much work is done by staff and how much by trainees. It is difficult to get an accurate picture of how busy staff are, as things such as travelling time are not included in the data. These systems need to be refined so that we can get warning before staff reach saturation point, as waiting lists could build up quickly if that happened. To date waiting times for a first appointment are between 2 – 4 weeks, and there is no waiting time between assessment and treatment.

8. **Complaints and Compliments** (Complaints are reported to the board every quarter. ) Please see table below

Date received	Location address	Dept	Core topics	Outcome/Lessons learned
26.04.13	NW1 7RT	CAMHS	<p>Diagnosis of child 'without backup'</p> <p>Unprofessional comments</p> <p>Over-involvement by therapist</p> <p>Breach of confidentiality</p> <p>Inappropriate use of mobile/phone/texts</p>	<p><b>NOT UPHELD</b></p> <p>Assessment found to be comprehensive with diagnostic tests well documented.</p> <p>Therapist's involvement appropriate in the light of the circumstances.</p> <p>Comments by therapist reflected events described by patient</p> <p>No evidence of breach of confidentiality</p> <p>No evidence of inappropriate use of mobile phone/texts although therapist had used personal mobile at a time when NHS mobiles were not issued by the Trust. Some evidence of inappropriate use of phone/texts by patient</p>

2013/14	Address not given, but Camden GP	C&F North Camden Team	Lack of response to referral from GP  Complaint about missing report	<p><b>PART UPHELD</b></p> <p><b>NOT UPHELD</b></p> <p>Investigation found that GP had not made a referral to the Trust</p> <p><b>UPHELD</b></p> <p>Complaint about missing report upheld. Despite extensive search the report had not been located</p>
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## **9. Patient Safety Incidents**

- 9.1 In 2013-14 there was one of the reported incident involved a Camden child , this was a no harm minor needle stick injury (with a sterile needle) during desensitisation therapy. As a result of this the CAMHS team are preparing guidelines for staff delivering desensitisation therapy, which state that therapy involving sharps etc should take place in a suitable place with safe disposal e.g. a doctors surgery.
- 9.2 Regarding the SUI in 2012-13, the death of a 15 year old girl who jumped under a train, the update is that the inquest into her death concluded in January 2014, and found that she intended to kill herself (she jumped in front of a train). The board have been informed about the outcome of the Tavistock internal investigation and the Coroner's Inquest. There was significant media coverage of the case. A Child Death Overview Panel met regularly throughout this period of time. Neither the clinical care provided nor the Trust risk assessment processes were criticised. The main lesson learned was that clinical staff need to develop expertise in how to talk to young people about their "digital lives", and two training days have now taken place on this subject. The girl involved used social networking sites extensively, and tended to promote herself on these sites as someone with "mental health issues", but rarely referred to this aspect of her life in her clinical sessions.

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

- 10.1 As stated in the last report use of the CHI Experience of Service Questionnaire is now routine. The number of ESQs gathered in this year was 444 (approximately 50% of open cases) compared to 150 during the year proceeding the last report. The table below related to the period 01/04/13 – 31/03/14.

Responses for Camden CAMHS	Certainly True	Partly True	Not True	Do not Know	Missing	% Certainly/Partly True
Listened to	406	33	2	1	2	99%
Easy to talk	354	79	7	2	2	98%
Treated well	416	20	1	3	4	98%
Views and worries	394	34	7	4	5	96%
Know how to help	329	95	6	12	2	95%
Given enough explanation	221	74	19	105	25	66%
Working together	353	49	3	32	7	91%
Comfortable facilities	322	92	7	13	10	93%
Convenient appointments	302	100	31	5	6	91%
Convenient location	371	53	10	4	6	95%
Recommend to friend	359	52	9	20	4	93%
Good help	390	34	6	4	10	95%

10.2 Although they have not been benchmarked, anecdotally our satisfaction scores are much better than other services, and we routinely exceed the target of 70% satisfaction. There are some areas to focus attention on (eg “given enough explanation” has been highlighted as a CIQIN to reach a target of 75%).

Andy Wiener  
Associate Clinical Director  
17<sup>th</sup> April 2014

## Appendix I

### Description of Camden CAMHS

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

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

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

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



Beyond this there is a Disability CAMHS Team called MOSAIC CAMHS which is managed by the Local Authority and PCT, but where the Trust employ the staff, and a small Complex Needs Outreach Team that provides expert assessment and advice to the Special Educational Needs Department.

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

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

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

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



## Board of Directors : April 2014

**Item :** 10

**Title :** Time to Change Initiative

### **Purpose:**

- To provide an Action Plan for Time to Change by building on the Trust's commitment to supporting staff with a declared disability
- To raise staff awareness of supporting colleagues about mental health
- To have a Section on the Trusts' website re: support of the Time to Change campaign
- To ensure that Time to Change is incorporated in the Trusts' equalities agenda and regularly discussed at the Trust's Equalities Committee.
- To re-launch the trusts Staff Advice and Consultation Service, ensuring all staff who offer this service are aware of Time to Change and can promote the positive message of inclusiveness.
- To host a Time to Talk event for Trust staff.

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

- Staff support
- Raising awareness
- Providing a positive message on mental health

**For :** Discussion

**From :** Susan Thomas, HR Director



# The Time to Change Organisational Pledge . . . the next steps

It's great you would like to sign the Time to Change Pledge and we can't wait for you to join the movement to bring about social change.

## About the Time to Change Pledge

To drive long term change, we are working with organisations to deliver campaign activity to their networks and communities. We are inviting organisations to take the Time to Change Pledge to begin this journey. By pledging, you will be aligning your organisation with a major national movement for change. As an organisation, pledging to support Time to Change is a display of your drive to be active in tackling mental health stigma and discrimination in your workplace. Importantly, it shows that this commitment has support from the top - helping to inspire the culture of your organisation.

**In order to begin processing your Pledge request please complete this document and return to us.  
If your action plan is still draft at this stage it's not a problem. You can add to and develop your plan at any stage.**

**Stage 1:** Is this right for you?

**Stage 2:** Get senior support

**Stage 3:** Complete your Pledge action plan (this document) and website summary about what the Pledge means to your organisation

**Stage 4:** Tell us about the Pledge signing event (this document)

**Stage 5:** Send the document to us with your **high res jpeg logo** and we will confirm receipt

**Stage 6:** After your Pledge - put your action plan in motion!



# Your Pledge action plan

The Pledge you are taking is not a measure of attainment or success; the Pledge is purely an aspiration. It is a statement of your organisation's intent to work towards improvement and therefore we want to know what you are aiming to do to, to support these aspirations. Completing a Pledge action plan will also help you transform your aspirations into tangible activity, helping to make them a reality.

And don't worry – we aren't asking for loads of action; obviously the more you do the better but we appreciate that sometimes these things start small and build momentum. So whether you're planning an internal campaign or rolling out a few staff awareness events using Time to Change materials then that is fine; all we want to see is that the Pledge is alive and meaningful within your organisation.

## Why do we want an action plan?

While neither a quality mark nor endorsement, for a Pledge to have real value, it should lead to some practical action. Your action plan document will not be shared with anyone outside of Time to Change but we need to see that you are serious about being active in the campaign to ensure the Time to Change Organisational Pledge maintains its value.

## Ideas for your action plan

To develop your commitment to the campaign you could consider activity such as the following:

- Run an internal campaign using your communications platforms and Time to Change artwork and other collateral
- Run a Time to Change healthcheck on your organisation <http://time-to-change.org.uk/healthcheck>
- Run Time to Change roadshow event with our event pack to raise awareness with staff
- Create a support network for staff with lived experience of mental health problems
- Create a line manager mentoring scheme to ensure managers feel confident to offer support and profile examples of good practice
- Provide Mental health awareness or Mental Health First Aid training for all staff
- Sign the Mindful Employer charter [www.mindfulemployer.net](http://www.mindfulemployer.net)





Project sponsor / lead staff member:  
 Susan Thomas  
 Tel: 0207 435 7111  
 Email: [susan.thomas@tavi-port.nhs.uk](mailto:susan.thomas@tavi-port.nhs.uk)  
 Organisation website: [tavi-port.org](http://tavi-port.org)

## Pledge action plan template

Activity description	Internal lead (include contact details)	Timescale	Time to change resources	Performance indicator (optional)
Include a positive statement about valuing the lived experience of Mental health difficulties in all adverts and job descriptions	Susan Thomas HR Director 0208 938 2380	From 1 <sup>st</sup> June 2014	None needed	Statement on all JDs
Include a section on the benefits of employing people with a lived experience of mental health difficulties in the Trust's staff training programme and documentation	Namdi Ngoka Deputy HR Director 0208 938 2510	From May 2014	Admin assistance	Clear record in training materials
To raise staff awareness of supporting colleagues and PPI reps with mental health issues	Sally Hodges Associate Clinical Director 0207 435 7111	Next Inset day 20 <sup>th</sup> May 2014	None needed	OHP's from the day to include points on this topic



## APPENDIX 1

Section on the trusts website re support of the time to change campaign	Emma Heath Communications and Stakeholder Engagement Manager 0208 938 2228	From website launch	None needed	Link on the website (already in place)
To ensure that time to change is incorporated in the trusts equalities agenda and regularly discussed at the trust's equalities committee.	Shilpi Sahai HR Manager 0208 938 2490  Louise Lyon Trust Director 0208 938 2394	From May 2014	Admin support	Equalities committee minutes
To engage with Staff Side colleagues at the JSCC on the Time to Change initiative	Susan Thomas HR Director 0208 938 2380	Achieved in March 2014	Admin support	JSCC minutes
To re-launch the trusts Staff Advice and Consultation Service, ensuring all staff who offer this service are aware of time to change and can promote the positive message of inclusiveness.  To update the literature about this service to include the time to change logo and positive messages	Susan Thomas HR Director 0208 938 2380  Shilpi Sahai HR Manager 0208 938 2490	From May 2014	Clinical Support And financial support for the leaflet revision	Leaflets and monitor of up take.

## APPENDIX 1

To host a Time to Talk event for Trust staff.	<p>Susan Thomas HR Director 0208 938 2380</p> <p>Sally Hodges Associate Clinical Director and PPI Lead 0207 435 7111</p> <p>Louise Lyon Trust Director and Chair of Equalities Committee 0208 938 2394</p>	Autumn 2014	Support from Senior Clinical colleagues catering.	Increases awareness and openness
To build on the Trust's commitment to supporting staff with a declared disability by developing a specific policy.	<p>Susan Thomas HR Director 0208 938 2380</p> <p>Shilpi Sahai HR Manager 0208 938 2490</p>	January 2015	Engagement from JSCC and Equalities Committee	A structure to support and develop staff with Mental Health and other disability within the Trust.



## APPENDIX 1

<p>Actions already undertaken</p> <p>The trust staff joined the local time to change road show in Islington with a stall re the work of the trust.</p> <p>We commit to be involved in any future roadshows in our area</p>	<p>Susan Thomas HR Director 0208 938 2380</p>	<p>July 2012</p>	<p>None needed</p>	<p>Presence at Islington roadshow and all future road shows in the area.</p>
<p>The Trust is committed to involving people with a lived experience of mental health difficulties in its recruitment process, We have the protocol in place for this and in 2013 7 interviews involved users on the panels (including the CEO recruitment process)</p>	<p>Susan Thomas HR Director 0208 938 2380</p>	<p>Already achieved</p>	<p>None needed</p>	<p>Users on panels</p>

## Pledge event planning form

**Please note:** in order to create a tailored pledge board for you in good time we require receipt of all information required, including your organisations logo, a minimum of **2 weeks in advance of your desired Pledge date**.

What is the event/occasion when the Pledge will be signed? (Please include event or meeting title)	Trust Board April 2014
Name and job title of person to sign the Pledge (as you would like it to appear on your Pledge board)	Angela Greatley, Trust Chair
Date of the Pledge signing	29 <sup>th</sup> April 2014
Event start and finish time	4.45-5 pm
Number of attendees at event and composition (e.g. all staff, line managers only, service commissioners, student, external communities)	15 Executive and Non-Executive directors PPI lead, governors, comms lead
Pledge Board to be sent FAO (name and dept.)	Susan Thomas, HR Director
Address for Pledge board to be sent	120 Belsize Lane, London, NW3 5BA



<p><b>Time to Change (TTC) representation</b></p> <p>Would you like us to see whether a TTC representative might be available to attend your event, deliver a brief presentation about the campaign and co-sign your Pledge?</p> <p><b>Please note: due to capacity it will not always be possible to supply a speaker for your pledge event. Minimum notice required for this request: 6 weeks.</b></p>	Not required
<p>If a TTC representative is available to attend your event would you be able to cover their travel costs?</p>	n/a
<p>Do you have plans to engage the media?</p> <p>If yes, please provide more details and email <a href="mailto:communications@time-to-change.org.uk">communications@time-to-change.org.uk</a> to request key campaign descriptors and a template press release. <b>Please note: if you are communicating externally, it's really important that we see the copy before it goes out.</b></p>	We will send a local press release
<p><b>Please include the contact details of your media/communications officer.</b></p>	<p>Emma Heath Communications and Stakeholder Engagement Manager 0208 938 2228</p>
<p>Any other details you wish to tell us?</p>	

# Tell the world! Your Pledge communications

## Website summary

Once you have signed the Pledge we will add your logo to our online [pledge wall](#) within **5 working days** of your event. Please supply us with a **200 character** summary of your commitment to accompany your logo. **Please note:** we may edit the text before it is published on the website.

We are proud to support the Time to Change campaign and we promise to continue to nurture an inclusive, anti-discriminatory, supportive culture for our patients and our staff putting them at the centre of all we do.

**Optional** - depending upon capacity we will endeavour to promote what you are doing via our TTC Communications channels. If you would like us to do this please provide us with a short (50-75 words) **summary** of your anti-stigma activity.  
**Please note:** we may edit the text before it is published on the website.

**If you are communicating externally, it's really important that we see the copy before it goes out. We can also provide key descriptions of the campaign and details of other organisations who have pledged.** Please email [communications@time-to-change.org.uk](mailto:communications@time-to-change.org.uk)

We hope you will be proud of your Pledge and tell your staff and networks about it!



Please send this completed form to:

[ttcPledge@time-to-change.org.uk](mailto:ttcPledge@time-to-change.org.uk)

**Checklist:**

- ✓ You have completed the action plan
- ✓ Written a website summary of your activity
- ✓ Attached a high resolution logo
- ✓ Completed the Pledge planning form





## Board of Directors : April 2014

**Item :** 11

**Title :** Annual Review of External Networks

### **Purpose:**

The Board of Directors is responsible for ensuring that the Trust co-operates with other NHS bodies, Local Authorities and other relevant organisations with an interest in the local health economy. Monitor requires that the Board ensure effective mechanisms are in place, and review the effectiveness of these annually<sup>1</sup>.

This schedule is below. Management has reviewed this schedule, its relationship with each of the listed parties, and highlighted the main contact for each party. The Trust has reviewed the mechanisms that are in place to cooperate with relevant third party bodies, and has ensured that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority.

This report has been reviewed by the following Committees:

- Management Committee, 3<sup>rd</sup> April 2014

The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance that the Trust is appropriately prepared to co-operate with external parties.

**For :** Approval

**From :** Gervase Campbell, Trust Secretary

<sup>1</sup> Monitor, *The NHS Foundation Trust Code of Governance*, Jan 2014, E.2

## Annual Review of External Trust Links

Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
Monitor	<p>Monitor is the independent regulator of NHS foundation trusts.</p> <p>Monitor's role as a regulator is to ensure that FTs are well led, that their leaders are focused on the quality of care patients get, and that they are financially strong</p> <p>Monitor look at whether FTs are meeting the required quality standards, as judged by the CQC, and at the Trust's financial strength</p> <p>Monitor regulates FTs to ensure they comply with the Terms of Monitor's licence.  <a href="http://www.monitor-nhsft.gov.uk/">http://www.monitor-nhsft.gov.uk/</a></p>	<p>The Trust must submit an Annual Plan and regular reports to the Trust. The frequency of reports is related to the Trust's risk ratings.</p> <p>Where Monitor feels the Trust is failing in an area, it requires the Trust to develop an action plan and monitors progress against that plan.</p> <p>The Trust must submit Annual Reports and Annual Accounts to Monitor (and Parliament) each year</p>	<p>The Trust has an annual planning process, which is led by the Chief Executive and the Director of Finance. The development of the Plan involves senior Trust staff, Non-Executive Directors, and the Board of Governors</p> <p>The Trust submits regular declarations on finance, governance, &amp; quality. These submissions inform Monitor's risk ratings</p> <p>The Directorate of Finance is responsible for the production of the Annual Accounts. The Trust Secretary's office is responsible for the production of the Annual Report, in consultation with senior Trust staff.</p>	<p><b><u>Paul Jenkins, Chief Executive</u></b></p> <p>Angela Greatley, Trust Chair</p> <p>Simon Young, Director of Finance</p> <p>Gervase Campbell, Trust Secretary</p>

<sup>2</sup> This list is partially informed by Appendix A to Monitor's Compliance Framework 2013/14 (published March 2011)

\* Lead contact appears in bold and underlined



Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
Care Quality Commission	<p>The CQC is the independent regulator of healthcare and adult social care in England.</p> <p>It monitors providers' compliance with Essential Standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 on an on-going basis</p> <p>It has a range of enforcement powers available to it to address failure to maintain compliance with these requirements up to removing registration to practice</p> <p>In the case of an NHS Foundation Trust failing to meet these standards, the CQC will liaise with Monitor and, taking account of their respective powers, Monitor and the CQC will work together to ensure these requirements are met</p> <p><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></p>	<p>All care providers in England must be registered with the CQC. In order to be registered, each provider must show they meet essential standards of quality and safety in all of their regulated services</p> <p>The CEO must ensure that the Board of Directors is informed of any declaration of compliance with Essential Standards</p> <p>The Trust must cooperate with any request for information and/or spot check visit that the CQC may choose to conduct</p> <p>The Trust must inform the CQC of any significant changes to practice and through relevant agencies (e.g. NPSA) of any significant adverse events</p>	<p>The Trust has fully completed registration processes and is currently fully registered</p> <p>The Trust has a nominated CQC Inspector who will approach the Trust directly with any concerns and/or requests for information</p> <p>The Trust will contact the Inspector directly in the event of changes or other information that it is required to inform the CQC of.</p>	<p><u>Pat Key, Director of Corporate Governance &amp; Facilities</u> (Nominated Manager registered with CQC)</p> <p>Paul Jenkins, Chief Executive Officer</p> <p>Jane Chapman Governance and Risk Adviser (co-ordinated CQC liaison)</p>
Regulators of	Currently there are nine regulators of individual health professionals, covering a range of professions. Each has the power to			

Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
individual health professionals	demand the release of information where it relates to a hearing about the fitness to practice of a health professional. Some regulators also have powers in relation to the accreditation of courses, education, or training for health professionals wishing to register			
<ul style="list-style-type: none"> <li>General Medical Council</li> </ul>	<p>The GMC registers doctors to practise medicine in the UK. Their purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine</p> <p><a href="http://www.gmc-uk.org/">http://www.gmc-uk.org/</a></p>	<p>All doctors must be registered with the GMC to practice medicine in the UK</p> <p>Doctors are required to maintain their registration and licence to practice through payment of an annual fee</p> <p>The Trust is required to respond to any requests for information made by the GMC under their investigation of complaints and/or disciplinary procedures</p> <p>The Trust is required to be in a state of readiness for new procedure for re-validation process</p>	<p>HR maintains a system of checking registrations at employment and annually thereafter</p> <p>Re-validation Lead nominated and preliminary work underway</p>	<p><b><u>Rob Senior, Medical Director</u></b></p> <p>Dr Jessica Yakeley , Associate Medical Director (Lead on Revalidation Process)</p>
<ul style="list-style-type: none"> <li>Health Professions Council</li> </ul>	<p>The HPC currently regulates 15 health professions, including practitioner psychologists, which covers educational psychologist, counselling psychologists and clinical psychologists.</p>	<p>All professionals covered by the HPC must be registered with the HPC to practice in the UK</p>	<p>Annual check is made by the HPC through Human Resources</p>	<p><b><u>Bernadette Wren, Trust-wide Head of Psychology Discipline</u></b></p>

Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
	The HPC registers the above health professions. It is a criminal offence for anyone to use a professional title if they are not registered with the HPC <a href="http://www.hpc-uk.org/">http://www.hpc-uk.org/</a>			
<ul style="list-style-type: none"> <li>Nursing and Midwifery Council</li> </ul>	The NMC registers all nurses and midwives and ensure that they are properly qualified and competent to work in the UK, and sets the standards of education, training, and conduct for nurses and midwives <a href="http://www.nmc-uk.org/">http://www.nmc-uk.org/</a>	<p>All nurses must be registered with the NMC to practice as nurses in the UK</p> <p>Nurses are required to maintain their registration through payment of fees set by the NMC, and by self-declaration of having completed required CPD</p> <p>The Trust is required to respond to any requests for information made by the NMC under their investigation of complaints and/or disciplinary procedures</p>	HR maintains a system of checking registrations at employment and annually thereafter	<b><u>Lis Jones, Nurse Director and Head of Nursing.</u></b>
General Social Care Council	The GSCC is the regulator of the social work profession and education in England The GSCC protects the public by	All staff using the title <i>Social Worker</i> register with the GSCC. It is illegal to use the title without registration	HR maintains a system of checking registrations at employment and annually thereafter	<b>Gill Rusbridger, Trust-wide Head of Social Work Discipline</b>

Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
	<p>requiring high standards of education, conduct, and practice of social workers by ensuring that only those who are properly trained and committed to high standards practise social work.</p> <p>The GSCC is the body that registers Social Workers</p> <p>The GSCC also accredits practice placements</p> <p><a href="http://www.gsc.org.uk/">http://www.gsc.org.uk/</a></p>	<p>Social Workers are required to maintain their registration through payment of fees set by the GSCC</p> <p>The Trust is required to respond to any requests for information made by the GSCC under their investigation of complaints and/or disciplinary procedures</p>		
Charities Commission	<p>The Charities Commission is a statutory regulator and registrar for charities in England and Wales</p> <p><a href="http://www.charity-commission.gov.uk/">http://www.charity-commission.gov.uk/</a></p>	<p>Submission of annual returns, Annual report and Accounts</p> <p>Response to any other enquiries</p>		<u>Simon Young, Director of Finance</u>
Equality and Human Rights Commission	<p>The Equalities and Human Rights Commission is an independent statutory body established to promote and monitor human rights, and to protect, enforce and promote equality across the nine "protected" grounds – age;</p>	<p>The Trust has no formal link with the Equality and Human Rights Commission and is not required to do so</p>	<p>The Website and Helpline are used on an ad hoc basis for information and/or advice</p>	<u>Julia Smith, Director of Service Development &amp; Strategy</u>

Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
	disability; gender; race; religion and belief; pregnancy and maternity; marriage and civil partnership; sexual orientation, and gender reassignment <a href="http://www.equalityhumanrights.com/">http://www.equalityhumanrights.com/</a>			
Environment Agency	The Environment Agency is the leading public body for protecting and improving the environment in England and Wales. It grants licences for waste management services, including clinical waste <a href="http://www.environment-agency.gov.uk/">http://www.environment-agency.gov.uk/</a>	The Trust must ensure that any waste it produces is handled safely and in accordance with the law according to the Duty of Care legislation	The Trust receives certification to verify safe and legal disposal of all electrical and electronic equipment under WEEE regulations	<u>Pat Key, Director of Corporate Governance &amp; Facilities</u>
Health Protection Agency	The Health Protection Agency is a statutory body set up to: identify and respond to hazards and emergencies; anticipate and prepare for emerging and future threats; alert and advise the public and Government on health protection; provide specialist health protection services; and support others in	A nominated member of staff and a Director must be available for alerts. Up to date contact details must be kept with the HPA  Security alerts and other reports must share information with staff	Nominated staff to react and cascade alerts  Health and Safety Manager and Director of Corporate Governance & Facilities receive security alerts and other reports (e.g. extreme weather)	<u>Pat Key, Director of Corporate Governance and Facilities</u>  Lisa Tucker, Health & Safety Manager

Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
	their health protection roles <a href="http://www.hpa.org.uk/">http://www.hpa.org.uk/</a>			
Fire Authorities	Fire Authorities are responsible for fire fighting and fire safety, and may require NHS Foundation Trusts to make changes to buildings or operations to prevent fires	Trust is required to ensure risk assessments are carried out regularly on all buildings  All staff must be appropriate trained on fire safety  The Trust must cooperate with any request for information and/or spot check visit that the Fire Authorities may choose to conduct	Risk Assessments for all buildings the Trust owns (updated if changes to fabric or usage of building)  Fire training; INSET; and local induction with Manager  Annual Fire warden training and evacuations	<b><u>Pat Key, Director of Corporate Governance &amp; Facilities</u></b>  Lisa Tucker, Health & Safety Manager  Dave King, Fire Safety Consultant
Health and Safety Executive	The Health and Safety Executive is responsible for the regulation of almost all the risks to health and safety arising from work activity  <a href="http://www.hse.gov.uk/">http://www.hse.gov.uk/</a>	Ensure Building Regulations and training for staff is delivered  Ensure Institute of Health & Safety qualified staff on site	Annual Estates Risk Assessments  Lone Worker Risk Assessments  Mandatory Health & Safety training for specific staff groups; Manual Handling training; Conflict resolution training  Incident reporting  Clinical Staff training; Supervision	<b><u>Pat Key, Director of Corporate Governance &amp; Facilities</u></b>  Lisa Tucker, Health & Safety Manager (IOSH)

Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
Information Commissioner	<p>The Information Commissioner's Office is the UK's independent authority set up to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals.</p> <p>To ensure organisations meet</p>	<p>The Trust must register annually with the ICO.</p> <p>The Trust must have policies and procedures to ensure compliance.</p> <p>The Trust must respond promptly and appropriately to any enquiries, investigations or</p>	<p>Risk and method statements and health and safety statements are supplied by contractors prior to projects starting</p> <p>HSE is given notification of projects where construction work is expected to: a) last more than 30 working dates; and/or b) involve more than 500 person days</p> <p>All contractors are given a site and orientation induction from the Support Services Manager. All contractors who attended site must be signed in. A permit to work system operates with in the Trust</p>	<p><b>Simon Young,</b> <b>Senior Information Risk Owner</b></p> <p>Caroline McKenna, Caldicott Guardian</p> <p>Lotte Higginson, Access to Health Records Officer &amp;</p>

Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
	<p>their information rights obligations they may issue monetary penalties, enforcement notices, issued decision notices and other actions including criminal prosecutions.</p> <p><a href="http://www.ico.gov.uk/">http://www.ico.gov.uk/</a></p>	<p>requests for information from the ICO.</p> <p>All public authorities are also obliged to provide public access to official information.</p>	<p>clause), health records, data security, Information Governance Management.</p> <p>Such enquiries are infrequent, but are dealt with appropriately.</p>	<p>FOI Officer</p> <p>Pat Key, Director of Corporate Governance &amp; Facilities</p> <p>Jonathan McKee, Governance Manager</p>
Public Accounts Committee	<p>The Public Accounts Committee is a Parliamentary Committee with the power to call any Accounting Officer of a public body (including NHS Foundation Trusts) before it.</p> <p><a href="http://www.parliament.uk/">http://www.parliament.uk/</a></p>	Accounting Officer required to provide information to Public Accounts Committee if called upon.	No direct contact to date.	<p><b><u>Paul Jenkins Chief Executive Officer</u></b></p> <p>Simon Young, Director of Finance</p>
Parliament	Requests for information	The Trust is required to respond to legitimate requests for information in relation to Parliamentary questions relating to the services we offer.	<p>Communication would come via the Chief Executive, or the Communications Team. Trust would respond as required. The Chief Executive would sign off on all communication.</p> <p>No direct contact to date.</p>	<p><b><u>Paul Jenkins, Chief Executive</u></b></p>



Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
Police	The Police have powers to investigate any crime in the United Kingdom and to arrest any persons suspected of illegal activities.	The Police have legitimate powers of entry and investigation of anyone suspected of criminal activity. Should the Police carry out an investigation, the Trust is required to share information as agreed under Memorandums of Understanding and to co-operate with enquiries.	There are Memorandums of Understanding between the Police and the National Health Service.  Requests for information from the Metropolitan Police must be on form 3022.	<u><b>Paul Jenkins, Chief Executive</b></u>  <u>Jonathan McKee,</u> <u>Governance</u> <u>Manager</u>

Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with a statutory role but no enforcement powers over NHS foundation trusts</b>				
Department of Health	<p>The DoH is a Government department, headed by the Secretary of State for Health which sets NHS policy and regulatory requirements for the delivery of health and social care.</p> <p>The DoH also commissions national frameworks for care delivery that must be reflected in trust plans and policies (e.g. mental health agendas). <a href="http://www.dh.gov.uk/">http://www.dh.gov.uk/</a></p>	<p>No direct cooperation is required, but the Trust shall ensure the Trust is up-to-date with any new requirements set by the relevant agency or regulator</p> <p>To ensure that the Trust maintains evidence of compliance with key requirements.</p> <p>To operate within the statutory framework (via Monitor) as an authorised NHS organisation.</p> <p>To report compliance with information governance standards.</p>	<p>These would usually be set out in contracts with the commissioners</p> <p>Information Governance Toolkit used to report compliance with IG standards.</p>	<p><u>Pat Key, Director of Corporate Governance &amp; Facilities</u> (for emergency planning)</p> <p>Jane Chapman, Governance &amp; Risk Advisor</p> <p>Jonathan McKee, Governance Manager</p> <p>Lisa Tucker, Emergency Planning Liaison Officer</p>
Commissioners	Commissioners specify in detail the delivery and performance requirements of NHS Foundation Trusts, and the responsibilities of each party through legally binding contracts.	<p>The provision of clinical services in line with contractual agreements.</p> <p>The provision of patient level activity data and Trust</p>	<p>Quarterly / six-monthly Commissioner meetings which review activity against contract.</p> <p>Monthly patient-level data reports to all Commissioners</p>	<u>Julia Smith, Commercial Director</u>

<sup>3</sup> This list is partially informed by Appendix A to Monitor's Compliance Framework 2011/12 (published March 2011)

\* Lead contact appears in bold and underlined

Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with a statutory role but no enforcement powers over NHS foundation trusts</b>				
	<p>NHS Foundation Trusts are required to meet their obligations to commissioners under their contracts. Any disputes about contract performance should be resolved in discussion between commissioners and NHS Foundation Trusts, or through their dispute resolution procedures.</p> <p>Commissioners should raise with Monitor serious and persistent concerns regarding an NHS Foundation Trust's willingness to attempt to agree contracts or ability to remain compliant with its Authorisation. NHS Foundation Trusts should similarly keep Monitor informed where disputes or potential disputes with commissioners may have an impact on an NHS Foundation Trust's ability to remain compliant with its Authorisation. Monitor does not expect to be involved in specific contractual disputes.</p>	performance-related data as required by the contract and CQUIN agreements.	<p>with whom the Trust has a contract.</p> <p>A systemised linking of informal contacts between the Trust Clinical Leads / Associate Director of Business Development / Director of Service Development &amp; Strategy and Commissioners.</p>	
Parliamentary and	The Parliamentary and Health	Respond to any requests from	Arrangements set out in the	<b>Paul Jenkins, Chief</b>

Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with a statutory role but no enforcement powers over NHS foundation trusts</b>				
Health Service Ombudsman	Service Ombudsman investigates complaints made by or on behalf of people who consider that the trust has failed to address their concerns via the NHS complaints procedure.  the PHSO has powers to request documentation and require staff to participate in interview and other reviews. <a href="http://www.ombudsman.org.uk/">http://www.ombudsman.org.uk/</a>	PHSO for records and/or other information in relation to internal investigation of complaints.  Respond to any formal letter of conclusion from PHSO following a complaints investigation conducted by his office.	Trust's Complaints Policy and managed by the Complaints Officer.	<b><u>Executive Officer</u></b>  Lotte Higginson, Complaints Officer  Pat Key, Director of Corporate Governance & Facilities
HM Coroner	Investigates all "unnatural" deaths that occur in his geographical jurisdiction.  Has the power order people to attend his court.  <a href="http://www.coronersociety.org.uk/">http://www.coronersociety.org.uk/</a>	To report any patient who dies whilst in therapy and to co-operate fully with any inquiry that HM Coroner chooses to undertake.	Direct reporting and/or response to requests from Coroners' Office.	<b><u>Rob Senior, Medical Director</u></b>  Jane Chapman, Governance & Risk Lead
Cooperation and Competition Panel	The CCP investigates potential breaches of the Principles and Rules of Cooperation and Competition, and makes independent recommendations to Strategic Health Authorities,	The Trust is required to cooperate with the CCP in relation to proposed transactions.  The Trust is subject to scrutiny	Trust will send relevant documentation as required.	<b><u>Paul Jenkins, Chief Executive</u></b>

Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with a statutory role but no enforcement powers over NHS foundation trusts</b>				
	the Department of Health and, in relation to NHS Foundation Trusts, Monitor, on how such breaches may be resolved. On receipt of advice from the CCP, Monitor will decide what, if any, action is required on the part of the NHS Foundation Trust(s) concerned. <a href="http://www.ccp-panel.org.uk/">http://www.ccp-panel.org.uk/</a>	on any mergers or acquisitions.		
NHS Information Centre for Health and Social Care	The NHS Information Centre is a special health authority which collects, analyses and presents national data and statistical information about health and social care. NHS Foundation Trusts are required to report information specified by Schedule 6 of their Authorisation to the NHS Information Centre. <a href="http://www.ic.nhs.uk/">http://www.ic.nhs.uk/</a>	Chief Executive required to sign annual declaration confirming compliance with fire regulations.	Annual declaration signed by CEO.	<b>Julia Smith,</b> Commercial Director
Overview and Scrutiny Committees of Local Authorities	The Overview and Scrutiny Committees of Local Authorities inquire into all "matters of local concern", including the NHS, e.g. health inequalities and	The Trust is required to send its Quality Report to the OSC for comment.  The Trust is invited to visit the	OSC feedback is built into the Quality Report timetable.  The Trust sends relevant documentation and will often	<b>Paul Jenkins Chief Executive Officer</b>

Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with a statutory role but no enforcement powers over NHS foundation trusts</b>				
	<p>access to services in the NHS.</p> <p>NHS Foundation Trusts must consult with the relevant Overview and Scrutiny Committees before making any material changes to service offerings that will result in a change to mandatory services, and must provide the Overview and Scrutiny Committees with any information requested.</p> <p>A number of Overview and Scrutiny Committees, some non-local, may take an interest in provision where NHS Foundation Trusts offer a tertiary referral service on a regional or national basis.</p>	OSC to report on various matters, e.g. ethnic diversity on the Boards of Governors and Directors, or the work of the Trust.	send a staff member to attend a meeting of the OSC.	
Local Involvement Networks (LINKs)	<p>The role of LINKs is to give local communities a voice in commissioning health and social care.</p> <p>The Local Government and Public Involvement in Health Act 2007 which established LINKs sets out their role and function and also gives the Secretary of</p>	Trust is required to send Quality Report to LINKs for feedback to be included in final version.	Trust sends Quality Report each year.	<u>Sally Hodges, PPI Lead</u>

Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with a statutory role but no enforcement powers over NHS foundation trusts</b>				
	State power to make regulations, imposing duties on commissioners and certain providers of health and social care services.  LINKs is due to be replaced by Healthwatch in April 2012.			
Ofsted	<b>Ofsted Education</b>  Ofsted is the inspectorate for children and learners in England.  It is Ofsted's job to contribute to the provision of better education and care through effective inspection and regulation.  <a href="http://www.ofsted.gov.uk/">http://www.ofsted.gov.uk/</a>	Gloucester House is required to meet Ofsted requirements in order to retain a DCSF number and independent school status.  The requirements are mandatory compliance requirements and Gloucester House needs to be able to provide evidence in relation to these.  Many of the requirements are in relation to the building, safeguarding etc. and the Directorates of Corporate Governance & Facilities and Human Resources need to be aware of these.  Other requirements relate to the quality of teaching and learning.	Head Teacher and other school staff need to be aware of requirements and have available evidence to support compliance.  Staff must cooperate with inspection procedures.  The Unit Director, the school administrator, the Trust Chair, CAMHS Director, and the Directorates of Corporate Governance & Facilities and Human Resources need to be aware of requirements and ensure the Head Teacher has evidence to support compliance measures.  The building has to be kept in a good state of repair in respect of this.	<b><u>Nell Nicholson,</u></b> <b><u>Head Teacher,</u></b> <b><u>Gloucester House</u></b>  Rita Harris, CAMHS Director

Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with a statutory role but no enforcement powers over NHS foundation trusts</b>				
		<p>The Head Teacher is responsible for ensuring standards of teaching and learning are adequate.</p> <p>The Trust Chair is the named person as the proprietor of Gloucester House.</p> <p>Inspections are carried out approximately every two years and the Head Teacher is given one or two days' notice of inspection. If the school does not meet requirements, Ofsted may visit more often and will ask for additional action plans in relation to specific issues. If they are not satisfied with the response they do have the power to de-register and close the school.</p>		
	<b>Ofsted Safeguarding Children</b> Trust is required to co-operate when partner organisations providing care to children are being reviewed by Ofsted / CQC.	To provide information as requested.	Direct request received from inspector or inspected organisation.  Would be led by Medical Director and Trust-wide Safeguarding Lead.	<b><u>Rob Senior, Medical Director</u></b>  Sonia Applby, Trust Safeguarding Lead





Party <sup>4</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>5</sup></b>				
Formally-appointed committees, working groups and forums advising the Department of Health on topics across health and social care	There are about 40 groups which advise the Department of Health on a range of topics across health and social care. Of these, about half may work with NHS Foundation Trusts from time to time, and include the NHS-wide Clearing Service, the National Specialist Commissioning Advisory Group, and the Specialist Advisory Committee on Antimicrobial Resistance.	Feedback on formal consultations.  Input into policy fora.	The Trust inputs via the NHS Confederation, the Foundation Trust Network, and the Mental Health Network on formal responses to consultations.  Individual Trust staff, e.g. the Trust Chair or the CEO, participate in more specific for a convened on policy (e.g. Children's IAPT).	<u>Paul Jenkins, Chief Executive Officer</u>
British Psychoanalytic Council	The confederation of senior psychoanalytic organisations which accredits and regulates psychoanalytic professional and training organisations and validates their training.	BPC registers registrants of member organisations, sets standards of CPD requirement, sets professional and ethical standards and deals with complaints for all of its allied organisations.	The Trust has representatives on various committees and groups.	Jo Stubley Adult Psychoanalytic Psychotherapist  Louise Lyon Trust Director
Confidential Enquiries	Confidential enquiries research the way patients are treated, to identify ways of improving the	Trust is required to respond to requests for identification of patients who falls into either of	Trust will send information as required on receipt of letter from the Director of the Enquiry.	Rob Senior, Medical Director

<sup>4</sup> This list is partially informed by Appendix A to Monitor's Compliance Framework 2011/12 (published March 2011)

\* Lead contact appears in bold and underlined

<sup>5</sup>These parties have no statutory powers over NHS Foundation Trusts. However, Monitor expects that NHS Foundation Trusts will generally cooperate with such bodies, and a failure to cooperate may, under certain circumstances, constitute a breach of the Authorisation and grounds for intervention

Party <sup>a</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>5</sup></b>				
	<p>quality of care. They publish reports summarising key findings and recommendations arising from the information they gather. They aim to identify changes in clinical practice that will improve quality of care and ultimately improve patients' outcomes.</p> <p>The two confidential enquiries relevant to the Trust are the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness and the Centre for Maternal and Child Health Inquiries.</p>	these enquiries and may be asked to undertake reviews of cases under the direction of the inquiry.		<u>Jane Chapman, Governance and Risk Advisor</u>
National Patient Safety Agency	<p>The NPSA coordinates the reporting of, and learnings from, mistakes and problems that affect patient safety.</p> <p>It also incorporates the National Clinical Assessment Service, which provides a support service where there are concerns over the performance of an individual doctor or dentist.</p> <p><a href="http://www.npsa.nhs.uk/">http://www.npsa.nhs.uk/</a></p>	<p>The Trust is required to advise the NPSA of all incidents involving patients.</p> <p>The Trust is required to respond to any relevant alert issued via the NPSA.</p>	<p>Nominated staff report all patient incidents via NPSA external web link on a quarterly basis incident and be recognised link for NPSA.</p> <p>All alerts issues via the CAS system are reviewed and any relevant alerts (e.g. estates alerts) are brought to the attention of appropriate senior staff for action.</p>	<p><u>Pat Key, Director of Corporate Governance and Facilities</u></p> <p>Jane Chapman, Governance and Risk Adviser</p>

Party <sup>4</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>5</sup></b>				
NHS Business Services Authority	The NHS Business Services Authority is responsible for policy and operational matters relating to prevention, detection, and investigation of fraud and corruption in the NHS. <a href="http://www.nhsbsa.nhs.uk/">http://www.nhsbsa.nhs.uk/</a>	Compliance with counter-fraud guidance.  Compliance with security management guidance.	Annual return submitted by the Trust and assessed by NHS Protect (the new name for this part of the NHS BSA, previously CFSMS), leading to a rating.	<u>Simon Young, Director of Finance</u>
		NHS Pensions Agency.  Provision of information from payroll.	Monthly and annual transfers of information on pension contributions.	<u>Simon Young, Director of Finance</u>
		Prescriptions pricing authority.  Procedures for security of prescriptions (few).  Paying invoices.	Medicines Management Procedure, approved October 2010.	<u>Rob Senior, Medical Director</u>  Pat Key, Director of Corporate Governance and Facilities  Simon Young, Director of Finance
NHS Litigation Authority	The NHSLA is responsible for handling negligence claims made against NHS bodies in England.	The Trust is required to register all claims for compensation brought as clinical negligence, employer liability, or public liability with the NHSLA, and	The Trust is a member of the NHSLA schemes – CNST, PES and LTPS.  The Trust's Governance and Risk	<u>Pat Key, Director of Corporate Governance and Facilities</u>

Party <sup>a</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>5</sup></b>				
	It helps to manage clinical risks (via the Clinical Negligence Scheme for Trusts) and non-clinical risks (via the Risk Pooling Scheme for Trusts) and manages claims and litigation for both. <a href="http://www.nhs.uk/home.htm">http://www.nhs.uk/home.htm</a>	then respond to all request during the management of each claim.  The Trust is required to be assessed by the NHSLA on a fixed schedule against standards for risk management.	Adviser ensures that claims are managed in line with NHSLA requirements.  The Trust has been assessed as required at Level 1 (Feb 2009) and at Level 2 (Feb 2011). Next assessment to be completed Feb 2014.	Jane Chapman Governance and Risk Adviser
National Treatment Agency for Substance Misuse	The NTA is a special health authority within the NHS, established by the Government in 2001 to improve the availability, capacity, and effectiveness of treatment for drug misuse in England. <a href="http://www.nta.nhs.uk/">http://www.nta.nhs.uk/</a>	Monthly reports to National Drug Treatment Monitoring Service, which is a part of NTA.	Monthly deadlines agreed with Commissioners.	<b>Sally Hodges,</b> <b>Assistant Associate</b> <b>Director, CAMHS</b>
Association of Medical Royal Colleges	Royal colleges aim to ensure high quality care for patients by improving standards and influencing policy and practice in modern healthcare. They set standards for clinical practice, conduct examinations, define and monitor education and training programmes for their members, support clinicians in their practice of medicine, and advise the Government, public and the profession on healthcare issues.			
Royal College of Psychiatrists	The Royal College of Psychiatrists is the professional and educational body for psychiatrists in the UK.	Respond to requests for information.  Ensure good standing of psychiatrists with college for	Appraisal system for individual psychiatrists.	<b>Rob Senior, Medical</b> <b>Director</b>

Party <sup>a</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>5</sup></b>				
	It aims to: set standards and promote excellence in psychiatry and mental healthcare; lead, represent, and support psychiatrists; and work with service users, carers and their organisations.	CPD.  Contribute to College Committees as requested.		
British Psychological Society	<p>The BPS is the representative body for psychology and psychologists in the UK.</p> <p>It is the body that registers psychologists as Chartered Psychologists.</p> <p>It is responsible for the development, promotion, and application of pure and applied psychology.</p> <p>The BPS also accredits practice placements.</p> <p>Chartered status, on top of mandatory HPC registration, is regarded as involving a higher threshold of professional scrutiny, and is therefore considered good practice.</p>	<p>All staff using the title <i>Chartered Psychologist</i> must register with the BPS. It is illegal to use the title <i>Chartered</i> without registration.</p>	<p>All Trust appointments are for psychologists who are Chartered or at least eligible for Chartered status at the time of application for employment.</p>	<p><b><u>Bernadette Wren,</u></b> <b><u>Trust-wide Head of</u></b> <b><u>Psychology</u></b> <b><u>Discipline</u></b></p>

Party <sup>a</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>5</sup></b>				
Association of Family Therapy	<p>The AFT is an alliance of professionals working therapeutically with children, adults, and those important in their lives, in health, social care, education, and third sector services.</p> <p>The AFT formally accredits professional training courses.</p>	AFT sets standards for supervision etc. that the Trust must comply with.	The Trust has representatives on various bodies.	<u>Ellie Kavner, Trust-wide Head of Systemic Psychotherapy Discipline</u>
Universities, post-graduate deaneries and the Postgraduate Medical Education and Training Board	<p>NHS foundation trusts may offer professional education or training in conjunction with universities or other professional bodies.</p> <p>The accreditation process for such education or training may include a requirement for inspection and monitoring of provision.</p> <p>For NHS Foundation Trusts with cross-border activities in Wales, the list also includes the Welsh Assembly, local health boards, Health Commission Wales, and Healthcare Inspectorate Wales.</p>	<p>To deliver undergraduate and postgraduate medical education, in the Trust, we must ensure that GMC/PMETB standards for our teaching and training are met, the London Deanery's strategic direction is supported, and that the educational contract between the Trust and the London Deanery/NHS London is fulfilled. We are required to complete an annual report for the London Deanery in line with the requirements of the Learning Development Agreement and Quality Management Manual. In addition, our trainers and trainees are required to</p>	<p>The Director of Medical Education (DME) is responsible for ensuring the delivery of medical teaching and training in line with these requirements. She reports to the Medical Director and the Trust Dean, both of whom sit on the Trust Board. The DME is aided in her work by the Medical Education Board, consisting of the PGME administrator, the Training Programme Directors, Librarian, and Trainee rep. The Board meets regularly throughout the year to promote the development and quality of education provision. The DME also consults regularly with the</p>	<u>Jessica Yakeley, Associate Medical Director</u>

Party <sup>a</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>5</sup></b>				
		complete an annual survey administered by the GMC/PMETB of the quality of training provided by the Trust. The London Deanery carries out an annual inspection of the quality of medical training provided by the Trust, taking into account the results of these reports.	wider consultant group of clinical and educational trainers, and ensures that they are fully trained in line with the London Deanery's Faculty Development Framework.	
Trades' Unions	Trades' unions protect the interests of their members. The Trust's staff are members of the British Medical Association, Unison, Royal College of Nursing, MiP, and Unite.	Trust is required to include trades' union representatives in discussions about restructuring changes that affect staff and to include them in discussions about banding and grading of new posts. All staff have a right to a union representative at any formal meetings and the Trust is required to ensure that union representatives receive copies of any formal papers in advance of any meetings.	The Trust works in close partnership with Staff Side colleagues both through the formal JSCC and regular bi-weekly meetings between the HR Director and Staff Side Chair. This approach allows many issues to be dealt with at an informal level therefore facilitating progress on management issues for the Trust.	<b>Susan Thomas,</b> <b><u>Director of Human Resources</u></b>



Party <sup>6</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with representation on the Trust's Board of Governors</b>				
Camden CCG	Camden CCG to appoint two members to the Council	As for all Governors, keep representatives informed of developments.	Camden CCG to nominate: Dr Thomas Das is the current nominee. Camden are not currently able to offer a second representative.	<b><u>Angela Greatley,</u></b> <b><u>Trust Chair</u></b>  Paul Jenkins, Chief Executive  Gervase Campbell, Trust Secretary
Local Authorities – Camden	At least one member of the board must be appointed by one or more qualifying local authorities. A qualifying local authority is a local authority for an area which includes the whole or part of an area specified in the constitution as the area for a public constituency <sup>7</sup> .	Ibid.	The London Borough of Camden agreed to represent Local Authorities. Cllr Claire-Louise Leyland (Con) is the incumbent.	<b><u>Angela Greatley,</u></b> <b><u>Trust Chair</u></b>  Paul Jenkins, Chief Executive  Gervase Campbell, Trust Secretary
Non-Statutory Sector – Voluntary	An organisation specified in the constitution as a partnership	Ibid.	Voluntary Action Camden agreed to represent the non-	<b><u>Angela Greatley,</u></b> <b><u>Trust Chair</u></b>

<sup>6</sup> This list is partially informed by Appendix A to Monitor's Compliance Framework 2011/12 (published March 2011)

\* Lead contact appears in bold and underlined

<sup>7</sup> National Health Service Act 2006, Schedule 7, paragraph 9(4) and (5)

Party <sup>6</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with representation on the Trust's Board of Governors</b>				
Action Camden	organisation may appoint a member of the board <sup>8</sup> .		statutory sector. Ms Simone Hensby, Director, is the incumbent.	Paul Jenkins, Chief Executive Gervase Campbell, Trust Secretary
University of Essex	Ibid.	Ibid.	Prof Nigel South is the incumbent	<u><b>Angela Greatley,</b></u> <u><b>Trust Chair</b></u> Paul Jenkins, Chief Executive Gervase Campbell, Trust Secretary
University of East London	Ibid.	Ibid.	Prof John Joughin is the incumbent	<u><b>Angela Greatley,</b></u> <u><b>Trust Chair</b></u> Paul Jenkins, Chief Executive Gervase Campbell, Trust Secretary

<sup>8</sup>National Health Service Act 2006, Schedule 7, paragraph 9(7)

## Board of Directors : April 2014

**Item : 12**

**Title : Quarter 4 Governance statement**

### **Purpose:**

The Board of Directors is asked to approve three elements of the governance statement to be submitted to Monitor for quarter 4.

#### For Finance

The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.

#### For Governance

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 A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.

#### Otherwise

The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 21, Diagram 6) which have not already been reported.

This paper has been reviewed by the Management Committee on 17 April.

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

*(delete where not applicable)*

- Risk
- Finance
- Quality

**For : Approval**

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

## Quarter 4 Governance Statement

### 1. **Introduction**

- 1.1 Monitor oversees NHS foundation trusts through the terms of our provider licence and through the Risk Assessment Framework.
- 1.2 A key element of the Risk Assessment Framework is the requirement to submit a governance statement each quarter.
- 1.3 This quarter's statement is to be returned to Monitor by 30 April.

### 2. **Finance declaration**

- 2.1 The financial forecasts for the next four quarters are based on the 2014/15 budget approved in March. The Trust's expected ratings on the two metrics which comprise the continuity of service risk rating (CoSRR) are detailed in the Appendix to this paper.
- 2.2 Our in-year Debt Service Cover rating is projected to be 3 or 4 for all quarters. Our Liquidity ratio starts at 4, but may fall to 2 during the year, though cash will remain satisfactory.
- 2.3 The two elements are each given a 50% weighting, and the result is rounded up to obtain the overall continuity of service risk rating (CoSRR). So with the lowest of the ratings predicted – Debt Service Cover 3 and Liquidity 2 – our CoSRR will be 3. With various combinations of higher ratings on the two elements, the CoSRR would be either 3 or 4.
- 2.4 We are thus able to affirm that we anticipate that the trust will continue to maintain a continuity of service risk rating of at least 3 over the next 12 months.

### 3. **Governance Declaration**

#### 3.1 **Declaration of risks against healthcare targets and indicators**

- 3.1.1 The Monitor template for our quarterly return sets out a list of targets and indicators, in line with the Risk Assessment Framework. These are the same as those in the previous Compliance Framework 2013/14 document. The targets and indicators which apply to this Trust are given in the table on the next page.
- 3.1.2 All targets and indicators are being met; and plans are sufficient to ensure that they continue to be met. Further details are given below. The Trust should therefore continue to receive a green governance rating.

Target/Indicator	Weighting	Quarter 4 result	
Data completeness: 97% completeness on all 6 identifiers	0.5	Achieved	0
Compliance with requirements regarding access to healthcare for people with a learning disability	0.5	Achieved	0
Risk of, or actual, failure to deliver Commissioner Requested Services	4.0	No	0
CQC compliance action outstanding	Special	No	0
CQC enforcement action within the last 12 months	Special	No	0
CQC enforcement action (including notices) currently in effect	4.0	No	0
Moderate CQC concerns or impacts regarding the safety of healthcare provision	Special	No	0
Major CQC concerns or impacts regarding the safety of healthcare provision	2.0	No	0
Unable to declare ongoing compliance with minimum standards of CQC registration	Special	No	0
		Total score	0
		Indicative rating	

### 3.2 Care Quality Commission registration

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

3.2.2 The Trust remains compliant with the CQC registration requirements.

### 3.3 Self certification against compliance with requirements regarding access to healthcare for people with a learning disability

3.3.1 The Trust Lead for Vulnerable Adults reviewed the Self certification against compliance with requirements regarding access to healthcare for people with a learning disability in December 2012.

3.3.2 The Trust has continued to develop its services for LD service users, and actively involves users to further refine and tailor provision.

### 3.4 Data Completeness

3.4.1 The target is 97% completeness on six data identifiers within the Mental Health Minimum Data Set (MHMDS). Statistics for the last two months confirm that we are still meeting and exceeding this target: see table below.

	Month 11 final	Month12 provisional
Valid NHS number	99.29%	99.20%
Valid Postcode	100.00%	99.82%
Valid Date of Birth	100.00%	100.00%
Valid Organisation code of Commissioner	99.69%	99.69%
Valid Organisation code GP Practice	99.20%	99.20%
Valid Gender	99.87%	99.87%

## 4. Other matters

4.1 The Trust is required to report any other risk to compliance with the financial and governance conditions of our licence. The 2013/14 Risk Assessment Framework gives – on page 21 – a non-exhaustive list of examples where such a report would be required, including unplanned significant reduction in income or significant increase in costs; discussions with external auditors which may lead to a qualified audit report; loss of accreditation of a Commissioner Requested Service; adverse report from internal auditors; or patient safety issues which may impact compliance with our licence.

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

Simon Young  
Deputy Chief Executive and Director of Finance  
17 April 2014

## Appendix

The **Debt Service Cover**<sup>1</sup> is calculated by Monitor as follows:

<u>2014/15 budget</u>		£000
Surplus		40
Depreciation		550
Dividend		<u>421</u>
Revenue available for Capital Service		<u>1,011</u>
 $\frac{\text{Revenue available 1,011}}{\text{Dividend 421}} = \text{Debt Service Cover 2.4}$		

(Note: The calculation set out by Monitor also includes a number of other factors which do not apply to this Trust at present, such as loan interest and impairment costs. Only the non-zero figures are shown in the table above.)

The thresholds for this metric are:

Top rating 4	2.5
Rating 3	1.75
Rating 2	1.25

Based on our budget, therefore, our rating on this metric is expected to be 3, since our cover is just below the threshold of 2.5. If we do not use all our contingency reserve and thus achieve a slightly higher surplus, our rating will be 4, as it has been in 2013/14.

All these budget figures are expected to be evenly spread across the year, and our in-year Debt Service Cover rating (which is based on the *cumulative* results each quarter) should therefore be 3 or 4 for all quarters.

<sup>1</sup> "A popular benchmark used in the measurement of an entity's ability to produce enough cash to cover its debt (including lease) payments" (Wikipedia)

The second metric, **Liquidity**, is calculated as

$$\frac{\text{"Cash for Continuity of Service Liquidity Purposes"}}{\text{Operating Expenses within EBITDA}}$$

The numerator in this formula includes not only cash but also almost all other elements of working capital: debtors and accrued income are added, while creditors, accrued expenditure and deferred income are deducted.

The thresholds for this metric are:

Top rating 4	0 days
Rating 3	minus 7 days
Rating 2	minus 14 days

Due to our planned capital expenditure in 2014/15, cash is projected to reduce significantly but to remain satisfactory. Our actual opening position and projected closing position are summarised in the table below:

	31 March 2014 <u>Actual</u>	31 March 2015 <u>Projected</u>
Cash	£ 2.8m	£ 1.0m
"Cash for liquidity purposes"	£ 0.5m	(£ 1.1m)
Liquidity	5 days	minus 11 days

Thus our rating on this metric may fall from 4 to 2 during the year.

We have noted in our Plan submission to Monitor (and previously) that the negative "cash for liquidity purposes" figure is entirely explained by our Deferred Income, which does not represent a liability due for immediate payment. The Trust does not need to cover Deferred Income by its cash balance at any point, and its inclusion in the ratio is, we believe, misleading.

It may be noted also that the Trust's financing facility of £2.4m is not now allowed for in Monitor's calculation.



## Board of Directors : April 2014

**Item :** 13

**Title :** Quarterly Quality Report 2013-14 for Quarter 4: April 2014

### **Summary:**

The report provides an update of the Quality Indicators for Quarter 4, 2013-14.

This report has been reviewed by the following Committee:

- **Management Committee on 17 April 2014.**

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

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

- Quality
- Patient / User Experience
- Safety

**For :** Noting

**From :** Quality Standards and Reports Lead

# Quarterly Quality Report for the Board of Directors

Quarter 4, 2013-2014

April 2014

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## Section One: Quality Key Performance Indicators Table

Quality Key Performance Indicators														
No.	Target	Monitoring	Progress						% Progress for 2013/14				Actions for Next Quarter	
			Q1		Q2		Q3		Q1	Q2	Q3	Q4 <sup>1</sup>		
1	Waiting time no more than 11 weeks (77 days from receipt of referral). *Please see Explanatory Notes on page 4.	Quarterly	N	%	N	%	N	%						
			1	0.3	5	1.7 <sup>2</sup>	4	1.0	8	1.7				
2a	DNA rates: Yearly average no larger than 10%	Quarterly	9%		11% <sup>3</sup>		8.9%		7%					
2b	Adolescent Department DNA rate	Annual	Annual audit has been undertaken and Action Plan completed.											
3a	85% staff with up-to-date child safeguarding training reported by level.	Quarterly	L1- 89%	L2- 94%	L1- 93%	L2- 89%	L1 – 91%	L2 – 89%	L1 – 94%	L2 – 88%	L3 – 89%			
3b	Vulnerable adults training (Adults at Risk): 85% of staff trained every 2 years.	Quarterly	89%		93%		91%		94%					
4	Patient information: In date written information sent to all new patients. Work on adolescents information leaflets during 2013/14.	To be reported in Q3	The new 'Adolescent and Young Adults Service' leaflet was finalised earlier than scheduled and can be accessed from the T+P Website. Complete.											
5	Outcome Monitoring: Target: Routine outcome monitoring for adult and CAMHS patients	Quarterly	Achieved and on-going											
6	Patient Satisfaction: Target 70% or more report satisfied with the service	Quarterly	Q3 ESQ data shows that 93% are satisfied indicating “certainly true” to the question of “Overall, the help I have received here is good” .											
7	Quality and Development of staff: Target 80% of staff to have a PDP.	Annually	Achieved - 96%											

8	Sickness and absence rates. Target: <2% green (2-6% amber, >6% red)	Annually	1.7%						
9	Trust Service cancellation rates. Target: <10% green (10-19% amber, >20% red)	Quarterly	N/A	3%	2.4%	1.9%			
10	% of staff with up-to-date mandatory for infection control. 100% = green. 80-99% is amber. < or = 80% red.	Annually	97%	Update on personal responsibility for reducing the risk of cross infection is raised at induction and biennial INSET training.					
11	% response to complaints within 25 days. Target: > 95% green (80-95% amber, <80% red.)	Quarterly	100% (8/8)	100% (2/2)	100% (1/1)	100% (1/1)			
12	The Trust's contribution to statutory assessments to be completed within 6 weeks. Target 100%.	Annually	Awaiting confirmation from Trust Child Safeguarding Lead						
13	Number and % of children reporting satisfaction with the service (as measured against CHI-ESQ). (To be baselined, in order to establish target.)	Quarterly	In Q3 91% of Children and 88% of young people in CAMHS reported satisfaction with the service as measured by the question "Overall, the help I have received here is good" on the ESQ. <sup>4</sup>						
14	Data Quality: That for 85% of patients discharged from SAAMHS and CAMHS a letter with comprehensive information is sent to the GP or the referring clinician within 2 weeks of final treatment session/appointment.	Annual - Case Note Audit	Achieved - 90% A hardcopy of the Discharge Letter audit can be provided by the Quality Standards and Reports Lead, if required. This provides a breakdown of findings.						

<sup>1</sup> RAG status for Q4 (31 March 2014). Please note the *Quality Standards and Reports Lead is not in a position to deliver these targets and only reports on the progress.*

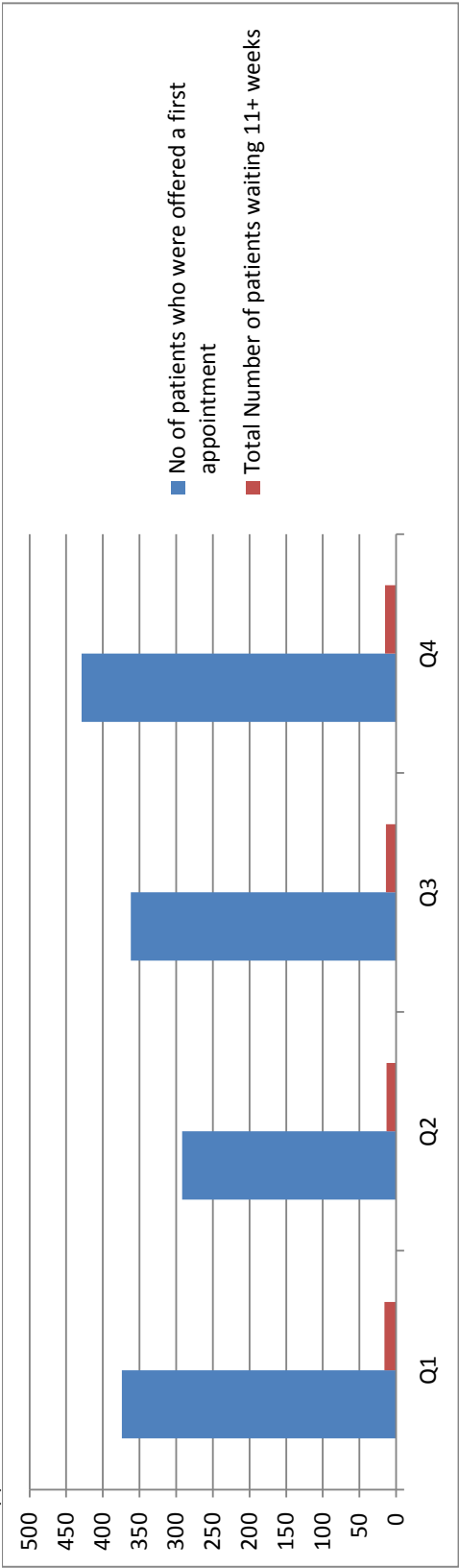
<sup>2</sup> Following further data validation this figure has been changed from 1.6% to 1.7%

<sup>3</sup> Q2 data had shown 11%, although by error 12% had been noted in the table above for Quarter 2.

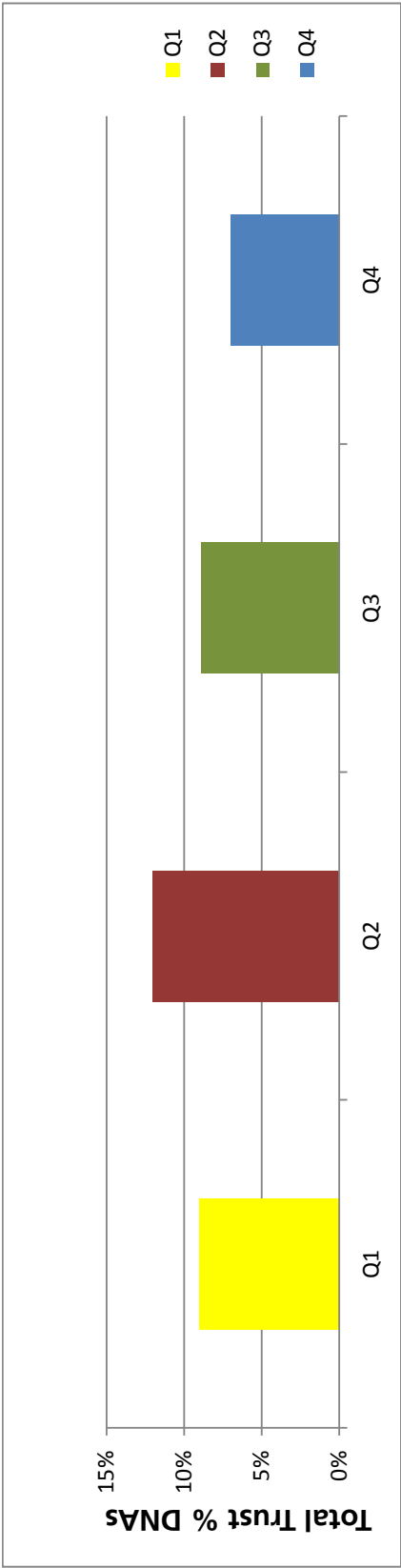
<sup>4</sup> For data quality and consistency purposes the Trust is now obtaining all ESQ data (Targets 6 and 13) from the PPI report. The Q4 data is not yet available but Target 13 has been updated with the Q3 figure from the 'ESQ Report 2013-2014 Q3'.

Section Two: Explanatory Notes

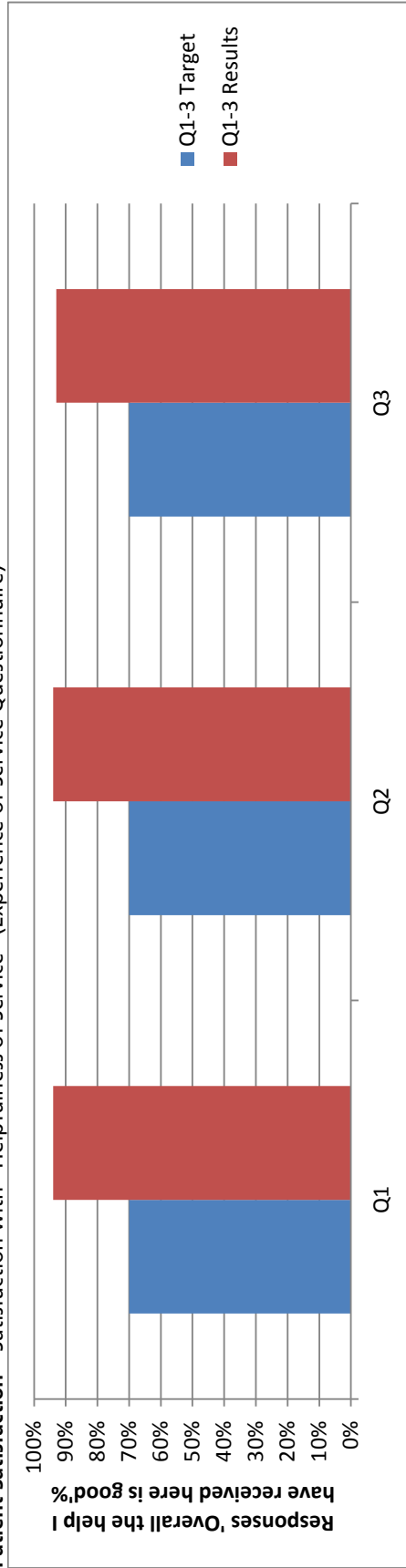
1. **Waiting Times (\*)** - For Quarter 4, there were 16 waiting time breaches, where patients were required to wait eleven weeks or longer for their first appointment, but only 8 of these breaches related to factors internal to the Trust and represented 1.72% of the total number of patients who were offered a first appointment in Quarter 4.



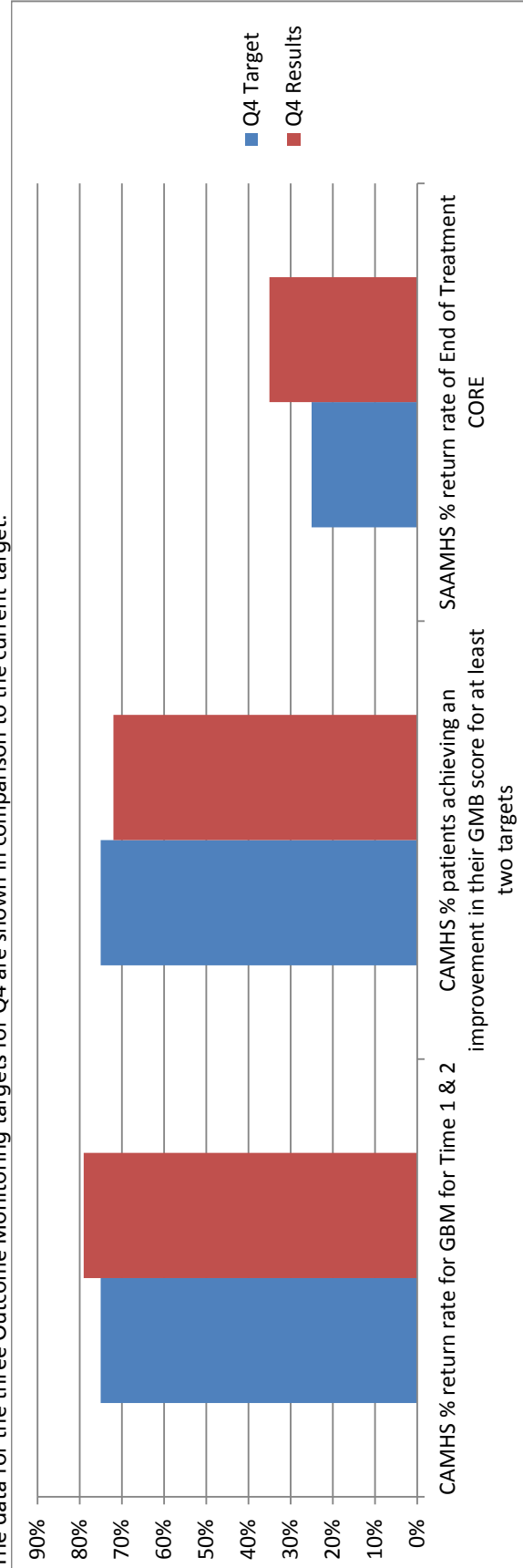
2. **DNA Rates** – The DNA rate for Quarter 4 is 7% which is lower than the 8.9%, achieved in Quarter 3 and under our target of 10%.



3. **Patient Satisfaction – Satisfaction with “Helpfulness of Service” (Experience of Service Questionnaire)**

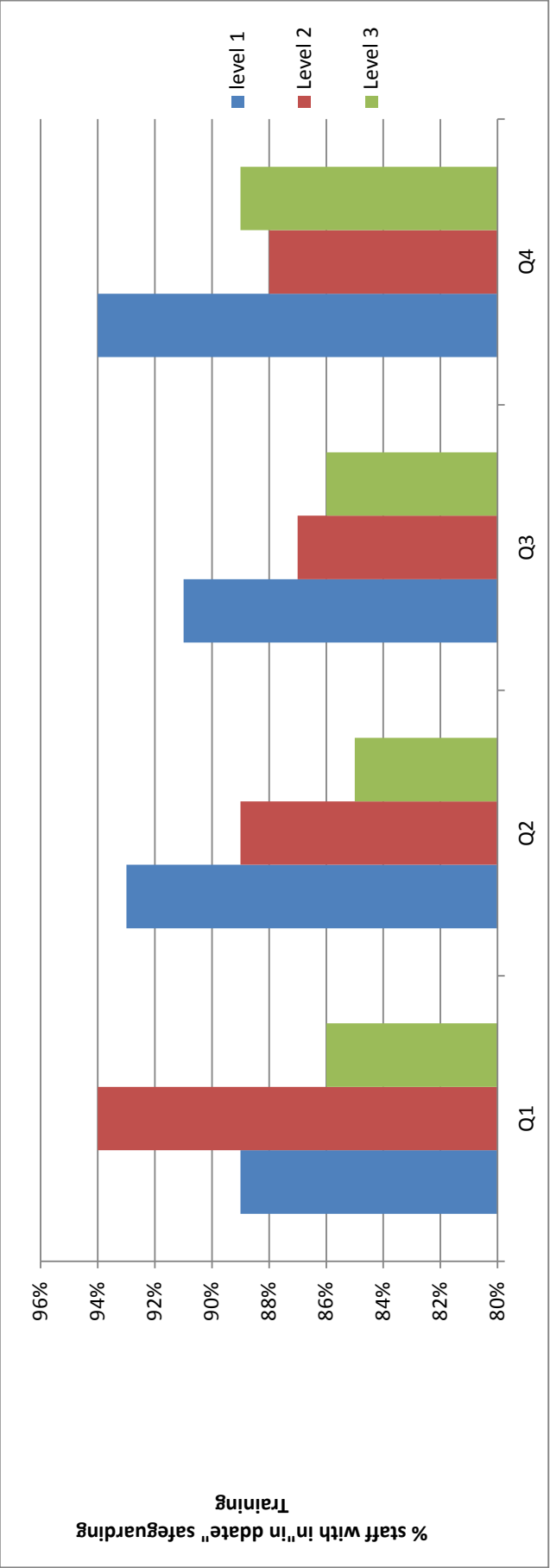


4. **Outcome Monitoring**  
The data for the three Outcome Monitoring targets for Q4 are shown in comparison to the current target.



5. **Child Safeguarding Training**

The percentage of staff with 'in date' Child Safeguarding training does not include those members of staff who have just recently joined the Trust and not yet attended the training, nor those staff who are on sick leave or maternity leave. (The training for Safeguarding Level 3 was provided in February, and twice in March 2014).





## Section Three: Quality Priorities Progress

Quality Priorities											
	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	End Date	Progress	% Progress for 2013/14			
								Q1	Q2	Q3	Q4 <sup>1</sup>
(1)Outcome Monitoring	1. CAMHS (Child and Adolescent Mental Health Service): For 75% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal Based Measure (GBM) at the Pre-Assessment stage (known as Time 1) and after 6 months or, if earlier, at the end of therapy/treatment (Time 2).	Caroline McKenna	OM tracking system  Monitoring of progress by the OM Lead  Quarterly progress report	• OM analysis of the % return rate for GBM for Time 1 and Time 2.	1 April 2013	31 January 2014	Achieved.				79%
	2. CAMHS (Child and Adolescent Mental Health Service): For 75% of patients (attending CAMHS who qualify for the CQUIN) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets.									72%	
		3. Adult Department: For the CORE outcome measures to be completed by at least 25% of patients over the age of 25, for those patients who have completed their treatment, attending at least one treatment appointment, on or after 1 April 2013 and on or before 31 January 31s 2014.	Michael Mercer	Quarterly review by the CQSG Committee and Board of Directors	• OM analysis of the % of patients who achieve an improvement in their score for at least two GBM targets  • OM analysis of the % return rate of the End of Treatment CORE form.	1 April 2013	31 January 2014	Please see comment on page 12 Indicator 2.			

Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2013/14			
								Q1	Q2	Q3	Q4 <sup>1</sup>
(2)* Access to Clinical Services and Health Care Information for Patients and Public	1. To ensure the Trust has a minimum of 12 published treatment leaflets which will include two leaflets developed by and written for children/young people.	Sally Hodges	<ul style="list-style-type: none"> <li>Monitoring of progress by PPI Lead</li> <li>Feedback from patients and members on the accessibility of this information leaflet</li> <li>Quarterly progress report</li> <li>Quarterly review by the CQSG Committee and Board of Directors</li> </ul>	<p>Analysis on the levels of satisfaction with information provided on treatment modality leaflets.</p> <p>To demonstrate accessibility through mystery shoppers, a telephone survey and a random audit of case files.</p> <p>To modify leaflets content and availability in light of feedback from mystery shoppers.</p>	1 April 2013	31 January 2014	<p>1. Two modality leaflets written by children were reviewed by the PPI Committee in January 2014 bringing the Trust total to 12.</p> <p>2. A mystery shop was run in August 2013 where the mystery shoppers were able to access the leaflets. Five commented on how these leaflets were organised and that more general leaflets would have been helpful.</p> <p>3. Following feedback from the mystery shoppers we have introduced the general leaflet on mental health from MIND.</p> <p>4. Following our telephone survey, where patients commented that they would have liked to have seen the leaflets in order to be able to comment, we decided that, based on patient feedback, a face to face survey with the leaflets present would be more helpful. We introduced a 'membership stand', which was run during the year on five occasions. Over 20 patients have visited</p>				

	to assess satisfaction with the level of information provided in the leaflets to support choice and decision making when treatments are offered. 5. To audit a random selection of case files to identify if treatment options were documented as discussed.								the membership stand during the year, and of these about 50% have been aware of the leaflets. 5. This audit took place during September 2013. Thirty files from the Adult services and 30 from the Children services were randomly selected. Fifty eight percent of the CAMHS files had a note about treatment options and 53% of the Adult files had this note present. This finding has been fed back to the CAMHS and SAAMHs directors for action.				
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\* Please note, it has become evident that not all of the Access Priority targets were included in the previous Quarterly Quality Reports to the Board of Directors. However, progress towards achieving these targets was monitored on a quarterly basis by the PPI Committee and the COSG.

Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achievement Date	Progress	% Progress for 2013/14			
								Q1	Q2	Q3	Q4 <sup>1</sup>
(3) Patient and Public Involvement	1. To have a protocol in place on: i. Payment of service users for participation on interview panels ii. Selection and training of service users for interviews iii. Training for staff including service users on interview panels.	Sally Hodges	<ul style="list-style-type: none"> <li>Maintain the minutes from the stakeholder quality meetings and patient forum</li> <li>Monitoring of progress by PPI Lead</li> <li>Quarterly progress report</li> <li>Quarterly review by the CQSG Committee and Board of Directors</li> </ul>	1. To have developed a protocol for the payment of service users for participation on interviews. 2. To have developed a protocol, reviewed by service users, for the selection and training of service users for interviews panels. 3. To have trained 15 members of staff on working with service users on interview panels.	1- April 2013	31- January 2015	i. Target over 2 years – protocol on payment for 2015 deadline. ii. A protocol for the involvement, training and payment of service users on interview panels was reviewed by the PPI Committee in January 2014. iii. For 2015.				
	2. To continue to expand and promote Bid for Better and to target engagement with our younger members			1. Promote Bid for Better in the Trust's CAMHS waiting rooms and via the Young Minds blog and schools' websites. 2. We will set a target of at least 10 applications of which four will demonstrate wider engagement and patient experience outcomes.	1- April 2013	31- March 2014 <sup>2</sup>	We launched the 2014 Bid for Better scheme in January 2014, with advertising and age appropriate 'friendly' forms in our children's services. The funding scheme was also advertised through Young Minds and other community organisations with a focus on the mental health of children and young people.				

<sup>1</sup> RAG status for Q4 (31 March 2014). Please note the Quality Standards and Reports Lead is not in a position to deliver these targets and only report on the progress.

<sup>2</sup> To fit in with the allocation of funding from the Trust in April 2014, the Bid for Better scheme which was launched in January 2014 ran until March 2014. For this reason, the achievement date was changed from January to March 2014.

## Appendix One: CQUIN Targets

	Detail of indicator	Performance at Q4	Progress	Q4 RAG <sup>1</sup>
CAMHS Outcome monitoring	<b>Indicator 1a</b> For at least 75% of patients (attending CAMHS who qualify for CQUINS) to complete the Goal Based Measure at Time 1 pre assessment and Time 2 (6 month or end of therapy)	79%		79%
CAMHS outcome monitoring	<b>Indicator 2</b> For at least 75% of patients (attending CAMHS who qualify for CQUINS) to show improvement from Time 1 to Time 2 on at least two targets.	72%	Clinicians anecdotally have reported that their cases sometimes did not show an improvement on at least two goals as the focus of the work necessarily had to move away from the service users original goals, or due to the need for an extended assessment there were very few "treatment" sessions during which an improvement could be seen.	72%
CAMHS ESQ	<b>Indicator 3a</b> For at least 75% of patients to complete CHI-ESQ at 6 months or case closure.	76%		76%
CAMHS User Involvement	<b>Indicator 3b</b> - Target: 75% satisfaction User Participation: ESQ analysis 2012/13 identified a specific area for improvement in relation to the following statement "Satisfaction with explanation of help available "	50%	The low "satisfaction with explanation" rate for ESQs may be due to a number of factors. Many service users answered "don't know" as they couldn't remember as far back as the start of their care. This question has also changed since last year when the figures were higher. Last year we asked a more general question about satisfaction with explanations about the help available, and it might be that although service users receive a satisfactory verbal explanation, the written information is less easy to retain or less helpful. Interestingly this year one theme to emerge is of parents/carers of children in the 7-12 age group commenting that information on what to tell a child about coming to the service would be useful. We will follow this up.	50%
CAMHS Clinical Effectiveness	<b>Indicator 4</b> - 1. Length of Treatment: All new cases whose first treatment attendance was 1 November 2012 or after, should not be in treatment for longer than a maximum of 2 years except where longer treatment is specifically agreed. 2. Developing and piloting a method of identifying treatment cases open for 18 months and paperwork necessary for requesting extension of treatment beyond 2 years. End July 2013.	Achieved for Quarter 4.		

<sup>1</sup> RAG status for Q4 (31 March 2014).

Please note the Quality Standards and Reports Lead is not in a position to deliver these targets and only report on the progress.

SAAMHS Outcome monitoring	<b>Indicator 6</b> - For the Total CORE (Clinical Outcomes for Routine Evaluation) scores to indicate an improvement from pre-assessment (Time 1) to post assessment (Time 2) of 61% for patients over the age of 25 who qualify for the CQUIN.	Achieved for Quarter 4.	63%
SAAMHS Outcome Monitoring	<b>Indicator 7</b> - For the CORE outcome measures to be completed by at least 25% of patients over the age of 25, for those patients who have completed their treatment.	Achieved for Quarter 4.	35%
SAAMHS ESQ	<b>Indicator 8</b> - Experience of Service Questionnaires to be completed by at least 25% of patients at the end of treatment.	Achieved for Quarter 4	27%
SAAMHS	<b>Indicator 9</b> - Smoking Cessation - Any new referrals between November 2013 and January 31 2014 with at least one attended treatment appointment.	Achieved.	100%

## Appendix Two: Quality Indicator Performance Supporting Evidence

### 1. Waiting times

QUARTER 4							
Target less than 77 days (11 weeks)							
Breaches: Cause internal to Tavi	3	Adult	Camden CAMHS	Other CAMHS	Portman	LCDS	Total
Breaches: Cause external to Tavi	2	2	2	1	0	1	8
Total number of breaches	5	5	4	1	0	1	16
Number of 'breaches' shown after data validation shown to be 'no breach'	1	2	0	0	0	0	3
Total number of patients offered a first appointment in the quarter	59	66	229	75	22	14	465
The percentage of patients that are breached in the quarter	8%	8%	2%	1%	0%	7.1%	3.44%
% internal	5.1%	4.5%	0.9%	0.0%	0.0%	0.0%	1.72%
% external	3.4%	3.0%	0.9%	1.3%	0.0%	7.1%	1.72%

### 2. DNA Rates

QUARTER 4							
Target <10%							
Total 1st appointments attended	57	Adult	Camden CAMHS	Other CAMHS	Portman	LCDS	Total
Total first appointments DNA's	5	5	29	1	0	1	41
Total first appointments	62	69	235	46	22	16	450
% 1st appointments DNA'd	8.1%	7.2%	12.3%	2.2%	0%	6%	9%
Total subsequent appointments attended	1192	2521	3272	2250	1238	192	10665
Total sub. appointments DNA'd	149	168	178	118	110	22	745
Total subsequent appointments	1341	2689	3450	2368	1348	214	11410
% DNA subsequent Appointments	11.1%	6.2%	5.2%	5.0%	8%	10%	7%

3. **Patient Satisfaction** – See ESQ Report 2013-2014 Q3 (A hardcopy of this Report can be provided by the Quality Standards and Reports Lead).
4. **Patient Experience** - See Annual PPI Report. (A hardcopy of this Report can be provided by the Quality Standards and Reports Lead, if required).
5. **Patient Information** - See patient leaflets on Trust Website. (In addition, a hardcopy of these leaflets can be provided by the Quality Standards and Reports Lead, if required).
6. **Outcome monitoring-** Please refer to CQUINs Targets in Section Two and see 2013-14 CQUINs Outline (A hardcopy of this CQUINs Outline can be provided by Quality Standards and Reports Lead, if required).
7. **Quality and Development of Staff** - Patient Development Plans (“PDPs”) are managed on an annual cycle with performance reported at end March each year, for implementation over the course of the next year. Updated figure for Q4 in table below.

Quality and Development of Staff - PDPs:			
Number of staff who require a PDP at 31.3.13	Number of staff with a PDP	% of staff with a PDP	
413	346	83.8%	

#### 8. Safety (Children Safeguarding)

Level 1 Safeguarding Training/Adults at Risk Training				
	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	89%	93%	91%	94%
Level 2 Safeguarding Training				
	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	94%	89%	89%	88%
Level 3 Safeguarding Training				
	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	86%	85%	86%	89%



# Board of Directors : April 2014

**Item :** 14

**Title :** Draft 2013/14 Annual Quality Report

## **Summary:**

We are asking the Board to review and provide feedback on the:

- Draft 2013/14 Quality Report

This report has been reviewed by the following Committee:

- **Management Committee 17 April 2014**

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

*(delete where not applicable)*

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

**For :** Discussion

**From :** Quality Standards and Reports Lead

## Draft Quality Report

### 1. Introduction

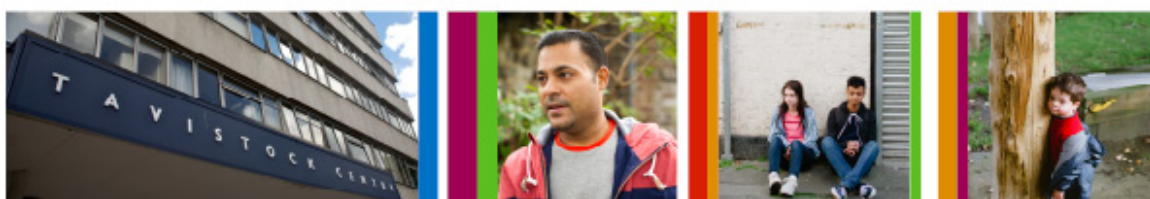
The Board of Directors are asked to review and provide feedback on the following document.

#### 1.1 The Draft Quality Report.

Feedback is invited by email or hardcopy to Justine McCarthy Woods, Quality Standards and Report Lead (JMcCarthyWoods@tavi-port.nhs.uk), by 2<sup>nd</sup> May 2014.

# Quality Report

2013/2014



DRAFT

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## Introduction

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

### Core Purpose

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

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

- Working actively with stakeholders to advance the quality of mental health and mental health care, and to advance awareness of the personal, social and economic benefits associated with psychological therapies.

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## Part 1: Statement on Quality from the Chief Executive

**To be updated in April/May 2014** after Mr Paul Jenkins, new CEO has had the opportunity to review the Draft QR).

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INSERT- CQC (on this page)

(This Insert will be added in May 2014)

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## 1.1. Achievements in Quality

We are proud to report that, in addition to our Quality Priorities, during the year 2013/14 we achieved the following:








- In October 2013 the Psychoanalytic Psychotherapy NOW panel awarded the Innovative Excellence Award to The City and Hackney Primary Care Psychotherapy Consultation Service. This award celebrates a striking example of ground-breaking work.
- At Royal College of Psychiatrists (RCPsych) 2013 award ceremony on 14 November 2013 the City & Hackney Primary Care Psychotherapy Consultation Service was named "Psychiatric Team of the Year, non-age specific". Winning this award was a fantastic achievement for the team, and one that recognised the high-quality of delivery of this service.
- Camden Child and Adolescent Mental Health Services (CAMHS) organised a Name Change Competition where anyone who lived, worked, studied, or volunteered in the Borough of Camden was invited to take part. The winner was selected from the 3 best entries via straw poll with the winning title being "Open Minded".
- In April 2013, the Family Nurse Partnership National Unit (FNP NU) transferred to the Tavistock and Portman NHS Foundation Trust. The Trust was successful in tendering for the FNP NU from the Department of Health, as part of a consortium with the Impetus Trust and Social Research Unit at Dartington (SRU).
- In July 2013 the Barnet Young People's Drug and Alcohol Service (YPDAS) successfully retendered and secured a further three year contract.
- The Tavistock and Portman Psychotherapy Services Project (based at London Red Cross Refugee Support Service), which supports refugees who can face significant challenges in accessing mental health services across London, was named winner in the Innovated Category at the British Red Cross (BRC) Excellence Awards on 22 March 2014. The award for this project delivered in partnership with the BRC is a real achievement and a demonstration of creative partnership working.
- **First Step**, the young Psychological Health Screening and Assessment Service for looked after children and young people in Haringey, held its first conference at the Professional Development Centre in Haringey on 25 October. This provided an opportunity to bring people together from a multi-agency perspective to think and learn together.

- The **Family Drug and Alcohol Court (FDAC)** is a pioneering specialist family court service (initially set up by the Tavistock and Portman NHS Foundation Trust in 2008) and which offers parents an opportunity of recovering from drug or alcohol addiction. During the year, it was agreed that the FDAC is to be extended across the UK following the securing of funding from the Department for Education to extend FDAC to at least two locations across the country.

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## 1.2 Overview of Quality Indicators 2013/14

Target	RAG Status	Achievement	Page Number
<b>Child and Adolescent Mental Health Service Outcome Monitoring Programme</b>			
For 75% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at the Pre-Assessment stage (known as Time 1) and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	Green	79%	
For 75% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).	Orange	72%	
For the CORE outcome measures to be completed by at least 25% of patients over the age of 25, for those patients who have completed their treatment, attending at least one treatment appointment, on or after 1 April 2013 and on or before 31 January 2014.	Green	35%	
<b>Access to Clinical Service and Health Care Information for Patients and Public</b>			
To ensure the Trust has a minimum of 12 published treatment leaflets which will include two leaflets developed by and written for children/young people.	Green	Achieved	
To demonstrate that 90% of mystery shoppers are able to access a leaflet relevant to their needs including young people.	Green	Achieved	
To modify leaflets content and availability in light of feedback from mystery shoppers.	Green	Achieved	
To undertake a telephone survey of a sample of patients offered one of the treatment modalities (for which there is now a new modality leaflet) to ensure patients are aware of the leaflets and to assess satisfaction with the level of information provided in the leaflets to support choice and decision making when treatments are offered.	Green	Achieved	
To audit a random selection of case files to identify if treatment options were documented as discussed.	Green	Achieved	
<b>Patient and Public Involvement</b>			
To have a protocol in place on: i. Payment of service users for participation on interview panels. ii. Selection and training of service users for interviews. iii. Training for staff on including service users on interview panels.	Green	Achieved	

To continue to expand and promote Bid for Better and to target engagement with our younger members.		Achieved
<b>Patient Safety Indicators</b>		
NHS Litigation Authority Level		Level 2 achieved Feb 2011
Patient Safety Incidents	n/a	42
Monitoring of Adult Safeguard Alerts	n/a	0
Safeguarding of Children – Level 1 Training	n/a	96%
Safeguarding of Children – Level 2 Training	n/a	88%
Safeguarding of Children – Level 3 Training	n/a	97%
<b>Clinical Effectiveness Indicators</b>		
Monitor number of staff with PDPs		96%
<b>Patient Experience Indicators</b>		
Complaints received	n/a	12
<b>Patient Satisfaction:</b>		
Percentage of patients that rated the overall help they had received as good:		
Quarter 1*		94%
Quarter 2*		97%
Quarter 3*		93%
<b>Did Not Attend Rate:</b>		
Trust Wide – First Attendances		10.5%
Trust Wide – Subsequent Appointments		8.7%
<b>Waiting Time Breaches:</b>		
Trust Wide – Number of patients waiting for first appointment for 11 or more weeks		TBC
Internal Causes		TBC
External Causes		TBC
Trust Wide – Percentage of patients waiting for first appointment for 11 or more weeks		TBC
Internal Causes		TBC
External Causes		TBC
<b>Other Achievements</b>		
<b>Maintaining a High Quality, Effective Workforce</b>		
Attendance at Trust Wide Induction Days		94%
Completion of Local Induction		97%
Attendance at Mandatory INSET Training		95%

\*<sup>1</sup> The Quarter 4 Experience of Service Questionnaire data was not available to include in this Report, as this data first needs to be presented to the Patient and Public Involvement Committee (PPI), and summary ESQ data to the Clinical Quality, Safety and Governance Committee (CQSG) and the Board of Directors. However, there is no reason to expect that the patient rating for 'the help they had received from the Trust as good' will change significantly in Q4.

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

### 2.1. Priorities for Improvement

#### Progress against 2013/14 Quality Priorities

Looking back, this section describes our progress and achievements against the targets we set for each quality priority for 2013/14.

#### Clinical Effectiveness (Clinical Outcome Monitoring)

As an organisation specialising in psychological therapies, it is very important for us to be able to demonstrate positive changes for patients as a consequence of the psychological intervention and/or treatment they have received from the Trust.

However, unlike treating a physical problem, such as an infection, where one can often see the benefits of medication in a matter of days, change in psychological therapy can be a long process, as for many individuals their difficulties extend back to earlier periods in their life.

In addition, while many individuals who attend psychological therapy will find the therapy helpful and attend and complete their course of treatment, others may find it less helpful. Some will not manage to engage, or may even disengage before the end of treatment. This second group includes people who are progressing and feel that they no longer require treatment. For these reasons, we are aware that we have to develop a longer-term strategy for gathering information to help determine which patients have benefited from therapy and the extent to which they may have changed/progressed, or not progressed, as the case may be.

#### Priority 1: Children and Adolescent Mental Health Service Outcome Monitoring Programme

##### What measure and why?

For our Child and Adolescent Mental Health Services (CAMHS), we have used the Goal-Based Measure again this year. Building on the knowledge we have already gained since 2012, with patients previously referred to CAMHS. The Goal-Based Measure enables us to know what the patient or service user wants to achieve (their goal or aim) and to focus on what is important to them.



As clinicians we wanted to follow this up to know if patients think they have been helped by particular interventions/treatments and to make adjustments to the way we work dependent on this feedback.

As a result, we set the following targets (in the table below), which also represent the CQUIN (see Glossary) targets we had agreed with our commissioners for 2013/14:

For CAMHS, Time 1 refers to the pre-assessment stage, where the patient is given the Goal-Based Measure to complete with their clinician when they are seen for the first time. Then, the patient is asked to complete this form again with their clinician after six months or, if earlier, at the end of therapy/treatment (known as Time 2).

1. Child and Adolescent Mental Health Service Outcome Monitoring Programme			
Targets for 2013/14	2011/12	2012/13	2013/14
1. For 75% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at the Pre-Assessment stage (known as Time 1) and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).*	85%	76%	79%
2. For 75% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).**	Not reported	99%	72%

\*The 2013/14 target was increased to 75%, from 70% in 2012/13.

\*\*The 2013/14 target was increased to achieving an improvement on at least two targets instead of at least one target, the target in 2012/13.

### How have we progressed?

1. We are pleased to report that we exceeded our target, by achieving a return rate of 79% for the Goal-Based Measure for the forms completed by patients/service users, in conjunction with clinicians, at both Time 1 and Time 2.
2. Last year, 99% of patients/service users showed an improvement from Time 1 and Time 2 for one of the goals they had initially agreed with their clinician, so for this reason we agreed with our commissioners to raise the bar for the target for 2013/14. This was achieved in two ways, both by setting a target for an improvement from Time 1 and Time 2 for two of the goals agreed by patients/service users in conjunction with clinicians, in addition to increasing

the percentage of patients/service users we expected to achieve this target. Unfortunately, we fell slightly short of the target of 75%, by achieving 72%. In exploring this with clinicians, it appeared that some patients/service users did not show an improvement in the two goals set at Time 1, as the focus of the work in some cases had to move away from these goals, as other issues and goals took precedence over the course of treatment. For other patients, due to the need for an extended assessment, there were very few "treatment" sessions during which an improvement could be achieved.

## Priority 2: Adult Outcome Monitoring Programme

### What measure and why?

The outcome measure used by the Adult Services the CORE (Clinical Outcomes for Routine Evaluation system, see Glossary) was designed to provide a routine outcome measuring system for psychological therapies. The 34 items of the measure cover four dimensions: subjective well-being, problems/symptoms, life functioning and risk/harm. It is used widely by mental health and psychological therapies services in the UK, and it is sensitive to change. That is, where it is useful for capturing improvements in problems/symptoms over a certain period of time. We think in the future this should enable us to use this data for benchmarking purposes, for providing information on how our improvement rates for adult patients compares with other organisations and services using the CORE.

For the Adult Service, we used the CORE form again for the current year, building on the knowledge we have already gained since 2012, with patients previously referred to the Adult Service. We set the following target, which also represent the CQUIN (see Glossary) target we had agreed with our commissioners for 2013/14:

2. Adult Outcome Monitoring Programme			
Targets for 2013/14	2011/12	2012/13	2013/14
For the CORE outcome measures to be completed by at least 25% of patients over the age of 25, for those patients who have completed their treatment, attending at least one treatment appointment, on or after 1 April 2013 and on or before 31 January 2014.	*	*	35%

\*The 2013/14 and 2012/13 targets were different, therefore cannot be compared.

### How have we progressed?

We are pleased to report that we exceeded our target, by achieving a return rate of 35% for the CORE forms completed and returned by patients/service



users at end of their treatment. By increasing the return rate of the CORE forms from patients/service users, we hope that it will enable us in the future to evaluate the effectiveness of treatment.

### Priority 3: Access to clinical service and health care information for patients and the public

#### What are we measuring and why?

3. Access to Clinical Service and Health Care Information for Patients and Public	
Targets for 2013/14	2013/14
1. To ensure the Trust has a minimum of 12 published treatment leaflets which will include two leaflets developed by and written for children/young people.	1. We have developed 4 modality leaflets this year taking the overall Trust total to 12. The content and design of two of this year's leaflets were developed by children and young people.
2. To demonstrate that 90% of mystery shoppers are able to access a leaflet relevant to their needs including young people.	2. Mystery shoppers who rated the readability and availability of our leaflets were able to access information relevant to their needs.
3. To modify leaflets content and availability in light of feedback from mystery shoppers.	3. The language and content has been changed in the modality leaflets, where applicable, in response to feedback from mystery shoppers.
4. To undertake a telephone survey of a sample of patients offered one of the treatment modalities (for which there is now a new modality leaflet) to ensure patients are aware of the leaflets and to assess satisfaction with the level of information provided in the leaflets to support choice and decision making when treatments are offered.	4. We decided not to undertake a telephone survey this year. Instead patients were asked a range of questions about the modality leaflets on the monthly membership stand days.
5. To audit a random selection of case files to identify if treatment options were documented as discussed.	5. A random selection on case files was audited and the findings indicated that more than half of all files had a note about treatment options.

We set the following targets for 2013/14:

### Target 1

To ensure the Trust has a minimum of 12 published treatment leaflets which will include two leaflets developed by and written for children/young people.

### Measure Overview

Our Quality Priority targets for the previous two years (2010/11 and 2011/12) have seen us develop eight patient information leaflets for the following treatment modalities (in this case psychological therapy): Child Psychotherapy, Family/Systemic Therapy, Psychoanalytic Psychotherapy, Cognitive Behavioural Therapy, Group Therapy, Eye Movement Desensitization and Reprocessing, Working with Couples, and Working with Parents. This year we set ourselves a target to develop a further four leaflets in the series. These targets were developed in response to patient feedback and information gathered from various sources including the Experience of Service Questionnaire, visual straw poll, feedback to the Patient Advice and Liaison Service, complaints, the comments book, and the Children's Survey, with the request for accessible information on the availability, process and possible side effects of the different modalities that we offer. The feedback also indicated that patients wanted more readily-available information about our different treatment modalities to enable them to be involved in the decisions about their care and treatment.

### How have we progressed?

This target was achieved. We now have an additional four leaflets on the following four areas: Dynamic Interpersonal Therapy, Mentalisation Based Therapy, Child Psychotherapy: Information for Children, and Family Therapy: Information for Children. Children and young people contributed to two of these leaflets through a survey run in the waiting rooms to gather their advice and ideas for the content and overall design of the leaflets. All leaflets have been agreed by the Patient and Public Involvement (PPI) Committee, where patient representatives and governors have been part of the review process.

### Target 2

To demonstrate that 90% of mystery shoppers are able to access a leaflet relevant to their needs including young people.

## Measure Overview

Feedback gathered from last year's mystery shop (2012/2013), as well as the Experience of Service Questionnaire, the Patient Advice and Liaison Service, telephone surveys, the visual straw poll and complaints, indicated that we need to continue to produce information that is relevant and easily accessible to those who might need it. To demonstrate the accessibility and readability of the information we produce, mystery shoppers were invited to comment on the information provided in the waiting areas.

### How have we progressed?

This target was achieved. A mystery shop was run in August 2013 where the mystery shoppers were able to access the leaflets. Of the six mystery shoppers, five commented on how these leaflets were organised and that more general leaflets would have been helpful.

### Target 3

To modify leaflets content and availability in light of feedback from mystery shoppers.

## Measure Overview

Last year (2012/2013) two mystery shops were conducted to review the availability and accessibility to our patient information including the five modality leaflets in circulation at that time. The information gathered from the mystery shoppers was used to make changes to the physical and electronic location of the information as well as the content of the leaflets, where appropriate. This year mystery shoppers rated and were asked to comment on the content and ease of access to the information in the waiting areas in order to ensure we continue to address issues raised concerning the readability and usefulness of the patient leaflets.

### How have we progressed?

This target was achieved. The mystery shoppers did not comment specifically on the content of the leaflets, however one did request a more general information leaflet, so we have introduced the general leaflet on mental health from MIND. The PPI Committee has raised some questions about the content of the leaflets and all the patient leaflets are currently undergoing a revision. Feedback to the Experience of Service Questionnaire regarding information has been taken into account as part of this work.

## Target 4

To undertake a telephone survey of a sample of patients offered one of the treatment modalities (for which there is now a new modality leaflet) to ensure patients are aware of the leaflets and to assess satisfaction with the level of information provided in the leaflets to support choice and decision making when treatments are offered.

### Measure Overview

Two telephone surveys were undertaken in the previous year (2012/2013) to determine how many patients or potential patients had seen the information on the different treatment modalities offered at the Trust. The results indicated that very few had seen the modality leaflets and as such it was not possible to assess whether the availability of patient information had supported patient choice. This year we committed to contacting patients by telephone or in person to ascertain whether more patients were aware of the leaflets this year than in the previous year.

### How have we progressed?

This target was achieved. Following our telephone survey, where patients commented that they were not sure and that they would have liked to have seen the leaflets to be able to comment we decided that, based on patient feedback, a face to face survey with the leaflets present would be more helpful. We introduced a 'membership stand'. This was run during the year on five occasions in our reception area, and it was felt that this was a forum that would be a more effective way to talk to patients about the leaflets. Over 20 patients have visited the membership stand during the year, and of these about 50% have been aware of the leaflets.

## Target 5

To audit a random selection of case files to identify if treatment options were documented as discussed.

### Measure Overview

To improve the process for consent for treatment, two case file audits were undertaken in the previous year (2012/2013) to ascertain whether treatment options were documented as discussed. These audits found that whilst the section on consent was being completed on the assessment form, only a small number of files included a narrative on treatment options being discussed.

This year the case file audit was repeated to see if discussions about the treatment options available to patients were recorded.

### How have we progressed?

This target was achieved. This audit took place during September 2013. Thirty files from the Adult services and 30 from the Children services were randomly selected. Fifty eight percent of the CAMHS files had a note about treatment options and 53% of the Adult files had this note present. This finding has been fed back to the executives of both directorates for action.

## Priority 4: Patient and Public Involvement

4. Patient and Public Involvement	
Targets for 2013/14	2013/14
1. To have a protocol in place on: i. Payment of service users for participation on interview panels. ii. Selection and training of service users for interviews. iii. Training for staff on including service users on interview panels.	1. We have developed a protocol for the payment of service users on interview panels. This same protocol includes guidance on the selection and training of service users on interview panels.
2. To continue to expand and promote Bid for Better and to target engagement with our younger members.	2. Bid for Better was expanded to encourage young people to participate.

We set the following targets for 2013/14:

### Target 1

To demonstrate that issues raised at the stakeholder quality meetings held in 2013/14 have been taken forward by the Trust and result in quality improvements. Issues to be taken forward in 2013/14:

To have a protocol in place on:

- i) Payment of service users for participation on interview panels
- ii) Selection and training of service users for interviews
- iii) Training for staff on including service users on interview panels.

## Measure Overview

Last year (2012/13) Camden CAMHS was set a Quality target to increase user input into staff interviews. Following a series of focus groups with parents, carers and young people, service user questions were introduced into the interview packs for CAMHS posts as an interim measure whilst a formal structure to involve parents, carers and young people on interview panels was developed. At the same time, the PPI Committee agreed to the development of a similar structure for adult service users to be involved in the recruitment and selection processes for staff appointments with patient contact.

### How have we progressed?

This target was achieved. We have a protocol in place that covers the first two areas above. We have developed the outline for the staff training programme in relation to including service users on panels.

## Target 2

To continue to expand and promote Bid for Better and to target engagement with our younger members in 2013/14.

## Measure Overview

The Bid for Better membership engagement scheme has been funding ideas from members, staff and community groups for the past three years. Last year (2011/12) the PPI Committee agreed to expand the scheme to encourage ideas from children and young people to improve the patient experience, promote mental wellbeing and make our services more accessible.

### How have we progressed?

This target was achieved. We launched the 2014 Bid for Better scheme in January 2014, with advertising and age appropriate 'friendly' forms in our children's services. The funding scheme was also advertised through Young Minds and other community organisations with a focus on the mental health of children and young people.



## Quality Priorities for 2014/15

In looking forward and setting our goals for next year, our choice of quality priorities for 2014/15 has been based on wide consultation with a range of stakeholders over the last year. We have chosen those priorities which reflect the main messages from these consultations, focussing on measurable outcomes from our interventions, increasing access to health care information, specifically ensuring that information on patient stories is included on our website and finding novel and effective ways of increasing patient and public involvement in our service delivery, by including service users on interview panels.

Camden CCG (Clinical Commissioning Group, see Glossary) and our clinical commissioners from other boroughs have played a key role in determining our priorities through review of the 2013/14 targets and detailed discussion to agree CQUIN targets for 2014/15.

Our Stakeholders Quality Group has been actively and effectively involved in providing consultation on clinical quality priorities and indicators. This group includes patient, governor and non-executive director representatives along with the Patient and Public Involvement (PPI) Lead, Quality Reports and Standards Lead and the Trust Director. In addition, this year Camden Healthwatch has made a useful contribution to this process.

### Clinical Effectiveness (Clinical Outcome Monitoring)

This section will be updated once the 2014/15 CQUINs have been confirmed.

#### Priority 1: Children and Adolescent Mental Health Service (CAMHS) Outcome Monitoring Programme

We have set the following targets, which also represent the CQUIN (see Glossary) targets we have agreed with our commissioners for 2014/15:

Insert new target for 2014/15 once agreed.

#### Measure Overview

Update for new target for 2014/15 once agreed.

#### Monitoring our Progress

During 2013 all staff were trained on entering the clinician measures directly onto the Outcome Monitoring Tracking System (OMTS) This has allowed

clinicians to take more control over their outcome monitoring data collection and so enabled better collection of outcomes data which is both clinically important and crucial for providing evidence to our commissioners. The system that we now use identifies when patients and clinicians are due to be issued with outcome monitoring forms and provides a clear way to record and track when these forms have been completed.

We will plan to monitor our progress towards achieving our outcome monitoring targets on a quarterly basis, providing reports to the Clinical, Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Lead for Outcome Monitoring in the CAMHS will ensure that action plans are in place when expected levels of assurance are not achieved.

### **Priority 2: Adult Outcome Monitoring Programme**

We have set the following target for 2014/15, which also represents the CQUIN (see Glossary) target we have agreed with our commissioners.

**Insert new target for 2014/15 once agreed.**

### **Measure Overview**

**Update for new target for 2014/15 once agreed.**

### **Monitoring our Progress**

During 2013 all staff were trained on entering the clinician measures directly onto the Outcome Monitoring Tracking System (OMTS) This has allowed clinicians to take more control over their outcome monitoring data collection and so enabled better collection of outcomes data which is both clinically important and crucial for providing evidence to our commissioners. The system that we now use identifies when patients and clinicians are due to be issued with outcome monitoring forms and provides a clear way to record and track when these forms have been completed.

We will plan to monitor our progress towards achieving these targets on a quarterly basis, providing reports to the Clinical, Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Lead for Outcome Monitoring in SAAMHS (see glossary) will ensure that action plans are in place when expected levels of assurance are not achieved.



### Priority 3: Access to clinical services and health care information for patients and public

We have set the following targets for 2014/15:

1. To ensure that information from the patient story is on the patient section of the website.
2. To run a visual straw poll on awareness of the patient stories.
3. Based on the feedback from the visual straw poll, to revise the communications campaign to publicise patient stories if necessary.

#### Target 1

To ensure that information from the patient story is on the patient section of the website.

##### Measure Overview

A patient's stories section is created on the website, where video and written transcripts will be available.

##### How we will collect the data for this target

The evidence will be a link to the patient story on the relevant pages of the patient section of the website.

#### Target 2

To run a visual straw poll on awareness of the patient stories.

##### Measure Overview

As part of our review of how we communicate with patients we will assess the level of knowledge about this initiative through the visual straw poll.

##### How we will collect the data for this target

Evidence will be the visual straw poll results.

#### Target 3

Based on the feedback from the visual straw poll, to revise the communications campaign to publicise patient stories if necessary.

## Measure Overview

In order to ensure the patients' stories are accessible, we will review the communications strategy around this initiative if the visual straw poll indicates this is necessary.

## How we will collect the data for this target

The evidence will be our communications strategy around patients' stories.

## Monitoring our Progress

We plan to monitor our progress towards achieving this target on a quarterly basis, providing reports to the Patient and Public Involvement Committee; Clinical, Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Patient and Public Involvement Lead will ensure that action plans are in place when expected levels of assurance are not achieved.

## Priority 4: Patient and Public Involvement

We have set the following measures and targets to monitor our performance during 2014/15:

1. To run at least two staff trainings on having services users on panels.
2. To have at least three interviews with service users on the panel.
3. To take a minimum of three real patient stories to the trust board in one of the following ways: a patient visiting the board, the board seeing a video or a transcript of the description of the journey.

## Target 1

To run at least two staff trainings on having services users on panels.

## Measure Overview

In order to ensure that both staff and patients can work effectively together we will have at least two training events for staff and users on recruitment.

## How we will collect the data for this target

The data will be reports of the events and action plans that come out of the trainings.

## Target 2

To have at least three interviews with service users on the panel.

### Measure Overview

We are committed to including service users on panels on at least three interview panels.

### How we will collect the data for this target

The evidence will be the panel staffing lists for the interviews. Service users will be asked to complete a brief questionnaire about their experience on the appointment process.

### Target 3

To take a minimum of three real patient stories to the trust board in one of the following ways: a patient visiting the board, the board seeing a video or a transcript of the description of the journey.

### Measure Overview

That at least three Trust Board meetings hear directly about patient experience, either from a patient visiting the board, the board seeing a video of the Patient's experience or are given a transcript of the patients' story.

### How we will collect the data for this target

Data will be the relevant trust board minutes.

### Monitoring our Progress

We plan to monitor our progress towards achieving these targets on a quarterly basis, providing reports to the Patient and Public Involvement Committee; Clinical, Safety and Governance Committee, the Board of Directors, Camden CCG and our clinical commissioners from other boroughs. The Patient and Public Involvement Lead ensure that action plans are in place when expected levels of assurance are not achieved.

# OMTS Outcome Monitoring Tracking System (OMTS)



## What is the project?

This was a Trust Wide project to train all appropriate clinical and admin staff on a new Outcome Monitoring Tracking System (OMTS). This enables clinicians to reliably monitor their patient's improvements overtime on measures such as the CORE (Clinical Outcomes in Routine Evaluation) and the GBM (Goal Based Measure).

The system has been developed by the Informatics to meet the individual needs of the different teams and services across the Trust who, together with the Clinical Governance team have worked to train and support all staff in learning these processes and ensuring that the system is user friendly. The OMTS has helped unite the Trust in a more cohesive structure and also engaged staff with outcome monitoring.

## Outcomes

In 2013 all staff were trained on entering the clinician measures directly onto the OMTS. This project has enabled better collection of outcomes data which is both clinically important and important in providing evidence to commissioners and allowed clinicians to take more control over their outcome monitoring data collection. This process change has improved data accuracy by cutting out multiple stages within the data entry procedure. It also gives clinicians an instant overview of their patient's information as recorded on RiO.

## Quotes from staff to the question - What features do you like most?

“ Having a warning when patients are high risk” (CORE risk graphs). ”

“ It seems to be very easy to use and to get information all in one place. ”

“ Helpful way in which system can help clinician manage caseload in the context of OM. Makes simple what can seem like a difficult and complicate task of understanding forms and when they should be given. Gives a clinical context of OM. ”

“ The tracking system is very easy to use, keeps me in touch with my outcome monitoring at the flick of a switch I can see where I am with each patient, and has hugely improved my confidence and compliance with the outcome monitoring system. ”

## 2.2 Statements of Assurance from the Board

*For this section (2.2) of the Report the information is provided in the format stipulated in the Annual Reporting Manual 2013/14 (Monitor).*

During 2013/14 The Tavistock and Portman NHS Foundation Trust provided and/or sub-contracted six relevant health services.

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

The income generated by the relevant health services reviewed in 2013/14 represents (% will be inserted at financial year end) of the total income generated from the provision of relevant health services by The Tavistock and Portman NHS Foundation Trust for 2013/14.

### Participation in Clinical Audits and National Confidential Enquiries (To be updated further)

During 2013/14 1 national clinical audit and 2 national confidential enquiries covered relevant health services that The Tavistock and Portman NHS Foundation Trust provides.

During 2013/14, The Tavistock and Portman NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust was eligible to participate in during 2013/14 are as follows:

- National Audit into Psychological Therapies
- Confidential inquiry into Homicide and Suicide

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust participated in during 2013/14 are as follows:

- National Audit into Psychological Therapies
- Confidential Inquiry into Homicide and Suicide

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Confidential inquiry into Homicide and Suicide we responded to one request for a review report of an adult male who had taken his life. The male had been seen at the Trust.

The reports of 2 national clinical audits were reviewed by The Tavistock and Portman NHS Foundation Trust in 2013/14 and The Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. There are no specific actions arising from the Confidential inquiry into Suicide as we submitted a case report only.

The reports of 8 local clinical audits were reviewed by The Tavistock and Portman NHS Foundation Trust in 2013/14 and The Tavistock and Portman NHS Foundation Trust has plans in place to improve care as a result of the learning from these audits;

Actions include:

- improvement in record keeping, data fed back for local discussion and understanding
- further work to set base line standards for intensive/once a week therapy in adult services
- further work to gather base line information on cases which receive 'intermittent' therapy
- establish a system for case review and action on dormant cases
- reaudit of record keeping scheduled to monitor effectiveness of action plan
- improve data accuracy in clinical record re attendance/DNA
- teaching on consent to improve understanding and record keeping about consent for treatment
- changes to the assessment form to improve accuracy of data included in some sections eg 'Formulation' section

## Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by The Tavistock and Portman NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 787.



## The use of the CQUIN Framework

A proportion of The Tavistock and Portman NHS Foundation Trust income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between The Tavistock and Portman NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at: **Tbc by May 2014**

The total financial value for the 2013/14 CQUINs was £ **tbc by May 2014** and The Tavistock and Portman NHS Foundation Trust expects to receive £ **tbc by May 2014**

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

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

The **Care Quality Commission** has not taken enforcement action against The Tavistock and Portman NHS Foundation Trust during 2013/14.

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

(The Trust was inspected by the CQC in March 2014. The trust has received informal feedback that the CQC found us to be fully compliant with all standards. The Trust is awaiting the publication of the formal report on the CQC website. **tbc**)

## Information on the Quality of Data

The Tavistock and Portman NHS Foundation Trust did not submit records during 2013/14 to the Secondary Users service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This is because The Tavistock and Portman NHS Foundation Trust is not a Consultant-led, nor an in-patient service.

The Tavistock and Portman NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was **X%** and was graded **RAG (tbc)**.

The Tavistock and Portman NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission.

Due to the nature of the services provided the Trust does not undertake clinical coding of the services/treatments it provides.

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

To be updated by April 2014

### 2.3 Reporting against core indicators - TBC



## Part 3: Other Information

This section contains information relevant to the quality of relevant health services provided or sub-contracted by The Tavistock and Portman NHS Foundation Trust during 2013/14 based on performance in 2013/14 against indicators selected by the Board in consultation with stakeholders.

### 3.1 Quality of Care Overview: Performance against selected indicators

This includes an overview of the quality of care offered by the Trust based on our performance on a number of quality indicators within the three quality domains of patient safety, clinical effectiveness and patient experience. Where possible, we have included historical data demonstrating how we have performed at different times and also, where available, included benchmark data so we can show how we have performed in relation to other trusts. These indicators include those reported in the 2011/12 and 2012/13 Quality Reports along with metrics that reflect our quality priorities for 2013/14. In this section, we have highlighted other indicators outside of our quality priorities that the Trust is keen to monitor and improve.

The Trust Board, the CQSG, along with Camden CCG and our clinical commissioners from other boroughs have played a key role in monitoring our performance on these key quality indicators during 2013/14.

#### Patient Safety Indicators

##### NHS Litigation Authority Level

Indicator	2011/12	2012/13	2013/14
NHS litigation Authority Level		Level 2 achieved (Feb 2011)	

##### What are we measuring?

To ensure we are promoting patient safety the NHS Litigation Authority monitors the Trust on various aspects of risk management.

There are 50 standards to achieve covering the categories of governance, workforce, safe environment, clinical and learning from experience. Level 1 assesses that the policies around each standard are in place, level 2 ensures

that processes around each policy are in place and level 3 ensures compliance with both the policies and processes for each of the individual standards.

In February 2011, the NHS Litigation Authority awarded the Trust a Level 2 for demonstrating compliance with its policies and procedures covering all aspects of risk management. The NHS Litigation Authority have now abolished its risk assessment from 2013/14 and no further scores will be awarded. Therefore the Trust retains its' level 2 compliance level.

### Patient Safety Incidents

Indicator	2011/12	2012/13	2013/14
Patient Safety Incidents	69	30	42

### What are we measuring?

The Trust monitors all incidents that compromise patient safety, which we also report to the NHS database National Reporting and Learning System.

The Trust has a low 'patient safety incident' rate due to the nature of its patient services, and all 42 incidents reported in 2013/14 were in the "no harm/low harm" category, and were therefore rated as suitable for no further action or for local review only.

Most of the reportable incidents relate to incidents of pupil behaviour which occurred in the Trust's Specialist Children's Day Unit, which is a school for children with emotional difficulties and challenging behaviour.

In 2013/14 one incident, which was reported centrally to NHS England (Patient Safety Team) triggered an investigation under the Trust's serious investigation procedure. This was of the suicide of a former patient who had been seen by the trust in the 6 months prior to his death. A full investigation was carried out and a report submitted to NHS England (Patient Safety Team). The report concluded that this death was neither predictable nor preventable. The incident has been closed by the national team and the trust is currently considering wider lessons that can be learned from the case.

We have robust processes in place to capture incidents, and staff are reminded of the importance of incident reporting at induction and mandatory training. However, there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on staff making the effort to report (often for this trust very minor events. Whilst we continue to provide training to staff and there are various policies in place relating to incident reporting, this does not provide full

assurance that all incidents are reported. We believe this is in line with all other Trusts.

### Monitoring of Adult Safeguards

Indicator	2011/12	2012/13	2013/14
Monitoring of Adult Safeguard Alerts	2	0	0

#### What are we measuring?

This measures the safeguarding of adults at risk, by identifying and reporting to Social Services under the 'Adults at Risk Policy', adults who are identified by the Trust as being at risk of physical or psychological abuse, and in need of input from Social Services. The importance of identifying these individuals is continually highlighted to staff in the Trust through the implementation of various education and awareness initiatives, including mandatory training provided at the Trust In-Service Education and Training day and team meeting presentations, which promote the Trust's policy and procedure for Safeguarding Adults.

In 2013/14, no adult safeguarding referrals were made.

### Attendance at Trust-wide Induction Days

Indicator	2011/12	2012/13	2013/14
Attendance at Trust Wide Induction Days	89%	77%	94%

#### Measure Overview

This measure monitors staff attendance at mandatory Trust-wide induction, which all new staff are required to attend, when they first join the Trust. The Trust schedules this induction event on a rolling basis to new staff at least three times a year. As part of this Induction, staff are provided with an introduction to the work of the Trust and introduction to the Trust's approach to risk management and incident reporting; health and safety; infection control, confidentiality and information governance; Caldicott principles; safeguarding of children and counter fraud awareness, to ensure that all new staff are able to provide a safe and good quality service to service users.

### Targets and Achievements

We are very pleased to report that 94% of staff joining the Trust in 2013/14 attended the Trust-wide induction.

We will continue to monitor the attendance at mandatory training events, and aim to maintain a high level of attendance.

### Local Induction

Indicator	2011/12	2012/13	2013/14
Completion of Local Induction	98%	95%	97%

### Measure Overview

The Trust provides all new staff with a local induction checklist in their first week of employment. This checklist needs to be completed within two weeks of commencing employment with line managers and a copy returned to Human Resources. This checklist is required by Human Resources to verify that the new staff member has completed their local induction.

This measure monitors the completion and return of the local induction checklist by new staff. The local induction process covers all local policies and procedures in place in individual service areas/directorates and ensures new staff are aware of all terms and conditions of employment, mandatory training requirements and arrangements in place locally that impact on working arrangements within the Trust.

### Targets and Achievements

It is important that all new staff undertake a local induction with the appropriate manager, in order to ensure that staff are aware of policies and procedures that apply locally within their service area/directorate, and so that staff newly recruited to the Trust are able to provide a relevant, safe and good quality service to patients.

We are very pleased to report that we received 97% returned forms to show that the local induction had been completed by almost all of staff joining the Trust in 2013/14.

### Attendance at Mandatory INSET Training

Indicator	2011/12	2012/13	2013/14
Attendance at Mandatory INSET Training	92%	93%	95%

Staff are expected to attend training every two years. In order to achieve this 100% attendance is expected over a two year period. Therefore, the figure reported shows the % of staff up to date with mandatory training at 31 March 2014.

## Measure Overview

This measure monitors staff attendance at mandatory training. The Trust provides the main mandatory training through an In-Service Education and Training (INSET) day, which all staff are required to attend once every two years. During this training day, staff receive training updates in risk management and assessment, health and safety, infection control, confidentiality, equality and diversity, information governance, safeguarding children and adults and fire safety.

## Targets and Achievements

It is important that staff remain up to date with developments in each of these areas, to ensure that they are able to provide a safe and good quality service to service users.

Again, we are very pleased to report that 95% of our staff who were required to attend INSET training had done so within the previous two years.

## Safeguarding of Children

Indicator	2011/12	2012/13	2013/14
Safeguarding of Children – Level 1 Training	*	*	96%
Safeguarding of Children – Level 2 Training	**	**	88%
Safeguarding of Children – Level 3 Training	86%	82%	97%

\*All staff receive level 1 training as part of mandatory INSET training.

\*\* Not reported.

## What are we measuring?

All staff receive Level 1 training as part of mandatory INSET training and must complete this training every 2 years.

All clinical staff who are not in contact with children and young people and do not fulfil requirement for level 3 are required to attend Level 2 training. This training must be completed every 3 years.

To ensure that as a Trust we are protecting children who may be at risk from abuse or neglect, the Trust has made it mandatory for all clinical staff in Child and Adolescent services and other clinical services working predominantly with children, young people and parents to receive Level 3 Safeguarding of Children training three yearly.

## Targets and Achievements

By March 2014, 96% of staff received Level 1 training and 88% of staff attended Level 2 training.

We are particularly pleased to report that 97% of staff requiring Level 3 training had attended this training, which is a significant improvement on the attendance level in 2012/13.

The Management Committee have approved a system of sanctions for any staff who persistently fail to attend mandatory training.

## Staff Survey

### Introduction

The Staff Survey is completed by staff annually and took place between October and December 2013. The Trust's results from this year's survey are good once again and indicate that staff still consider the Trust to be a good employer.

### Summary of Performance

The overall survey results, have also improved with a number of key areas showing marked improvements, when compared with 2012 results. Out of a total of 28 key findings this year, the Trust was rated as being in the highest/best category in 14 areas (compared to 10 areas in 2012) and rated as better than average in 5 areas and average in only 1 area. Overall the trust had good scores in 20 areas compared with 17 in 2012.

(A copy of the 2013 National NHS staff survey for The Tavistock and Portman NHS Foundation Trust is available at

[http://www.nhsstaffsurveys.com/Caches/Files/NHS\\_staff\\_survey\\_2013\\_RNK\\_full.pdf](http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2013_RNK_full.pdf) )

Some of the areas where the trust received the best scores include:

- The percentage of staff reporting good communication between senior management and staff.
- The percentage of staff witnessing potentially harmful errors, near misses or incidents in last month.
- The percentage experiencing harassment, bullying and abuse from patients and public.
- The percentage of staff feeling pressure to attend work while feeling unwell.



- Staff job satisfaction.

There are, however, a number of areas where the trust still needs to improve, some of which are highlighted below:

- *The higher than average percentage of staff indicating that they are working extra hours.* (We believe that this is linked with the very positive score we received for staff satisfaction. Notwithstanding this, work has been undertaken to improve the Trust's job planning process which forms part of the annual appraisal process. Going forward, it is hoped that with effective job planning, staff can work together with managers to ensure that they are making effective use of their working time and so reduce the number of staff who work extra hours.)
- *The percentage reporting errors, near misses and incidents.* (It is important to note when considering this indicator that due to the nature of the work of the Trust our overall incident rate is very low. when compared to other mental health trusts.)
- *The percentage of staff receiving health and safety and equality and diversity training.* (The Staff Survey includes questions about annual training in this area. However, as the Trust provides refresher training for all staff every two years, it means that performance against this indicator for the Staff Survey is low (compared to other trusts). Nonetheless, the Trust will consider whether the risks it experiences require the Trust either to increase the frequency of training or to consider alternative methods of ensuring staff receive updates in this area. Equality and diversity training is offered to staff throughout the year, in addition to the mandatory Induction and INSET day training.
- *And the percentage of staff appraised in the last 12 months.* (While our records show that in 2012/13 just over 86% of staff had an appraisal, this year in 2013/14 we have been able to improve on this, with 96% of staff having completed their appraisal by the March 31st deadline.)

## Infection Control

Due to the types of treatment offered (talking therapies) this Trust is at very low risk of cross infection. All public areas are cleaned to a high standard by internal cleaning staff. Toilets and washrooms are stocked with soap and paper towels and we have alcohol hand gel available for staff and public use in public areas of the Trust (for example, at the entrance to the lifts in the Tavistock Centre. The Trust organised onsite access to flu vaccination for staff

in the autumn of 2013. Update on personal responsibility for reducing the risk of cross infection is raised at induction and biennial INSET training.

No reports of infection incidents or inoculation injuries have been reported/received in 2013/14.

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## Clinical Effectiveness Indicators

### Monitor Number of Staff with Personal Development Plans

Indicator	2011/12	2012/13	2013/14
Monitor number of staff with Personal Development Plans	85%	84%	96%

#### What are we measuring?

Through appraisal and the agreement of Personal Development Plans (PDP) we aim to support our staff to maintain and develop their skills. It also provides an opportunity for staff and their managers to identify ways for the staff member to develop new skills, so as to enable them to take on new roles within the organisation, as appropriate. A Personal Development Plan also provides evidence that an appraisal has taken place. In addition, the information gathered from this process helps to highlight staff requirements for training and is used to plan the Trust Staff Training Programme for the up-coming year.

The data collection period for Personal Development Plans takes place from January to March each year. However, it is important to note, that the staff group who have not completed a PDP include those staff who are on a career break or sick leave, new starters, or those who have not submitted their PDPs by the Trust deadline.

#### Targets and Achievements

We are very pleased to report that 96% of staff had attended an appraisal meeting with their manager and agreed and completed a PDP for the upcoming year by the March 31<sup>st</sup> deadline, which is a significant improvement on the performance for this indicator in 2012/13.

#### Range of Psychological Therapies

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

Over the last year we have continued to strengthen our capacity to offer a range of interventions through a staff training and supervision programme. Over the last year staff have been supported to train in VIPP (Video Interaction to Promote Positive Parenting). A group of staff from across the Trust have been developing

their skills in mindfulness based interventions and are now providing colleagues with opportunities to learn about this approach. We have continued to support training in Interpersonal Therapy (IPT) through which a number of staff across the Trust have completed practitioner level training and a smaller number have achieved supervisor status. We continue to offer specialist supervision and training in Cognitive Behaviour Therapy (CBT) for CAMHS staff and specialist supervision and training for CBT for Post Traumatic Stress Disorder for the adult and adolescent trauma service. An increasing number of staff have been trained in Eye Movement Desensitisation and Reprocessing (EMDR) for children with Post Traumatic Stress Disorders. We plan to offer training in EMDR for those working with over 18s in the coming year in response to increased identified need for this form of intervention. In addition, a group of staff have been trained in Dynamic Interpersonal Therapy (DIT), now recognised as an approved treatment within the Improving Access to Psychological Therapies Programme. This innovative therapy was developed by a member of our staff in partnership with colleagues at the Anna Freud Centre, London. Further applications of the model are in development such as a version adapted for adolescents and young adults. We continue to develop our work in a range of other models including, Family and Schools Together (FAST), Relationship Development Intervention (RDI) and Mentalisation Based Therapy (MBT).

Our priority for the coming year is to continue to train staff to increase their capacity to identify treatment choices, including a range of psychological therapies, for patients and to present the range of treatment options clearly so that patients are confident that they have been offered choices where appropriate. Patient choice is supported by increasing the range of leaflets describing treatment modalities on offer. We continue to add to our range of leaflets (available as hard copies and electronically) as we broaden our range of interventions.

## **Clinical Outcome Monitoring**

### **Outcome Monitoring – Child and Adolescent Mental Health Service (CAMHS)**

See Part 2.1 (Priority 1).

### **Outcome Monitoring – Adult Service**

See Part 2.1 (Priority 2).

### **Outcome Monitoring – Portman Clinic**

Please go to [weblink tbc May 2014](#) to review the Portman targets and achievements for 2013/14.

## Patient Experience Indicators

### Complaints Received

Indicator	2011/12	2012/13	2013/14
Complaints received	9	16	12

#### What are we measuring?

During 2013/14 the Trust received 12 formal complaints, fewer than the Trust received the previous year. All the complaints related to aspects of clinical case, we received no complaints about our environment, general communication, car parking or other aspects of the non clinical experience of our patients.

All the complaints were investigated under the Trust complaints procedure and a letter of response sent by the Chief Executive to the complainant.

During the year no new complaints were submitted to MH Ombudsman, but one old complaint remains open at his office.

We endeavor to learn from each and every complaint, regardless of whether it is upheld or not. In particular, each complaint gives us some better understanding of the experience of our services for service users, a critical contribution to all of our service development.

During the year we have continued to make efforts to improve communication with and information for patients. We have also run discussion seminars with clinical staff about letters to GPs as this has been featured in complaints received.

### Patient Satisfaction

Indicator	Q1	Q2	Q3	Q4 <sup>1</sup>
Patient rating of help received as good	94%	97%	93%	

The Trust has formally been exempted from the NHS National Mental Health Survey which is targeted at patients who have received inpatient care. For eleven years, up until 2011 we conducted our own annual patient survey which incorporated relevant questions from the national survey and questions developed by patients. However the return rate for questionnaires was very low and therefore in 2011 the Trust discontinued using its own survey and started to

<sup>1</sup> The Quarter 4 Experience of Service Questionnaire data was not available to include in this Report, as this data first needs to be presented to the Patient and Public Involvement Committee (PPI), and summary ESQ data to the Clinical Quality, Safety and Governance Committee (CQSG) and the Board of Directors. However, there is no reason to expect that the patient rating for 'the help they had received from the Trust as good' will change significantly in Q4.

use feedback received from the Experience of Service Questionnaire (CHI-ESQ) to report on the quality of the patient experience on a quarterly basis. The ESQ was chosen because it was already being used as a core part of the Trust's outcome monitoring, and so we anticipated obtaining reasonable return rates to enable us to meaningfully interpret the feedback. We took the standard ESQ form and added some additional questions.

### Targets and Achievements

Results from the Experience of Service Questionnaire found that 94% of patients in Quarter 1 (April to June 2013), 97% of patients in Quarter 2 (July to September 2013) and 93% of patients in Quarter 3 (October to December 2013) rated the help they had received from the Trust as good.

Compared to other trusts using the Patient Survey, our results reveal a consistently high level of patient satisfaction with our Trust's facilities and services. This includes clinical services and staff along with reception and security staff and anyone else whom the patient has interacted with during their visit.

However, feedback from patients has provided us with an understanding of areas we need to work to improve for the year ahead and we are working closely with the clinical directorates to improve patient choice and the involvement of patients in decisions about their care and treatment, and patient satisfaction with the verbal explanation and/or the content of the written information about the help available at the Trust.



## What is the Service?

This is a confidential and non-judgemental service for any young person with worries that are affecting their emotional well-being. Young people can receive free counselling from our staff who have expertise in adolescent mental health, which can help them get a clearer idea of their problem.

## Who is the service for?

YPCS sees young people aged 16-30 years, who have a personal or emotional problem. These might include problems in relationships with family, friends or partners, or there may be difficulties at school, college or work.

The YPCS is open to young people regardless of class, culture, ethnicity, sexuality and whether or not they are physically disabled.

## Outcomes

Since April 2013 15 patients have completed the new SAAMHS ESQ (Experience of Service Questionnaire). 100% responded 'certainly true' to the questions 'I feel that the people who saw me listened to me' 'I was treated well by the people who saw me' and 'My appointments are usually at a convenient time'. 93% responded 'certainly true' to the question 'I feel the people here know how to help me'.

“ Free and easy to access.  
Counsellor was friendly  
and helpful. ”

“ The counselling  
was extraordinarily  
insightful and non-  
judgmental. ”

“ I really needed to  
talk and was able  
to do so. ”

“ It made me feel very  
comfortable and at ease  
and I was able to open  
up easily. ”



## Did Not Attend Rates (2,3,4,5)

Indicator	2011/12	2012/13	2013/14
<b>Trust Wide</b>			
First Attendance	11.4%	9.6%	10.5%
Subsequent Appointments	10.7%	8.9%	8.7%
<b>Adolescent</b>			
First Attendance	13.1%	9.5%	7.7%
Subsequent Appointments	14.1%	13.7%	14.3%
<b>Adult</b>			
First Attendance	11.1%	7.3%	7.5%
Subsequent Appointments	9.1%	7.6%	9.1%
<b>Camden Child and Adolescent Mental Health Service (Camden CAMHS)</b>			
First Attendance	17.9%	13.6%	14.1%
Subsequent Appointments	20.2%	10.1%	8.1%
<b>Developmental (including Learning and Complex Disability Service)</b>			
First Attendance	9.9%	3.0%	2.0%
Subsequent Appointments	7.4%	7.4%	6.9%
<b>North Camden Child and Adolescent Mental Health Service</b>			
First Attendance	12.3%	Unable to compare due to Directorate restructure	Unable to compare due to Directorate restructure
Subsequent Appointments	13.2%	Unable to compare due to Directorate restructure	Unable to compare due to Directorate restructure
<b>Portman</b>			
First Attendance	2.8%	4.6%	9.8%
Subsequent Appointments	10.2%	11.0%	9.4%
<b>South Camden Child and Adolescent Mental Health Service</b>			
First Attendance	13.8%	Unable to compare due to Directorate restructure	Unable to compare due to Directorate restructure
Subsequent Appointments	13.6%	Unable to compare due to Directorate restructure	Unable to compare due to Directorate restructure
<b>Other Child and Adolescent Mental Health Service (Other CAMHS)</b>			
First Attendance	Unable to compare due to Directorate restructure	4.5%	6.4%
Subsequent Appointments	Unable to compare due to Directorate restructure	4.8%	5.8%
<b>Vulnerable Children</b>			
First Attendance	6.2%	Unable to compare due to Directorate restructure	Unable to compare due to Directorate restructure
Subsequent Appointments	7.1%	Unable to compare due to Directorate restructure	Unable to compare due to Directorate restructure

2. Please note that our patient administration system (PAS) is a 'live system' and therefore with data cleansing and the addition of missing data taking place after quarter end, the final outturn figures for DNA and waiting time may be slightly different to quarterly performance figures published in year.

3. The 2011/12 and the 2012/13 DNA rates are not directly comparable, because of a change in criteria used by the Trust for identifying DNAs.

4. DNA figures for North and South Camden CAMHS are included in the 2012/13 figures for Camden CAMHS and DNA figures for Vulnerable Children are included in 2012/13 figures for Other CAMHS.

5. DNA figures for the City & Hackney Primary Care Psychotherapy Consultation Service (PCPCS) have not been included due to a different DNA target being agreed with the City and Hackney (PCPCS) and their commissioners.

## What are we measuring?

The Trust monitors the outcome of all patient appointments, specifically those appointments where the patient Did Not Attend (DNA) without informing us prior to their appointment. We consider this important, so that we can work to improve the engagement of patients, in addition to minimizing where possible wasted NHS time.

## Targets and Achievements

There has been an increase in DNA rates for first attendances (10.5%), compared with 2012/13 (9.6%), but are pleased to report that the 2013/14 Trust-wide DNA rate for subsequent/follow-up appointments (8.7%) has decreased from 2012/13 (8.9%). We believe that this has been as a consequence of the on-going efforts undertaken by all services to reduce the number of appointments patients fail to attend. For example, by offering a greater choice concerning the times and location of appointments and emailing patients and sending them text reminders for their appointments, as required. By comparison, the average DNA rate reported for mental health trusts is around 14%.<sup>6</sup>

As DNA rates can be regarded as a proxy indicator of patient's satisfaction with their care, the lower than average DNA rate for the Trust can be considered positively. For example, for some patients not attending appointments can be a way of expressing their dissatisfaction with their treatment. However, it can also be the case, for those patients who have benefited from treatment that they feel there is less need to continue with their treatment, as is the case for some patients who stop taking their medication when they start to improve. However, this is only one of the indicators that we consider for patient satisfaction, which needs to be considered along with other feedback obtained from patients, described elsewhere in this report.

6. Mental Health Benchmarking Club, April 2010, Audit Commission: <http://www.audit-commission.gov.uk/SiteCollectionDocuments/Events/2010/mental-health-benchmarking-club-presentations-april-2010.pdf>

**Waiting Times (7,8)** - (Data validation required for 2013/14 data)



## What is the service?

The central aim of the service is to support the development of gender identity. We do this by exploring the nature and characteristics of the patient's gender identity.

We consider difficulties of gender identity in the context of the developmental process. The aims of the service are to understand the nature of the obstacles or adverse factors in the development of gender identity, and to try minimise their negative influence.

The GIDS is a nationally designated, highly specialist service offering a service to young people from all over the UK. We have bases in London and Leeds and operate a satellite clinic in Exeter.

The GIDS project works in collaboration with the Departments of Paediatric Endocrinology at University College London Hospital and Leeds General Infirmary.

## Who is the service for?

We see children and young people (up to the age of 18) and their families who are experiencing difficulties in the development of their gender identity. This includes children who are unhappy with their biological sex.

Our approach is always tailored to the needs of the individual families. Any decisions made about treatment are made with input from the whole team so that there are contributions from all areas of expertise.

## Outcomes

- 84% of young people and 89% of parents answered "certainly true" to the question "I was treated well by the people who have seen me/my child."
- 81% of young people and 86% of parents answered "certainly true" to the question "Overall, the help I have received here is good."

“ As a family and individually we have been given good advice and feel well supported. No aspect of our child's situation has been left uncovered and every issue dealt with seriously and professionally. ”

“ [It is good] that I know that if I ask them to help with school for instance that they will contact the school on my behalf. They always do what they say they will. ”

“ The clinic and hospital have both acted quickly to help us; they made us feel comfortable and treated our concerns seriously ”

“ The staff were very accepting and put me at ease with my child who has behavioural problems. They were punctual and I didn't feel hurried. They spent a long time with us. ”



### 3.2 Performance against relevant Indicators and Thresholds

The majority of the mental health indicators set out in the Compliance Framework/Risk assessment framework are not applicable to The Tavistock and Portman NHS Foundation Trust, as they relate to inpatient and/ or medical consultant lead services which the Trust does not provide. However, the 'mental health identifiers' (NHS number; date of birth; postcode; current gender; Registered General Medical Practice organisation code, and Commissioner organisation code) apply to the Trust and in 2013/14 the Trust met the 97% threshold for completeness of data.

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

## Part 4: Annexes

### 4.1 Statements from Camden Clinical Commissioning Group (CCG), Governors, Camden Healthwatch, Overview and Scrutiny Committees (OSCs), and Response from Trust.

To be updated by May 2014

DRAFT

## 4.2 Statement of Directors' Responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the content of the quality report is not inconsistent with internal and external sources of information, including:
  - board minutes and papers for the period April 2013 to [the date of signing of this statement];
  - papers relating to quality reported to the board over the period April 2013 to [the date of signing of this statement];
  - feedback from the commissioners, dated XX/XX/20XX;
  - feedback from governors, dated XX/XX/20XX;
  - feedback from local Healthwatch organisations, dated XX/XX/20XX;
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX;
  - the [latest] national patient survey, dated XX/XX/20XX;
  - the [latest] national staff survey, dated XX/XX/20XX;
  - the Head of Internal Audit's annual opinion over the trust's control environment, dated XX/XX/20XX;

- Care Quality Commission quality and risk profiles, dated XX/XX/20XX;
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at [www.monitor.gov.uk/annualreportingmanual](http://www.monitor.gov.uk/annualreportingmanual)) as well as the standards to support data quality for the preparation of the quality report (available at [www.monitor.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/\\_openTKFile.php?id=3275](http://www.monitor.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)).

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

By order of the board

Note: sign and date in any colour ink except black

.....Date.....Chair

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

## Appendix – Glossary of Key Data Items

**Black and Minority Ethnic (BME) Groups Engagement** - We plan to improve our engagement with local black and minority ethnic groups, by establishing contact with Voluntary Action Camden and other black and minority ethnic community groups based in Camden.

**CCG (Clinical Commissioning Group)** - CCGs are new organisations created under the Health and Social Care Act 2012. CCGs are independent statutory bodies, governed by members who are the GP practices in their area. A CCG has control of the local health care budget and 'buys' local healthcare services on behalf of the local population. Some of the functions a CCG carries out replace those of Primary Care Trusts that were officially abolished on 31st March 2013, such as the commissioning of community and secondary care. Responsibilities for commissioning primary care transferred to the newly established organisation, NHS England.

**Care Quality Commission** – This is the independent regulator of health and social care in England. It registers, and will license, providers of care services, requiring they meet essential standards of quality and safety, and monitors these providers to ensure they continue to meet these standards.

**Clinical Outcome Monitoring** - In "talking therapies" is used as a way of evaluating the effectiveness of the therapeutic intervention and to demonstrate clinical effectiveness.

**Clinical Outcomes for Routine Evaluation** - The 34 items of the measure covers four dimensions, subjective well-being, problems/symptoms, life functioning and risk/harm.

**Commission for Health Improvement Experience of Service Questionnaire** - This captures parent and child views related to their experience of service.

**CQUIN (Commissioning for Quality and Innovation Payment Framework)** - This enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.

**Complaints Received** - This refers to formal complaints that are received by the Trust. These complaints are all managed in line with the Trust's complaints policy.

**Did Not Attend (DNA) Rates** - The DNA rate is measured for the first appointment offered to a patient and then for all subsequent appointments.

There is an 11% upper limit in place for the Trust, which is the quality standard outlined in our patient services contract.

The DNA Rate is based on the individual appointments attended. For example, if a family of three is due to attend an appointment but two, rather than three, family members attend, the appointment will still be marked as attended. However, for Group Therapy the attendance of each individual will be noted as they are counted as individual appointments.

DNA rates are important to the Trust as they can be regarded as a proxy indicator of patient's satisfaction with their care.

**Goal Based Measure** - These are the goals identified by the child/young person/family/carers in conjunction with the clinician, where they enable the child/carer etc. to compare how far they feel that they have moved towards achieving a goal from the beginning (Time 1) to the end of treatment (either at Time 2 at 6 months, or at a later point in time).

**Infection Control** - This refers to the steps taken to maintain high standards of cleanliness in all parts of the building, and to reduce the risk of infections.

**Information Governance** - Is the way organisations 'process' or handle information. It covers personal information, for example relating to patients/service users and employees, and corporate information, for example financial and accounting records.

Information Governance provides a way for employees to deal consistently with the many different rules about how information is handled, for example those included in The Data Protection Act 1998, The Confidentiality NHS Code of Practice and The Freedom of Information Act 2000.

**Information Governance Assessment Report** - The Trust is required to carry out a self-assessment of their compliance against the Information Governance requirements.

The purpose of the assessment is to enable organisations to measure their compliance against the central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Where partial or non-compliance is revealed, organisations must take appropriate measures, (for example, assign responsibility, put in place policies, procedures, processes and guidance for staff), with the aim of making cultural changes and raising information governance standards through year on year improvements.

The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. This in-turn increases public confidence that 'the NHS' and its partners can be trusted with personal data.

**Information Governance Toolkit** - Is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance included in the various Acts and presents them in one place as a set of information governance requirements.

**In-Service Education and Training/Mandatory Training** - The Trust recognises that it has an obligation to ensure delivery of adequate and appropriate training to all staff groups, that will satisfy statutory requirements and requirements set out by the NHS bodies, in particular the NHS Litigation Authority and the Care Quality Commission Standards for Better Health. It is a requirement for staff to attend this training once every 2 years.

**Local Induction** - It is the responsibility of the line manager to ensure that new members of staff (including those transferring to new employment within the Trust, and staff on fixed-term contracts and secondments) have an effective induction within their new department. The Trust has prepared a Guidance and checklist of topics that the line manager must cover with the new staff member.

**Monitoring of Adult Safeguards** - This refers to the safeguarding of vulnerable adults (over the age of 16), by identifying and reporting those adults who might be at risk of physical or psychological abuse or exploitation.

The abuse, unnecessary harm or distress can be physical, sexual, psychological, financial or as the result of neglect. It may be intentional or unintentional and can be a single act, temporary or occur over a period of time.

**National Clinical Audits** - Are designed to improve patient care and outcomes across a wide range of medical, surgical and mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care.

**National Confidential Enquiries** - Are designed to detect areas of deficiency in clinical practice and devise recommendations to resolve these. Enquiries can also propose areas for future research programmes. Most confidential enquiries to date are related to investigating deaths and to establish whether anything could have been done to prevent the deaths through better clinical care.



The confidential enquiry process goes beyond an audit, where the details of each death or incident are critically reviewed by a team of experts to establish whether clinical standards were met (similar to the audit process), but also to ascertain whether the right clinical decisions were made in the circumstances.

Confidential enquiries are “confidential” in that details of the patients/cases remain anonymous, though reports of overall findings are published.

The process of conducting a national confidential enquiry process usually includes a National Advisory Body appointed by ministers, guiding, overseeing and co-ordinating the Enquiry, as well as receiving, reporting and disseminating the findings along with recommendations for action.

**NHS Litigation Authority (NHSLA)** - The NHSLA operate a risk pooling system into which trust contribute on annual basis and it indemnifies NHS bodies in respect of both clinical negligence and non-clinical risks and manages claims and litigation under both headings. The Authority also has risk management programmes in place against which NHS trusts are assessed.

**NHS Litigation Authority Level** - The NHSLA has a statutory role “to manage and raise the standards of risk management throughout the NHS” which is mainly carried out through regular assessments, ranging from annually to every three years, against defined standards developed to reflect the risk profiles of the various types of healthcare organisations. Compliance with the standards can be achieved at three levels, which lead to a corresponding discount in contributions to the NHSLA schemes.

There are 50 standards to achieve covering the categories of governance, workforce, safe environment, clinical and learning from experience. Level 1 assesses that the policies around each standard are in place, level 2 ensures that processes around each policy are in place and level 3 ensure compliance with both the policies and processes for each of the individual standards.

**Patient Administration System (PAS)** - This is the patient administration system using RiO, which is a ‘live system’ for storing information electronically from patient records.

**Participation in Clinical Research** - The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited during the year to participate in research approved by a research ethics committee.

**Patient Feedback** - The Trust does not participate in the NHS Patients Survey but conducts its own survey annually, as it has been exempted by the Care Quality



Commission from using the NHS Patient Survey, with the recognition that the nature of the services provided by the Trust differ to other mental health trusts.

There are various other methods used to obtain feedback from patients, including small scale surveys and audits (such as the Children's Survey, the Ground Floor Environment Survey, the Website Survey), the suggestions box, feedback to the PALS officer and informal feedback to clinicians and administrators.

**Patient Forums/Discussion Groups** – These meetings aim to increase the opportunities for patients, members and the public to obtain information, and to engage in discussions about topics, such as therapy - how it can help, and issues such as confidentiality. In turn, the feedback to the Trust generated by these meetings is used to improve the quality of our clinical services.

**Patient Safety Incidents** – This relates to incidents involving patient safety which are reportable to the National Patient Safety Agency database National Reporting and Learning System.

**Percentage Attendance** – The number of staff members who have attended the training or completed the inductions (Trust-wide and Local) as a percentage of those staff required to attend training or complete the inductions. Human Resources (Staff Training) record attendance at all mandatory training events and inductions using the Electronic Staff Record.

**Periodic/Special Reviews** - The **Care Quality Commission** conducts special reviews and surveys, which can take the form of unplanned visits to the Trust, to assess the safety and quality of mental health care that people receive and to identify where and how improvements can be made.

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

**Range of Psychological Therapies** - This refers to the range of psychological therapies available within the Trust, which enables us to offer treatment to a greater range of patients, and also offer a greater choice of treatments to our patients.

**Return rate** - The number of questionnaires returned by patients and clinicians as a percentage of the total number of questionnaires distributed.

**SAAMHS** - Specialist Adolescent Adult Mental Health Service. This includes the Portman Clinic, Adolescent and Young Adult Service and the Adult Service.

**Safeguarding of Children Level 3** - The Trust has made it mandatory for all clinical staff from Child and Adolescent Mental Health Services and the Adolescent Directorate to be trained in Safeguarding of Children Level 3, where staff are required to attend Level 3 training every 3 years.

The training ensures that Trust staff working with children and young people are competent and confident in carrying out their responsibilities for safeguarding and promoting children's and young people's welfare, such as the roles and functions of agencies; the responsibilities associated with protecting children/young people and good practice in working with parents. The Level 3 training is modeled on the core competencies as outlined in the 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' (Intercollegiate Document 2010); Working Together to Safeguard Children, 2010; the London Child Protection Procedures 4th Ed., 2010; NICE Clinical Guidance 2009: 'When to Suspect Child Maltreatment'.

**Specific Treatment Modalities Leaflets** - These leaflets provide patients with detailed information on the different treatment modalities offered by the Trust, to facilitate patients making informed choices and decisions about their treatment.

**Stakeholder Quality Meetings** - These include consultation meetings with stakeholders (Patient and Public Involvement representatives), Non-Executive Directors and a Governor, and the separate meeting with governors. The purpose of these meetings is to contribute to the process of setting quality priorities and to help improve other aspects of quality within the Trust.

**Time 1** - Typically, patients are asked to complete a questionnaire during the initial stages of assessment and treatment, prior to their first appointment.

**Time 2** - Patients are again asked to complete a questionnaire at the end of assessment and treatment. The therapist will also complete a questionnaire at Time 2 of the assessment and/or treatment stage.

Our goal is to improve our Time 2 return rates, which will enable us to begin to evaluate pre- and post- assessment/treatment changes, and provide the necessary information for us to determine our clinical effectiveness.

**Trust-wide Induction** – This is a trust-wide induction event for new staff, which is held 3 times each year. All new staff (clinical and non-clinical) receive an invitation to the event with their offer of employment letter, which makes clear

that they are required to attend this induction as part of their employment by the Trust.

**Trust Membership** - As a foundation trust we are accountable to the people we serve. Our membership is made up of our patients and their families, our students, our staff and our local communities. Members have a say in how we do things, getting involved in a variety of ways and letting us know their views. Our members elect governors to represent their views at independent boards where decisions about what we do and how we do it are made. This way we can respond to the needs of the people we serve.

**Waiting Times** - The Trust has a policy that patients should not wait longer than 11 weeks for an appointment from the date the referral letter is received by the Trust to the date of the first appointment attended by the patient.

However, if the patient has been offered an appointment but then cancelled or did not attend, the date of this appointment is then used as the starting point until first attended appointment.

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait, especially beyond eleven weeks. A list of breached first appointments is issued at the end of each quarter for each service, together with reasons for the long wait and, if appropriate, the actions to be taken to prevent recurrence.



## Board of Directors : April 2014

**Item :** 15

**Title :** CQC Inspection Visit March 2014

**Purpose:**

The purpose of this report is to provide feedback to the Board on the CQC routine inspection visit that took place in March 2014.

The Board of Directors is invited to accept the assurance of the CQC that the Trust remains fully compliant with the Essential Standards.

The feedback report has been reviewed by the following Committees:

- Management Committee

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

- Patient / User Experience
- Regulation compliance
- Quality and safety and clinical care

**For :** Noting

**From :** Ms Pat Key, Director of Corporate Governance

## CQC Routine Inspection 2014

The CQC conducted an announced routine inspection of the Tavistock Centre in March 2014. Inspectors were on site on the 3<sup>rd</sup>, 5<sup>th</sup> and 6<sup>th</sup> March 2014. The inspectors, mindful of the nature of the work the Trust does and the difficulties of being able to directly observe care, provided the Trust with a few days' notice of their inspection and attended an initial planning meeting with Pat Key and Jane Chapman so that we could plan opportunities for the inspectors to visit department to observe aspects of care they wishes to focus on.

The inspection was successful and the trust was found to continue to full meet the CQC standards.

### Tavistock and Portman NHS Foundation Trust

The Tavistock Centre, 120 Belsize Lane, London, NW3 5BA

Tel: 02074357111

Date of Inspections: 06 March 2014  
05 March 2014  
03 March 2014

Date of Publication: April 2014

We inspected the following standards as part of a routine inspection. This is what we found:

<b>Respecting and involving people who use services</b>	✓	Met this standard
<b>Care and welfare of people who use services</b>	✓	Met this standard
<b>Cooperating with other providers</b>	✓	Met this standard
<b>Supporting workers</b>	✓	Met this standard
<b>Assessing and monitoring the quality of service provision</b>	✓	Met this standard

The inspection focussed on the services the trust provides for children and adolescents. The inspectors met staff and patients from the South Camden CAMHS. They also met with staff from the following services: Gender Identity Development Service (GIDS), the Adolescent and Young Adult Service, and the service for people with disabilities, including children on the autistic spectrum, and their families. During the inspection they spoke to 17 members of staff and carried out observations of team meetings and training. They also spoke with some young people who were using the service.

They reviewed responses to the trust's Experience of Service Questionnaire (which is used as part of outcome monitoring). The inspectors found that

in general feedback they found the feedback to be very positive, the report quotes three examples of this:

*"I learned how to build up my confidence and sort out my problems."*

*"The people was [sic] listening to me and helping me with my problems."*

*"That it is consistent and regular and I get good advice on my issues."*

Following their visit the inspectors were able to confirm that the trust continues to meet all CQC standards and the report makes no formal recommendations.

The CQC have published a detailed report of their findings and the evidence they considered in support of each standard and this will shortly be uploaded onto the CQC website.

A copy is embedded here:



CQC Final inspection  
report April 2014.pdf

The Corporate Governance team would like to pay tribute to all the staff who so willingly gave up their time to meet with the inspectors and the enthusiasm for the service that they portrayed. The inspectors reported that they found the inspection interesting, and enjoyable.

Pat Key Director of Corporate Governance  
Jane Chapman Governance and Risk Adviser

April 2014





BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 29<sup>th</sup> April 2014, 14.00 – 16.00  
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.9
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.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To note	Enc.	p.10
7.	Finance & Performance Report Mr Carl Doherty, Deputy Director of Finance	To note	Enc.	p.13
8.	Annual Complaints Report Mr Paul Jenkins, Chief Executive	To note	Enc.	p.25
9.	Camden CAMHS Service Report Dr Andy Wiener, Associate Clinical Director	To note	Enc.	p.30
STRATEGY				
10.	Time to Change Initiative Mr Paul Jenkins, Chief Executive	To approve	Enc.	p.43
QUALITY & GOVERNANCE				
11.	Corporate Governance – External Contacts List Mr Gervase Campbell, Trust Secretary	To note	Enc.	p.54
12.	Q4 Governance Statement Mr Carl Doherty, Deputy Director of Finance	To approve	Enc.	p.82
13.	Q4 Quality Report Ms Louise Lyon, Trust Director	To approve	Enc.	p.88

14.	<b>Draft Annual Quality Report</b> Ms Justine McCarthy Woods, Quality Standards and Reports Lead	To approve	Enc.	p.104
15.	<b>CQC Inspection Report</b> Ms Jane Chapman, Governance ad Risk Adviser	To note	Enc.	p.163
<b>CONCLUSION</b>				
16.	<b>Any Other Business</b>		Verbal	
17.	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"><li>• Tuesday 27<sup>th</sup> May 2014: Board of Directors, 2pm-5pm, Board Room, Tavistock Centre</li><li>• Tuesday 10<sup>th</sup> June 2014: Directors' Conference, 12pm-5pm, Lecture Theatre</li><li>• Tuesday 24<sup>th</sup> June 2014: Board of Directors, 2pm-5pm, Board Room, Tavistock Centre</li><li>• Thursday 26<sup>th</sup> June: Council of Governors, 2pm-5pm, Board Room, Tavistock Centre</li></ul>		Verbal	