The Tavistock and Portman **NHS**

NHS Foundation Trust

Board of Directors Part One

Agenda and papers
of a meeting to be held in public

2.00pm–4.00pm
Tuesday 27th May 2014

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

The Tavistock and Portman **NHS**
NHS Foundation Trust

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 27th May 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 Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.19
8.	**Staff Survey 2013 Report and Action Plan** Mr Namdi Ngoka, Deputy Director of Human Resources	To approve	Enc.	p.26
9.	**CQSG Quarter 4 Report** Dr Rob Senior, Medical Director	To note	Enc.	p.44
10.	**Equalities Report** Ms Louise Lyon, Trust Director	To note	Enc.	p.64
11.	**Workforce Information** Ms Shilpi Sahai, Human Resources Manager	To note	Enc.	p.72

12.	**Annual Report and Accounts**
	Mr Simon Young, Deputy Chief Executive & Director of Finance and Mr Gervase Campbell, Trust Secretary
	    a) **Annual reports**
	    b) **Annual Accounts**
	    c) **Letters of Representation**
		To approve	Enc.	p.82
				p.146
				p.207

The Tavistock and Portman **NHS**
NHS Foundation Trust

	CORPORATE GOVERNANCE			
13.	**Annual Quality Report** Ms Justine McCarthy Woods, Quality Standards and Reports Lead	To approve	Enc.	p.215
14.	**Register of Interests** Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.289
15.	**Scheme of Delegation of Powers** Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.296
16.	**Monitor Annual self-certification Governance Statement** Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.307
	CONCLUSION			
17.	**Any Other Business**		Verbal	
18.	**Notice of Future Meetings** • Tuesday 10th June 2014: Directors' Conference, 12pm-5pm, Lecture Theatre • Tuesday 24th June 2014: Board of Directors, 2pm-5pm, Board Room, Tavistock Centre • Thursday 26th June: Council of Governors, 2pm-5pm, Board Room, Tavistock Centre		Verbal	

Board of Directors

Meeting Minutes (Part One)
Tuesday 29th April 2014, 2.00 – 3.45pm

Present:			
Ms Angela Greatley Trust Chair	Mr Martin Bostock Non- Executive Director (Senior Independent Director)	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 Joyce Moseley Non-Executive Director
Dr Rita Harris CAMHS Director (non-voting)	Ms Caroline Rivett Non-Executive Director	Dr Rob Senior Medical Director	
Attendees:			
Ms Fiona Fernandes Assistant Trust Secretary (minutes)	Mr Gervase Campbell (Trust Secretary)	Mr Carl Doherty Deputy Director of Finance (items 7,12)	Ms Miranda Alcock Governor
Dr Andy Wiener Associate Clinical Director (item 9)			
Apologies:			
Mr Simon Young Deputy Chief Executive & Director of Finance	Mr Malcolm Allen Dean	Dr Justine McCarthy Woods Quality Standards & Reports Lead	

Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to be made to minutes	FF	Immed
2	4	Notes on Tiered model and finance FAQ to be re-circulated to NEDs	GC	Immed
3	8	Time to respond to be added to future complaints reports	JC	2015
4	8	Letters of compliments to be forwarded to the PPI Committee	RH	ongoing
5	10	Contact the Governors about Time to Change pledge, and raise it at the next meeting.	AG	Before June

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.

AP1   ### 3. Minutes of the Previous Meeting
The minutes were agreed subject to minor amendments.

4. Matters Arising

- The minutes had been amended (AP1).

- AP2 and AP3 (culture of openness and whistle blowing in the Trust), Ms Jones confirmed that she had met with Ms Thomas about this and they were working on an addition to contracts, but also noted that the Trust Policy has been updated, the Staff and Advice Consultation Service would be re-launched to give it a higher profile, and several training events on whistle-blowing were planned. Ms Jones commented that the Trust's HR Department had an open door welfare orientation, rather than a transactional focus, which helped encourage staff to raise concerns with them.

AP2

- AP4 and AP5 (Finance FAQs and CAMHS Service Delivery tiered model) – a number of the NEDs commented that they had not received the documents, so it was agreed that Mr Campbell would recirculate them.

5. Trust Chair and NEDs' Report

Ms Greatley mentioned that prior to the meeting they had been taken through the new website and it looked like a great improvement, and thanked Mr Bostock and colleagues who had worked on it.

6. Chief Executive's Report

Mr Jenkins reported that he had launched his 100 day consultation to ascertain the views from staff, service users, members, governors and stakeholders on the future of the Trust, and he hoped to complete the process in time to report back to the July board meeting. Mr Jenkins added that he has already had some good discussions with the PPI Committee and that he has had a chance to visit teams across the Trust, as well as meeting some of the Governors on a one-to-one basis.

Mr Jenkins mentioned that the Trust has submitted the two year forecast to Monitor and await their feedback. Mr Jenkins added that he and Mr Young have a routine call with Monitor on 13th May and whilst we are confident that the forecasts are deliverable, it has been recognised that there will be challenges represented by the targets for both new business growth and savings. 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. It has been agreed with Dr Harris that it would be helpful to undertake some work to refresh some of our models that we currently offer and how we might offer additional value in providing services across a number of different geographical locations, and that there will be a strategy event on 14th May to get this started.

Mr Jenkins mentioned that he had met with Jen Hyatt and Nicky Runeckles from the Big White Wall, and whilst they have developed a stand-alone enterprise and do not feel they require our clinical input any longer, the meeting was constructive and the parting will be amicable, and there may be other areas to collaborate on in the future. Dr McPherson commented that there are now more organisations working in this field, some of whom would be attending our conference in June.

7. Finance & Performance Report

Mr Doherty introduced the written report by highlighting that there were no significant changes and that at the end of the financial year there will be a £1.2 million surplus and that we would retain a Monitor Continuity of Service rating of 4.

The Board **noted** the report.

8. Annual Complaints Report

Ms Chapman introduced the report by commenting that the number of complaints received had fallen, following the previous year's rise. This year there has been no involvement with the Ombudsman, however there is still one outstanding complaint from 2012 which is still with them.

Ms Greatley mentioned that we regard the exposure of the complaints to be a healthy exercise, and that we had been worried in case last year's increase was evidence of something going wrong, and so she and some colleagues on the board had reviewed some of the files to assure themselves this wasn't the case.

Ms Moseley asked whether there had been a change and clinicians were now more open to learning from complaints. Ms Chapman explained that she and Ms Higginson supported clinicians in reflecting on the complaint as part of the process of responding to them. Dr Senior commended Ms Chapman on how well they are handled, and suggested that even though few of the complaints were upheld, there was often a kernel of learning to be taken from them.

Ms Rivett wanted to know whether we talk to the complainants on how they are feeling regarding the process. Ms Chapman explained that they do and invited the NEDs to review the files if they were interested in learning more of the process.

AP3

Mr Holt asked about the timeframe in which the complaints were dealt with and Ms Chapman explained that all complaints are dealt with within 25 days. Mr Holt suggested that the speed of response could be added to the report in the future.

AP4

Mr Holt asked whether we had also received compliment letters, and Ms Chapman explained that she had not. Mr Bostock added that at the PPI Committee they had seen verbatim comments from feedback which were often positive, and Ms Harris mentioned that CAMHS had received letters of compliment, and that she would forward them to the PPI Committee in the future.

Mr Jenkins added that the complaints are handled to a very high standard and the complaints procedure was being updated to give the CEO the

ability to terminate a complaint when required, as sometimes they can develop into something which is not helpful to the patient or the clinician. The complaints form part of the spectrum of feedback and we need to look at the whole.

Ms Greatley thanked Ms Chapman, Ms Higginson and Ms Jones for all the work that has been undertaken.

The Board **noted** the report.

9. **Camden CAMHS Service Report**
Dr Wiener presented his report and highlighted the key areas:

That an annual sum of one 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. CAMHS have also recruited to 15 new posts across the Camden service as part of the new investment in complex needs, developmental concerns and parental mental health.

Nationally there is a struggle with Tier 4 which NHS England has been slow to react to, which is leading to children being kept on wards for a long time, and then having to be found spaces in units far from home.

A small Complex Needs Outreach Team 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.

Camden MALT have benefited from additional staff: an outreach CAMHS nurse has increased the offer for Looked After Children, and Adult mental health staff have joined the team, which means that assessments for families can be more holistic.

The CCG have given £1 million for 16-24 year olds as part of Minding the Gap, and an integrated youth community hub has been set up with a café and mental health workers in the guise of youth workers, to provide a single point of access. However, the steering group is looking for transitioning champions at all levels of involved organisations. Ms Greatley suggested that Ms Moseley could be the board champion for this as she was already working on it. Ms Moseley agreed and commented that the work Camden were doing on transition and this age group was very good, and it was a shame they felt it needed to be tendered out.

Mr Bostock questioned paragraph 7.6, where it said that work was not always purposeful, and Dr Wiener explained that this referred to case reviews conducted by multi-disciplinary teams to review the care plan and identify what has worked and what needs doing differently.

Mr Bostock questioned paragraph 7.8, where it stated there was a lack of clarity about who was accountable, and Dr Wiener explained that this referred to an attempt to support children within the borough instead of in residential placements outside the borough, by bringing together teachers, social workers and therapists, with the intention that CAMHS would lead the teams, however there were organisational obstacles with 4 sites and some very part time staff, and members reporting within their professional silos, but Dr Wiener was going to attend the next meeting and support the manager in developing the vision.

Dr Wiener concluded by addressing the inquest into the SUI of 2012/13 which had recently concluded with no criticism of the Trust or requests for changes to our processes, but that the Trust was working on ensuring staff were better trained and equipped to address concerns regarding children's digital lives.

The Board thanked Dr Wiener, and **noted** the report.

10   Time To Change Initiative

Mr Jenkins reported that this initiative was a significant gesture of the Trust's commitment to bringing consideration of people with lived experience of mental health to the forefront, and Ms Thomas has worked out an Action Plan, which if agreed would be reported back to the board so that they could be held to account on it, and a signing event arranged.

Ms Thomas added that we already do a lot within the Trust, and can build on the existing work by:
* Re-launching the Staff Consultation Service to give it a higher profile.
* Ensuring that Time to Change is incorporated in the Trust's equalities agenda and is regularly discussed at the Trust's Equalities Committee.
* Raising staff awareness of supporting colleagues with mental health issues.
* Having a section on the Trusts' website regarding the pledge.
* Hosting a Time to Talk event for Trust staff to help embed it within the organisation.

Ms Greatley commented that addressing this at the Equalities Committee would be an excellent opportunity for reflection and looking at how we treat each other. Ms Lyon mentioned that conversations had started with colleagues about this initiative and it was important to be nuanced and

take the time to do things well. Dr Senior commented that we need to ensure that managers and staff are trained to be open and thoughtful, and have an understanding about why people struggle with mental health. Mr Holt suggested that we could encourage other trusts to sign up, and perhaps make it an expectation of new partnerships we took on. Mr Jenkins thought that we should not restrict our potential partners, but take on a leadership role on the issue.

AP5 Ms Greatley said that she would inform the Governors by email about the Time to Change pledge and bring it to the June meeting.

Mr Jenkins mentioned that when the event is launched, we should get a speaker, perhaps a patient, who could speak about their experience.

The Board **approved** adoption of the Time to Change Initiative.

11 Corporate Governance – External Contacts List

Mr Campbell presented the list, explaining that this is a requirement from Monitor for the Trust to keep an overview of the external contacts and the board to review it. He explained there were some errors in the document, which would be corrected: that practicing psychologists and social workers were now represented by the Health Care Professionals Council, and that Healthwatch had replaced LINKS.

Dr McPherson commented that many important contacts were in informal networks and asked if it would be helpful to also capture these on the list, or a similar one.

A discussion was held around the logistics of how information is obtained and Mr Holt asked how feedback on important changes might be passed from the key contacts to the board, and it was agreed this would be looked at.

Ms Greatley thanked Mr Campbell for report.

The Board **noted** the report.

12 Quarter 4 Governance Statement

Mr Doherty presented the report and highlighted that we have met all the targets and indicators in the previous quarter and expect to continue to do so in the coming one, with a continuity of service rating of at least 3 and a green governance rating.

The Board **approved** the report.

13 Quarter 4 Quality Report

Ms Lyon presented her report and mentioned that overall the performance

indicators are being met and are in the green, with the only red in relation to CQUIN targets on CAMHS User Involvement where the low "satisfaction with explanation" rate may be due to service users not remembering back to the start of their care when questioned, and also due to the change in the phrasing of the question.

Mr Holt asked about the low score for convenient appointments. Dr Harris explained that parents don't want to take children out of school, but we don't have the capacity to only offer appointments in the mornings and evenings, so priority is given to those children studying for exams. Ms Lyon commented that the low DNA rate shows that although the appointments may not be the most convenient, they are manageable.

The Board **approved** the report.

14   Draft Annual Quality Report

Ms Lyon commented that this was a draft document and parts were missing as they could not be included until the last minute for procedural reasons, but that they were on track for preparation of the final report, and were waiting for comments from the auditors and partners such as Healthwatch and the CCG.

The Board identified some amendments that needed to be made, including adding 'mystery shopper' to the glossary and giving a rationale for not undertaking telephone surveys in item 4 on page 120, and Ms Lyon noted them.

Mr Holt commented that the report was very positive, and asked whether there was anything we were not doing well that we could include to make it more balanced, and open. Ms Lyon agreed it was a good idea but explained that they were constrained in what they could include, and the targets are agreed with the commissioners to be achievable. Dr Senior commented that we can have our own internal higher standards to aspire to, and Ms Greatley asked if there was a way to include areas where we want to do better. Ms Moseley suggested that we add reflection to the priorities section (p.126). Mr Bostock suggested that the Chief Executive's introduction could also address this, and Dr Senior commented that it would be best if we could include details and evidence of areas where we wanted to improve.

The Board **noted** the draft report.

15   CQC Inspection Report

Ms Greatley formally thanked Ms Chapman and the staff involved in the inspection. Dr Senior added that this positive report has been picked up and noted by CCGs.

The Board **noted** the report.

16   Any Other Business

Ms Greatley mentioned that over the next month there will be a Board review process and Mr Jeremy Keeley will be returning to undertake some work with the board, and facilitate an event at the June Director's conference.

17   Notice of Future Meetings

The Board noted its future meetings.

Part 1 of the meeting concluded at 4.10pm

The Tavistock and Portman **NHS**
NHS Foundation Trust

Outstanding Action Part 1

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	

Outstanding Actions

Board of Directors : May 2014

Item : 6

Title : Chief Executive's Report (Part1)

Summary:

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

For : Discussion

From : Chief Executive

CEO Report

Chief Executive's Report

1. Induction

1.1 I have continued to have the opportunity to visit teams across the organisation.

2. Shaping our Future – 100 day consultation

2.1 I am now well into my 100 day consultation. I have received an amount of individual feedback and have had the chance to meet and discuss the issues with a number of teams and groups across the organisation. I would propose bringing some initial feedback on the exercise to the June Board of Directors with fuller feedback and conclusions to the July Board.

3. Hackney

3.1 I have continued to chair the Programme Board for the "One Hackney" project involving all the providers in City and Hackney CCG. The final proposal to the CCG will include an opportunity for us to support training and development around integrated working. Using the insights we have gathered through the One Hackney work, a number of colleagues are working on how we develop a package on integrated care which we can market more widely as there are clearly opportunities and designated funding for this in other areas.

4. Monitor

4.1 With Simon Young and Rob Senior I have had the Trust's routine quarterly call with Monitor. They asked a number of questions about the 2 year plan we submitted at the beginning of April and raised no specific issues of concern.

4.2 We are due to submit at the end of June our 5 year strategic plan. Work is hand to develop this and will be discussed at the Productivity Programme Board in 12th June prior to it being considered at the June Board of Directors meeting.

4.3 We are using the Productivity Programme Board, chaired by Simon Young, to oversee the growth and savings targets highlighted in our 2 year operational plan.

5.   CAMHS Development Strategy

5.1   We had a very successful day on 14th May looking at refreshing our strategy for CAMHS services. As part of this we were joined for some of the day by around 15 young people and family members who inputted their views on the development of services.

5.2   In the light of the day we agreed in principle:

- Undertake a programme of work to update our CAMHS model.

- On the basis of the updated model prepare to bid a number of the CAMHS services which are anticipated to be put out to tender in the next 2 years.

5.3   Rita Harris and Julia Smith are preparing a paper analysing the resource required to support a significantly enhanced level of ambition in our CAMHS work which will help inform our overall development plan which I hope to present to the Board of Directors at its July meeting.

6.   Waiting Times

6.1   I attended a consultation meeting with the Department of Health and the NHS Confederation on plans for the introduction from April 2015 of waiting times in mental health.

7.   My Health London

7.1   I attended on the 1st May a first meeting of My Health London Transparency Steering Group chaired by Tim Kelsey, National Director for Patients and Information at NHS England. The group has been set up to explore how London can be at the heart of developments around data transparency and digital health solutions. Tim is keen to progress initiatives around mental health with perhaps a particular focus around CAMHS.

8.   Mail on Sunday article about GIDS

8.1   An article about the Gender Identity Services (GIDS) appeared in the Mail on Sunday on 18th May.

8.2   The article was written by Sanchez Manning who has previously written about the service. It covered the use of the blocker to pause puberty in the early stages of puberty. The headline was unhelpful

and misleading but the article was more balanced. The main inaccuracy from the services perspective was a claim that the treatment was being offered to 9 year olds whereas in fact the intervention has only been available from the age of 12 to carefully selected cases under a research protocol.

8.3 The Comms team and Dr Polly Carmichael have responded to subsequent media interest in the story and I am very grateful to them for the work at the weekend in handling the story.

Paul Jenkins
Chief Executive
19th May 2014

16 May 2014

Mr Paul Jenkins ,
Chief Executive
Tavistock and Portman NHS Foundation Trust
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Dear Mr Jenkins

Understanding the financial challenge

We are writing to you in response to our initial findings from reviewing trusts' two year operational plans for 2015/16 and to respond to questions around the current planning process following engagement with the Foundation Trust Network (FTN).

As you know, there have been a number of major changes to the 2014/15 planning round. These are intended to help improve decision making across the system in the context of the unprecedented pressures facing the NHS. It is vital that individual Boards, Monitor and fellow regulators have a realistic view of the scale of the financial challenge faced over the next few years. This needs to be based on sound assumptions both of the level of pressures[1] faced and the likely impact of initiatives to address these pressures.

Analysis of previous Annual Plan Review submissions[2] has found that, in general, foundation trusts (FTs) had been reasonably accurate at forecasting the first year of the plan[3], but that their expectations of sustained recovery in outer years have not been delivered. In fact, the operating earnings[4] of the FT sector have continued to erode.

In aggregate, the two year operational plans once again appear to demonstrate this pattern, with an expected continued decline in operating earnings in 2014/15 followed by a recovery in 2015/16. This profile appears to be somewhat optimistic, given the expectation that financial pressures will increase in 2015/16 and with little concrete evidence to suggest that delivered cost savings are likely to be substantially ahead of recent years.

We recognise that in the current environment financial planning is particularly difficult. There are heightened uncertainties as to commissioning intentions, the impact of the Better Care Fund and the ability to deliver large cost savings across the system year after year.

---

[1] As part of our Annual plan review 2014/15 guidance, we published, jointly with NHS England, our estimates of financial pressure and tariff efficiency for the next five years

[2] see *Meeting the needs of patients: Improving strategic planning in NHS foundation trusts*

[3] this finding does not include analysis of performance against plan in 2013/14 which was materially worse than plan

[4] Defined as earnings before interest, tax, depreciation and amortisation as a percentage of revenue.

This means that in all likelihood you will be basing projections on reasonable assumptions, only some of which will be supported by fully worked up plans.

However, both individual Boards and regulators need to have the best information to inform decision making. To this end, we are inviting FTs to consider if their projections for 2015/16 need to be revisited[5] and to encourage them to be realistic in their 5 year plan submission due at the end of June 2014. We will also be seeking further information as to how providers have engaged with the Better Care Fund as part of our work to review plans.

We know that there is some concern that showing a financial deficit or the true level of strategic challenge in your five-year plan may trigger a greater degree of regulatory scrutiny and intervention. We want to reassure you that our primary concern is that FT boards are basing decisions on the best and most realistic view of the future.

We will consider situations on a case by case basis. However, in general, Monitor will be most concerned by overly optimistic planning as a potential indicator of broader failures of governance. Where Boards have identified risks to sustainability at an early stage, we will want to engage in a supportive manner and discuss what can be done to help.

If you have any questions please contact your relationship team or compliance@monitor.gov.uk.

Yours sincerely

Mark Turner

Regional Director for London and APR

cc: Ms Angela Greatley , Chair

        Mr Simon Young , Finance Director

---

[5] more detail on the process is set out in section 1 of the annex

ANNEX

1. Process for revision of 2015/16 financial plans

We had originally communicated in our APR guidance that the two-year (2014/15 and 2015/16) financial plans submitted should not be changed and the template would be locked for the first two years for the five-year plan submissions. However, given the findings of the operational plan review set out in the main body of this letter and the importance of understanding the scale of the financial challenge we are inviting FTs to review and reconsider their planned outcomes for 2015/16 and to amend these if they believe revisions are required.

To facilitate this the financial template will be reissued to FTs with only 2014/15 locked. If revisions are made to 2015/16, please include in your written commentary:

- a summary of the rationale for resubmission of the 2015/16 plan; and
- detailed analysis of the changes between the original and revised 2015/16 plans, including bridging analysis of all material differences.

The decision as to whether the financial figures need revising is for each FT to make bearing in mind materiality and in many cases we do not expect any changes. However, Monitor will place more emphasis on performance against multiyear plans as part of our future assessment of governance for each trust.

2. Strategic plan summary

We recognise that some FTs maybe concerned about confidential information being placed in the public domain. Therefore as set out in the original planning guidance, we expect FTs to prepare a summarised version of the strategic plan, which will be published at the end of the annual review process.

This summary should cover a controlled amount of information, including a summary of the market analysis and context, strategic options, plans and supporting initiatives and an overview of the financial projections. Whilst we expect this to be a fairly short public engagement piece, it must be consistent with the substance of the full strategic document. We believe this approach allows both FTs and Monitor to meet our obligations of transparency and candour whilst protecting any confidential elements of the plan.

3. Timeline for publication of information

We understand that following the submission of your two-year plans you are keen to know what we intend to do with the information provided, both in terms of coming back to you and publishing any information publicly. We have therefore set out below a clear timeline on both:

- June - Monitor publication of commentary on the sector forecasts in respect of the operational plan submissions;
- Early June - Communication with individual FTs as to our findings on their operational plan and any regulatory action we may be taking;

- June - Publication on Monitor website of each operational plan commentary document excluding confidential annexes in line with previous years;
- August - Monitor public board papers including commentary on the sector forecasts in respect of the strategic plan submissions;
- October - Communication with individual FTs as to our findings on their strategic plan and any regulatory action we may be taking; and
- Shortly following the individual findings - Publication on Monitor website of each strategic plan summary (as described of section 2 of this annex).

4. Freedom of information

We understand there may be concerns around what information may be subject to a request for information under the Freedom of Information Act 2000 (FOIA).

Each request for information made under FOIA that is received by Monitor is dealt with according to its own facts. We are therefore not able to state in advance of any request whether we will supply some or all of the requested information or whether we will consider that its disclosure is exempt under one or more of the exemptions provided by FOIA. However we have set out below an overview of our handling of such requests:

i. FOIA applies to all recorded information held by Monitor (or held by a third party on Monitor's behalf). When a request is received, it is administered by the Legal Services directorate, which will allocate it to a specific lawyer.

ii. The lawyer will then liaise with and offer advice to the members of Monitor staff who have the necessary expertise in and background knowledge of the information that has been requested. This approach ensures that each request is handled within the context of both detailed factual knowledge and expert legal advice.

iii. Monitor cannot provide any guarantee that any information it holds will not be disclosed under FOIA because each request is decided on its own merits on a case-by-case basis. However, there are a number of exemptions within FOIA which might potentially apply to information provided to Monitor by a FT as part of the planning process, meaning that we would not then have to disclose that information.

iv. For example, under section 41 of FOIA, if information is provided to Monitor in confidence and its disclosure, including to a FOIA requester, would constitute an actionable breach of confidence, Monitor can withhold this information (providing that there is not an overriding public interest in its disclosure).

v. Similarly, under section 43 of FOIA, if the disclosure of information would, or would be likely to, prejudice commercial interests, including those of a FT, Monitor can withhold this information (providing, again, that there is not an overriding public interest in its disclosure).

vi. It should be emphasised that these are just examples: there is a range of exemptions, any one or more of which may be appropriate, depending on the nature of the information requested under FOIA and the circumstances surrounding it.

vii.   It is also important to note that where Monitor receives a FOIA request for information that has been provided to us by a FT and we are provisionally of the view that we are legally required to release it in a non-anonymised and non-generic format, we will liaise with the trust in order to take its view. Whilst we are not bound by those views, we will, of course, take them into account before arriving at our final decision.

viii.   So, whilst there are no absolute guarantees, nevertheless, if a genuine detriment would flow from elements of a FT's planning process information being made public, it is quite likely that an exemption would apply, so allowing us legally to withhold that information.

5. Importance of collaborative working

It is clear from planning process that plans are markedly better where providers and CCGs have undertaken robust engagement, best exemplified in the Better Care Fund planning process. We would therefore like to reiterate the importance of collaborative working during this planning process and the opportunity for the plans to cover, as much as possible, a cross-health and social care economy view.

Monitor have taken a number of steps during this planning round, for example aligning the submission timetable with that of NHS England and the NHS Trust Development Authority as well as publishing joint assumptions.

Board of Directors : May 2014

Item :   7

Title :   Finance and Performance Report

Summary:

The Annual Accounts for 2013/14 are presented separately for approval.

After the first month of the new year, a deficit of £2k is reported, £22k below the planned surplus of £20k. We aim to have a small surplus by the end of the year.

Analysis by service line is not provided this month.

The cash balance at 30 April was £4,441k. Cash projections are presented to the meeting as part of the Annual Plan.

For :   Information.

From :   Simon Young, Director of Finance

Finance & Performance Report

1. **External Assessments**

1.1 Monitor

1.1.1 Monitor's assessment on Quarter 4 is awaited. It is expected that our Continuity of Service Risk Rating will remain at 4, and the rating for governance remain green.

1.1.2 The two year Plan was submitted to Monitor at the end of March. The full five tear plan is due to be submitted at the end of June. The Plan should lead to a Continuity of Service Risk Rating of 3.

2. **Finance**

2.1 2013/14

2.1.1 The annual report and accounts are due to be approved at this meeting of the Board. They will then be submitted to Monitor, and will be laid before Parliament early in July. The surplus was £1,243k before restructuring costs of £139k; exactly in line with the draft figures reported last month.

2.2 Income and Expenditure 2014/15

2.2.1 After April the trust is reporting a deficit of £2k before restructuring costs, £22k below budget. Income is £193k below budget, and expenditure £171k below budget.

2.2.2 The income shortfall for April of £193k is due the following;

2.2.2.1 £88k shortfall on Training, £34k of this is for Child Psychotherapy Trainees which has been offset by a corresponding under spend on expenditure and there is a shortfall across fees and short courses.

2.2.2.2 Other Income is £40k below target mainly due to Finance CAMHS Tariff project which has a corresponding under spend.

2.2.2.3 Consultancy is £32k below budget £23k of which is due to TC.

2.2.2.4 Clinical income was £31k below budget which was a combination of both in CAMHS and SAMHS new income targets not yet achieved. All the main income sources and their variances are discussed in sections 3, 4 and 5.

2.2.3 The favourable movement of £171k on the expenditure budget was due mainly to the Family Nurse Partnership (FNP) under spend of £78k due to vacancies and lower than expected non pay costs. The remainder of the under spend was mostly vacancies spread across the organisation.

2.2.4 As noted in 4.1 below, Tavistock Consulting features on both sides of the April variances, with income and expenditure both below budget.

2.2.5 The key financial priorities remain to achieve income budgets; and to identify and implement the future savings required through service redesign.

page 2 of 7

2.3 <mark>Cash Flow</mark>

2.3.1 The actual cash balance at 30 April was £4,441k this is an increase of £1,684k on the opening cash balance of £2,756k. The increased balance was mainly due to a payment in advance from NHS London but the late payment form the Doh for the final quarter of the FNP contract and earlier payments of many of the March projects leaves us £1.7m below Plan.

3. Patient Services

3.1 <mark>Activity and Income</mark>

3.1.1 All the major contracts have now been agreed. Total contracted income for the year is expected to be in line with budget. Part of the budgeted income for the year is dependent on meeting our CQUIN[1] targets agreed with commissioners and achievement is reviewed on a quarterly basis.

3.1.2 There are more significant variances, both positive and negative, in other elements of clinical income, as shown in the table on the next page. However, the forecast for the year is currently in line with budget in most cases, not in line with the figures shown as "variance based on year-to-date."

3.1.3 After one month the income budget for named patient agreements (NPAs) is on plan.

3.1.4 Court report income has a reduced budget from £113k for 2013/14 to £28k in 2014/15. It was £2k below budget after April. This shortfall is expected to be recovered over the course of the year.

3.1.5 Day Unit was reduced by £150k in 2014/15 and is on target after April. The service is working to secure the additional income required to meet their revised target.

3.1.6 Project income is forecast to be balanced for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.

---

[1] Commissioning for Quality and Innovation

page 3 of 7

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	1,047	1,049	0.2%	23	0	
Cost and vol variances	27	27	-0.3%	-1	0	
NPAs	16	16	0.0%	0	0	
Projects and other	104	85		–	0	Income matched to costs, so variance is largely offset.
Day Unit	59	58	-1.4%	-10	0	
FDAC 2nd phas	64	54	-16.2%	-125	0	Income matched to costs, so variance is largely offset.
Court report	2	0	-98.9%	-28	0	
Total	1,320	1,289		-141	0	

4. Consultancy

4.1 TCS income was £52k in April, compared to the phased budget of £75k. The shortfall was offset, however, by savings of £15k, mainly on associates. Our forecast for the year assumes at present that the budget is achieved.

4.2 Departmental consultancy is £10k below budget after one month. The majority of the shortfall is within Portman. Actions to recover the shortfall will be required to deliver against plan.

5. Training

5.1 Training income is £88k below budget after April, with the shortfall on Psych Trainees being offset by Training Fees. There were also refunds backdated to last financial year which have also contributed to the shortfall.

5.2 Income from university partners remains under negotiation. Apart from this, the other key area of uncertainty is, as always, fee income from students and sponsors for the academic year starting in October.

Carl Doherty
Deputy Director of Finance
19 May 2014

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2014-15

		Apr-14			CUMULATIVE			FULL YEAR 2014-15		
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	FORECAST OUTTURN £000	BUDGET VARIANCE £000
INCOME										
1	CLINICAL	1,320	1,289	(31)	1,320	1,289	(31)	15,817	15,817	0
2	TRAINING	1,641	1,553	(88)	1,641	1,553	(88)	20,747	20,747	0
3	CONSULTANCY	124	92	(32)	124	92	(32)	1,490	1,490	0
4	RESEARCH	10	8	(2)	10	8	(2)	123	123	0
5	OTHER	69	28	(40)	69	28	(40)	824	824	0
TOTAL INCOME		3,163	2,970	(193)	3,163	2,970	(193)	39,000	39,000	0
OPERATING EXPENDITURE (EXCL. DEPRECIATION)										
6	CLINICAL DIRECTORATES	1,583	1,494	89	1,583	1,494	89	19,006	19,006	(0)
7	OTHER TRAINING COSTS	772	756	17	772	756	17	10,510	10,510	0
8	OTHER CONSULTANCY COSTS	66	50	15	66	50	15	790	790	0
9	CENTRAL FUNCTIONS	603	577	25	603	577	25	7,226	7,226	0
10	TOTAL RESERVES	39	0	39	39	0	39	463	463	0
TOTAL EXPENDITURE		3,063	2,878	185	3,063	2,878	185	37,994	37,994	0
EBITDA		100	93	(8)	100	93	(8)	1,006	1,006	(0)
ADD:-										
11	BANK INTEREST RECEIVED	0	1	(0)	0	1	(0)	5	5	0
LESS:-										
12	DEPRECIATION & AMORTISATION	46	61	(15)	46	61	(15)	550	727	177
13	FINANCE COSTS	0	0	0	0	0	0	0	1	1
14	DIVIDEND	35	35	0	35	35	0	421	421	(0)
SURPLUS BEFORE RESTRUCTURING COSTS		20	(2)	(23)	20	(2)	(22)	40	(138)	(178)
15	RESTRUCTURING COSTS	0	4	(4)	0	4	(4)	0	4	(4)
SURPLUS/(DEFICIT) AFTER RESTRUCTURING		20	(7)	(28)	20	(7)	(27)	40	(142)	(182)
EBITDA AS % OF INCOME		3.2%	3.1%		3.2%	3.1%		2.6%	2.6%	

Finance & Performance Report

	All figures £000	Apr-14			CUMULATIVE			FULL YEAR 2014-15			
		BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	OPENING BUDGET	REVISED BUDGET	FORECAST	REVISED BUDGET VARIANCE
	INCOME										
1	CENTRAL CLINICAL INCOME	588	588	0	588	588	0	7,054	7,054	7,054	0
2	CAMHS CLINICAL INCOME	335	319	(16)	335	319	(16)	3,987	3,993	3,993	6
3	SAAMHS CLINICAL INCOME	397	382	(15)	397	382	(15)	4,398	4,770	4,770	372
4	NHS LONDON TRAINING CONTRACT	605	605	0	605	605	0	7,254	7,254	7,254	0
5	CHILD PSYCHOTHERAPY TRAINEES	179	145	(34)	179	145	(34)	2,148	2,148	2,148	0
6	JUNIOR MEDICAL STAFF	80	69	(11)	80	69	(11)	1,022	957	957	(65)
7	POSTGRADUATE MED & DENT'L EDUC	8	2	(6)	8	2	(6)	94	94	94	(0)
8	DET TRAINING FEES & ACADEMIC INCOME	40	23	(17)	40	23	(17)	1,739	1,362	1,362	(377)
9	CAMHS TRAINING FEES & ACADEMIC INCOME	595	594	(1)	595	594	(1)	6,743	7,120	7,120	377
10	SAAMHS TRAINING FEES & ACADEMIC INCOME	112	97	(15)	112	97	(15)	1,530	1,530	1,530	0
11	TC TRAINING FEES & ACADEMIC INCOME	22	19	(4)	22	19	(4)	282	282	282	0
12	TC INCOME	75	52	(23)	75	52	(23)	925	900	900	(25)
13	CONSULTANCY INCOME CAMHS	9	8	(1)	9	8	(1)	110	110	110	0
14	CONSULTANCY INCOME SAAMHS	40	31	(9)	40	31	(9)	492	480	480	(12)
15	R&D	10	8	(2)	10	8	(2)	123	123	123	0
16	OTHER INCOME	69	28	(40)	69	28	(40)	1,159	824	824	(335)
	TOTAL INCOME	**3,163**	**2,970**	**(193)**	**3,163**	**2,970**	**(193)**	**39,059**	**39,000**	**39,000**	**(58)**
	EXPENDITURE										
17	COMPLEX NEEDS	297	317	(21)	297	317	(21)	3,560	3,560	3,560	0
18	PORTMAN CLINIC	102	98	4	102	98	4	1,225	1,225	1,225	(0)
19	GENDER IDENTITY	126	82	44	126	82	44	1,253	1,513	1,513	(260)
20	DEV PSYCHOTHERAPY UNIT	9	10	(1)	9	10	(1)	114	114	114	(0)
21	NON CAMDEN CAMHS	349	335	14	349	335	14	4,231	4,183	4,183	48
22	CAMDEN CAMHS	361	360	1	361	360	1	4,350	4,332	4,332	17
23	CHILD & FAMILY GENERAL	42	72	(30)	42	72	(30)	503	503	503	(0)
24	FAMILY NURSE PARTNERSHIP	298	220	78	298	220	78	3,575	3,575	3,575	(0)
25	JUNIOR MEDICAL STAFF	83	75	8	83	75	8	966	993	993	(27)
26	NHS LONDON FUNDED CP TRAINEES	179	159	20	179	159	20	2,148	2,148	2,148	0
27	TAVISTOCK SESSIONAL CP TRAINEES	2	3	(1)	2	3	(1)	19	19	19	0
28	FLEXIBLE TRAINEE DOCTORS & PGMDE	25	30	(5)	25	30	(5)	394	306	306	88
29	EDUCATION & TRAINING	200	178	22	200	178	22	3,447	3,447	3,447	(0)
30	VISITING LECTURER FEES	86	97	(10)	86	97	(10)	1,229	1,229	1,229	0
31	CAMHS EDUCATION & TRAINING	119	128	(9)	119	128	(9)	1,429	1,429	1,429	0
32	SAAMHS EDUCATION & TRAINING	78	86	(8)	78	86	(8)	939	939	939	0
33	TC EDUCATION & TRAINING	0	0	(0)	0	0	(0)	0	0	0	0
34	TC	66	50	15	66	50	15	815	790	790	25
35	R&D	20	10	10	20	10	10	169	242	242	(73)
36	ESTATES DEPT	173	185	(12)	173	185	(12)	2,078	2,078	2,078	(0)
37	FINANCE, ICT & INFOMATICS	169	141	28	169	141	28	2,326	2,026	2,026	300
38	TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	83	77	6	83	77	6	998	998	998	(0)
39	COMMERCIAL DIRECTORATE	61	56	5	61	56	5	738	736	736	2
40	HUMAN RESOURCES	53	63	(10)	53	63	(10)	632	632	632	(0)
41	CLINICAL GOVERNANCE	44	45	(2)	44	45	(2)	587	514	514	73
42	PROJECTS CONTRIBUTION	0	0	0	0	0	0	(73)	0	0	(73)
43	DEPRECIATION & AMORTISATION	46	61	(15)	46	61	(15)	550	550	727	0
44	IFRS HOLIDAY PAY PROV ADJ	0	0	0	0	0	0	100	100	100	0
45	PRODUCTIVITY SAVINGS	8	0	8	8	0	8	(134)	0	0	(134)
46	INVESTMENT RESERVE	(1)	0	(1)	(1)	0	(1)	120	(14)	(14)	134
47	CENTRAL RESERVES	31	0	31	31	0	31	315	377	377	(62)
	TOTAL EXPENDITURE	**3,109**	**2,938**	**171**	**3,109**	**2,938**	**171**	**38,603**	**38,544**	**38,721**	**58**
	OPERATING SURPLUS/(DEFICIT)	**55**	**32**	**(23)**	**55**	**32**	**(23)**	**456**	**456**	**279**	**(0)**
48	INTEREST RECEIVABLE	0	1	0	0	1	0	5	5	5	0
49	DIVIDEND ON PDC	(35)	(35)	0	(35)	(35)	0	(421)	(421)	(421)	0
	SURPLUS/(DEFICIT)	**20**	**(2)**	**(22)**	**20**	**(2)**	**(22)**	**40**	**40**	**(137)**	**(0)**
50	RESTRUCTURING COSTS	0	4	(4)	0	4	(4)	0	0	4	0
	SURPLUS/(DEFICIT) AFTER RESTRUCTURING	**20**	**(7)**	**(27)**	**20**	**(7)**	**(27)**	**40**	**40**	**(141)**	**(0)**

page 6 of 7

2014/15 Plan

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	2,757	5,732	4,794	3,697	5,045	3,994	2,533	4,683	3,608	2,174	3,979	3,207	2,757
Operational income received													
NHS (excl SHA)	2,908	1,468	1,339	1,414	1,338	1,308	1,299	1,337	1,309	1,299	1,338	1,309	17,666
General debtors (incl LAs)	671	502	656	663	737	552	721	592	609	564	932	592	7,791
HEE for Training	2,567	142	79	2,567	143	79	2,567	142	79	2,567	143	79	11,156
Students and sponsors	325	150	150	100	0	200	800	250	100	750	100	100	3,025
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
	6,471	2,262	2,224	4,744	2,218	2,139	5,387	2,321	2,097	5,180	2,513	2,080	39,638
Operational expenditure payments													
Salaries (net)	(1,346)	(1,346)	(1,358)	(1,357)	(1,358)	(1,378)	(1,409)	(1,395)	(1,392)	(1,386)	(1,386)	(1,386)	(16,497)
Tax, NI and Pension	(991)	(995)	(995)	(1,003)	(1,003)	(1,003)	(1,018)	(1,042)	(1,031)	(1,029)	(1,025)	(1,025)	(12,160)
Suppliers	(1,159)	(860)	(859)	(934)	(709)	(709)	(709)	(709)	(709)	(709)	(709)	(709)	(9,487)
	(3,496)	(3,201)	(3,212)	(3,294)	(3,070)	(3,090)	(3,136)	(3,146)	(3,132)	(3,124)	(3,120)	(3,120)	(38,144)
Capital Expenditure	0	0	(100)	(100)	(200)	(300)	(100)	(250)	(400)	(250)	(166)	(450)	(2,316)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	0	1	0	1	0	1	0	0	1	0	1	0	5
Payments from provisions	0	0	(9)	(2)	0	0	0	0	0	0	0	0	(11)
PDC Dividend Payments	0	0	0	0	0	(211)	0	0	0	0	0	(210)	(421)
Closing cash balance	5,732	4,794	3,697	5,045	3,994	2,533	4,683	3,608	2,174	3,979	3,207	1,507	1,507

2014/15 *Actual/Forecast*

	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	2,757	4,441	4,803	3,696	5,045	3,993	2,532	4,682	3,607	2,173	3,979	3,207	2,757
Operational income received													
NHS (excl SHA)	1,982	2,768	1,339	1,414	1,338	1,308	1,299	1,337	1,309	1,299	1,338	1,309	18,040
General debtors (incl LAs)	886	502	656	663	737	552	721	592	609	564	932	592	8,006
HEE for Training	2,443	142	79	2,567	143	79	2,567	142	79	2,567	143	79	11,032
Students and sponsors	277	150	150	100	0	200	800	250	100	750	100	100	2,977
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
	5,588	3,562	2,224	4,744	2,218	2,139	5,387	2,321	2,097	5,180	2,513	2,080	40,055
Operational expenditure payments													
Salaries (net)	(1,344)	(1,346)	(1,358)	(1,357)	(1,358)	(1,378)	(1,409)	(1,395)	(1,392)	(1,386)	(1,386)	(1,386)	(16,495)
Tax, NI and Pension	(1,033)	(995)	(995)	(1,003)	(1,003)	(1,003)	(1,018)	(1,042)	(1,031)	(1,029)	(1,025)	(1,025)	(12,202)
Suppliers	(1,498)	(860)	(869)	(934)	(709)	(709)	(709)	(709)	(709)	(709)	(709)	(709)	(9,836)
	(3,875)	(3,201)	(3,222)	(3,294)	(3,070)	(3,090)	(3,136)	(3,146)	(3,132)	(3,124)	(3,120)	(3,120)	(38,533)
Capital Expenditure	(29)	0	(100)	(100)	(200)	(300)	(100)	(250)	(400)	(250)	(166)	(450)	(2,345)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	0	1	0	1	0	1	0	0	1	0	1	0	5
Payments from provisions	0	0	(9)	(2)	0	0	0	0	0	0	0	0	(11)
PDC Dividend Payments	0	0	0	0	0	(211)	0	0	0	0	0	(210)	(421)
Closing cash balance	4,441	4,803	3,696	5,045	3,993	2,532	4,682	3,607	2,173	3,979	3,207	1,507	1,507

Finance & Performance
Report

Board of Directors: May 2014

Item : 8

Title : Summary results, findings and action plan from the 2013 staff survey

---

Purpose:

The purpose of this report is to provide the Board with a summary and analysis of the 2013 staff survey results, highlighting important areas and to provide assurance that the views expressed by staff in the survey are being addressed.

Summary of the report:

- Brief discussion of the Trust's survey results from 2012
- Findings from 2013: In particular, areas where the Trust needs to improve
- Other important areas such as Equalities , demographic groupings and specific work areas
- Any other areas of concern and action plans to ensure improvements

Some of the key highlights from the report are summarised below –

- Staff response rates have improved this year but are still below the national average of 49%
- The overall staff engagement score is once again higher than the national average (national average is 3.71 and the Trusts score is 3.91, measured on a scale of 1 – 5, 5 being highly engaged and 1 poorly engaged)
- Some of the other areas where the trust received the best scores include –
  1. The percentage of staff reporting good communication between senior management and staff.
  2. The percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
  3. The percentage experiencing harassment, bullying and abuse from patients and public
  4. The percentage of staff feeling pressure to attend work while feeling unwell
  5. Staff job satisfaction

- In addition, of the 8 areas rated as poor or below average in 2012,

Summary results, findings and action plan: 2013 Annual Staff Survey

Staff Survey

5 of those areas have shown improvements this year.

- While most areas this year have shown improvements and have been rated as good, some areas such as reporting of errors and near misses and staff working extra hours are still not so good.
- Outcomes for disabled staff as in previous years are also not so good. (In terms of respondents, 9% of trust staff in the survey (20 staff) stated that they have a longstanding illness, health problem or a disability).
- The main areas to tackle this year, include staff working additional hours, availability of hand washing materials, reporting of errors and near misses, low outcomes for attendance at health and safety and equalities training and staff experiencing bullying and harassment from staff.
- Action plans to tackle these and to improve response rates are contained in this report.

This report has been reviewed by the Management Committee on 15th May 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
- Staff

For : Discussion and Approval

From : Susan Thomas, Director of HR

2013 Annual Staff Survey

Summary Results, Findings and Action Plan

Contents

Staff Survey

Introduction

This document summarises the results from the **2013** NHS annual staff survey. This national survey, commissioned by the Care Quality Commission (CQC) for NHS staff, takes place annually between October and December, with results published in February. Over the years the Trust has done very well in this survey and is regularly commended externally on its survey results.

The results from this year's survey (2013) are once again good and better than last year for a number of key survey areas. Out of a total of 28 key findings this year, the Trust has been rated as being in the highest/best category in 14 areas, rated as 'better than average' in 5 areas, average in 1 area and below average in 8 areas. The Trust also has the highest score of all mental health trusts in 6 of the areas where it is rated as being in the highest/best category.

The overall results in comparison with 2012 results are shown in the graph below
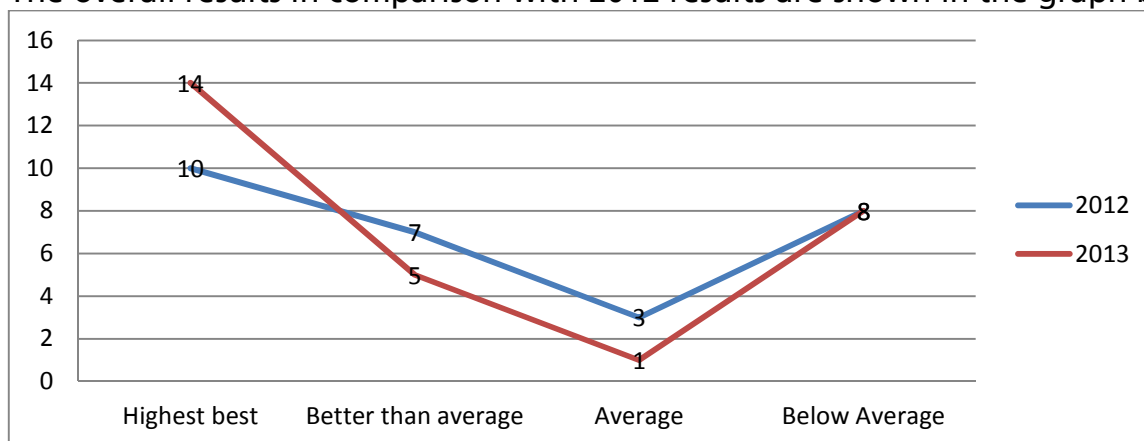
Another important achievement to highlight this year is the Trust's score for staff engagement. The Trust's staff engagement score is not only once again much higher than the national average but has also improved when compared with 2012. The staff engagement score is an important indicator of how staff feel and is calculated using findings from three key areas,- *Staff ability to contribute towards work improvements, staff recommending the Trust as a place to work and receive treatment and staff motivation at work*.

Other areas where the Trust had the highest scores include staff indicating good communication exists between management and staff, staff job satisfaction, staff feeling that their roles make a difference to patients, the numbers witnessing potentially harmful errors and the numbers experiencing bullying and Harassment from patients and the public.

In terms of response rates this year, questionnaires were sent out to 504 eligible staff and 235 staff responded. This is a response rate of 47%. While this has increased when compared with a return rate of 45% in 2012, it is still below the national response rate of 49%. Plans to improve the Trust's response rate in future surveys are discussed further in this report. The table below gives an indication of changes to the Trust's response rate over the last 4 years –

Summary results, findings and action plan: 2013 Annual Staff Survey

Year	2013	2012	2011	2010
Response (%)	47	45	52	51

Please note that the Tavistock is classified as a mental health/learning disability (MHLD) Trust, and is therefore compared with other MHLD Trusts across the country. The Trust scores are also weighted[1] based on the numbers of staff in each occupational group e.g. Nursing. This report contains the <u>weighted</u> scores. Unweighted scores are available on the main survey website.

2.   Summary of action taken to address concerns from the 2012 survey

A number of areas were identified as requiring improvement in the 2012 survey. Improvement plans were put in place to address those areas. This section highlights those plans and discusses areas where improvements have been identified from the 2013 survey results.

2.1 Key areas of concern from the 2012 Survey

The Trust did not do so well in the following areas in 2012

1. The number of staff working extra hours
2. The numbers agreeing that their roles made a difference to patients
3. The numbers receiving job relevant training
4. The numbers stating that they had undertaken health and safety training
5. The numbers suffering work related stress
6. The numbers stating adequate hand washing materials were available
7. The numbers reporting errors and near misses
8. The numbers feeling that the Trust provides equal opportunities for career progression

2.2 Action plans to secure improvements

A number of action plans were put in place to address the areas of concern above. Some of these include –

1. To address the issue of staff working additional hours, training sessions on managing pressure and time and workload management were provided throughout the year. In addition, some improvements were made to the job planning process for clinical staff.

2. To ensure staff get a better understanding of the work of the Trust and how their roles fit into patient care and deliver, throughout the year, staff were encouraged to prioritise attendance at mandatory Trust events as well as non-

---

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

Staff Survey

mandatory meetings and events such as team meetings, staff meetings and scientific meetings, which would.

3. Managers were encouraged to discuss training needs with staff thorough out the year and at appraisals. The HR staff training team provided regular information on available training and ensured that training funds were made available to staff throughout the year, in order to address the issue of job relevant training.

4. Additional stress awareness sessions were provided, which included health and safety briefings and further incident reporting training and e-mail briefings were provided throughout the year as well as during Induction sessions for new staff.

2.3   Outcomes from 2013 survey for the 2012 key improvement areas

Improvements were seen in the recent survey in five out of the eight areas highlighted as requiring improvement in 2012, these are shown below -

1. The percentage of staff working extra hours has improved, with 76% of staff stating this compared with 80% in 2012.
2. The number agreeing that their role makes a difference to patients has increased from 86% to 93%. The Trust's score of 93% is also the best score of all MHLD Trusts in 2013.
3. The number receiving job relevant training has improved, increasing from 73% in 2012 to 86% this year.
4. The numbers suffering work related stress has reduced from 43% to 40%, which is also lower than the average score for MHLD Trusts.
5. The numbers feeling that the Trust provides equal opportunities for career progression has improved slightly from 85% in 2012 to 86% this year.

The Three areas that haven't improved include -

6. The numbers stating adequate hand washing materials are available has reduced from 51% in 2012 to 48% this year.
7. The numbers undertaking health and safety training has reduced from 66% in 2012 to 60% in 2013.
8. The numbers reporting errors and near misses has reduced from 76% to 58%.

Further action will need to be taken to address these areas.

The next section of this report covers the findings from the 2013 survey and includes action plans to address specific areas, including those mentioned above.

3.   Findings and Action Plans (2013 survey)

The staff survey this year (2013) is once again structured around the four pledges of the NHS constitution with two additional themes. The four pledges and two additional themes from the survey are shown below:

Summary results, findings and action plan: 2013 Annual Staff Survey

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

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

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

Pledge 4: *staff involvement and engagement*

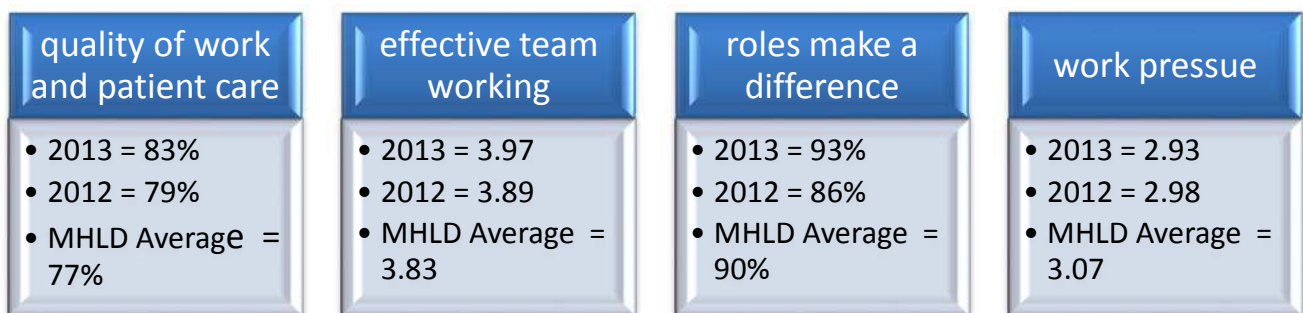**Additional Themes**

Theme 1: *Staff Satisfaction*

Theme 2: *Equalities and Diversity*

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

The Trust has done well in four out of five key findings for this pledge (compared with three out of five in 2012) and has been rated as being in the highest best category for all four key findings. This is a marked improvement; especially as the Trust was only rated as better than average for the three key findings in 2012. One key finding for this pledge still requires improvement and this relates to the higher proportion of staff working additional/extra hours.

3.1.1 Positive findings

The Trust has done well in the key areas shown below, all of which have improved when compared with 2012 results.

quality of work and patient care	effective team working	roles make a difference	work pressue
• 2013 = 83% • 2012 = 79% • MHLD Average = 77%	• 2013 = 3.97 • 2012 = 3.89 • MHLD Average = 3.83	• 2013 = 93% • 2012 = 86% • MHLD Average = 90%	• 2013 = 2.93 • 2012 = 2.98 • MHLD Average = 3.07

In addition, some of the Trust's results when considering demographic groupings have also shown improvements as seen below

Summary results, findings and action plan: 2013 Annual Staff Survey

Staff Survey
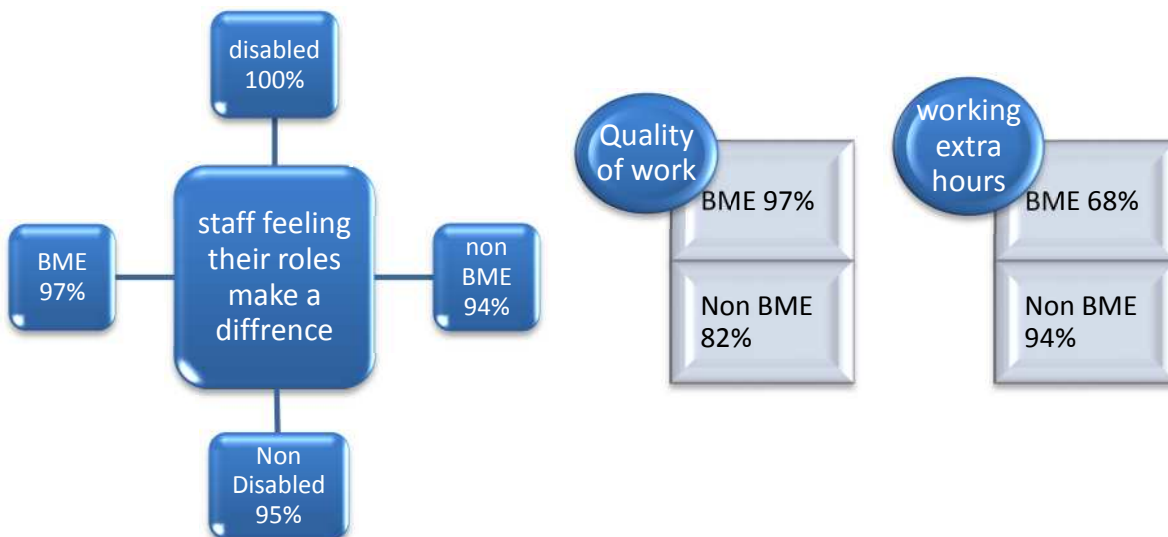
In summary, a higher proportion of BME staff compared to non-BME staff feel satisfied with the quality of their work and that their roles make a difference to patients. The lowest proportion of staff indicating that they are working extra hours is also seen the BME staff category. This group also scored highest than any other group for effective team working and lowest for work pressures. Disabled staff also scored highest in terms of feeling that their roles made a difference to patients

3.1.2 Negative Findings

As mentioned the only negative finding for this pledge relates to the number of staff working extra hours. This figure has however improved in comparison with 2012, though at 76% it is still higher than the MHLD average of 71%. The Trust's score in 2012 was 80%.

Further analysis of this outcome shows that working additional hours is higher for those staff aged 41 and above as well as for clinical staff. Other significant demographic findings for this pledge include a higher proportion of clinical staff and disabled staff experiencing pressure at work and a higher proportion of disabled staff stating that they work extra hours in comparison with other groups. A lower proportion of disabled staff also indicated that they feel satisfied with the quality of work and patient care they are able to deliver.

quality of work
disabled = 75%
non disabled = 85%

work pressure
disabled = 3.12
non-disabled = 2.90
clinical = 3.05
non-clinical = 2.71

working extra hours
disabled = 80%
non disabled = 78%

working extra hours
clinical staff = 85%
non-clinical = 67%
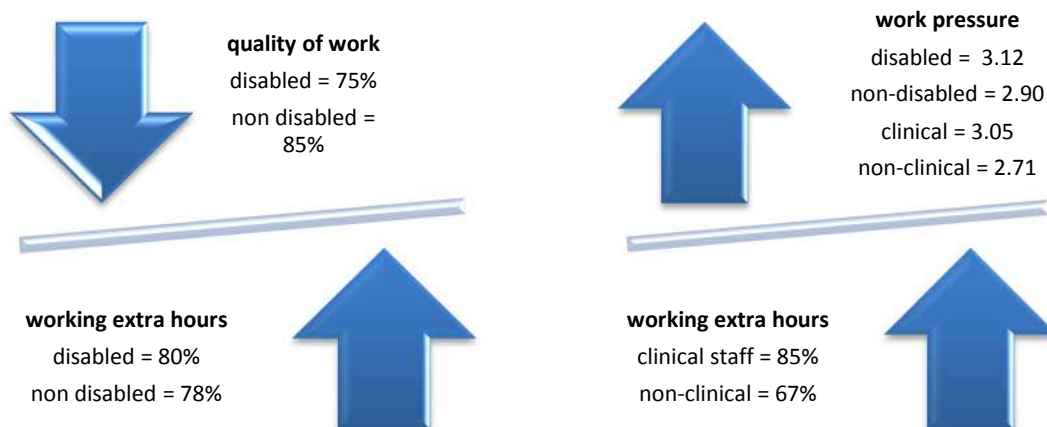
Action

The findings from this year's survey show that the main issue is still the number of staff working extra hours. It is important that improvements to the Job planning process continue this year. As in previous surveys, working extra hours is much more prevalent with clinical staff, with this staff group also experiencing higher levels of work pressure. Further training events on managing pressure and time and workload management will need to be rolled out and clinical staff in particular should be encouraged to attend these events. Consideration should also be given to running time management sessions at clinical staff meetings.

The slightly poorer outcomes for staff with disabilities in a number of areas also requires further work and a number of the interventions mentioned above will need to be targeted at those groups.

Responsibility for Action – Director of Human Resources, Trust Director

Completion Date – April 2015

3.2 Pledge 2 – Personal development and access to training

In 2012, the Trust was rated as average in three out of four key areas for this pledge and below average in one area. This year, the Trust has shown an even better result, with higher than average scores in two areas, a highest best score in one area and a lower than average score in just one area.

3.2.1 Positive findings

Staff receiving Job relevant training	Staff having well structured appraisals	support from immediate managers
• 2013 = 86% • 2012 = 73% • MHLD Average = 82%	• 2013 = 44% • 2012 = 45% • MHLD Average = 42%	• 2013 = 3.86 • 2012 = 3.79 • MHLD Average = 3.82

Summary results, findings and action plan: 2013 Annual Staff Survey

Staff Survey
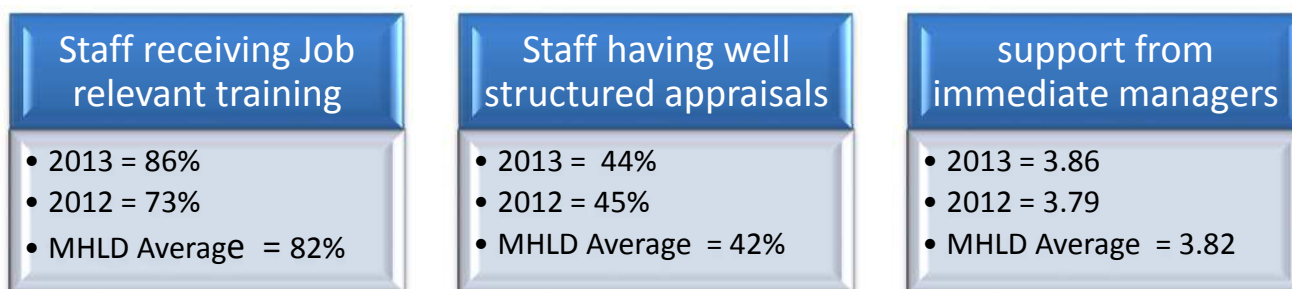
Of the three areas above, the number of staff receiving job relevant training has shown the most increase, when compared with the Trust's 2012 result. This score is also higher than the MHLD average and just 2% lower than the best score for MHLD Trusts. This is a good outcome as this area was rated as below average in 2012.

Other positive demographic and occupational findings include good outcomes for BME staff in terms of receiving job relevant training and a higher proportion of disabled staff and administrative staff indicating that they have been appraised in the last 12 months.

3.2.2 Negative Findings

The only area rated as not so good for this pledge is in relation to the number of staff appraised in the last 12 months. The Trust's score of 84% is lower than the MHLD average of 87% and lower than its 2012 score of 86%. Further analysis of demographic data also shows that as in previous years overall outcomes for administrative staff and staff in central functions are generally lower for this pledge in a number of areas such as receiving job relevant training and having well structured appraisals. Outcomes for disabled staff are also lower in three areas of this pledge when compared to other staff groups.

These outcomes for administrative and disabled staff are shown below
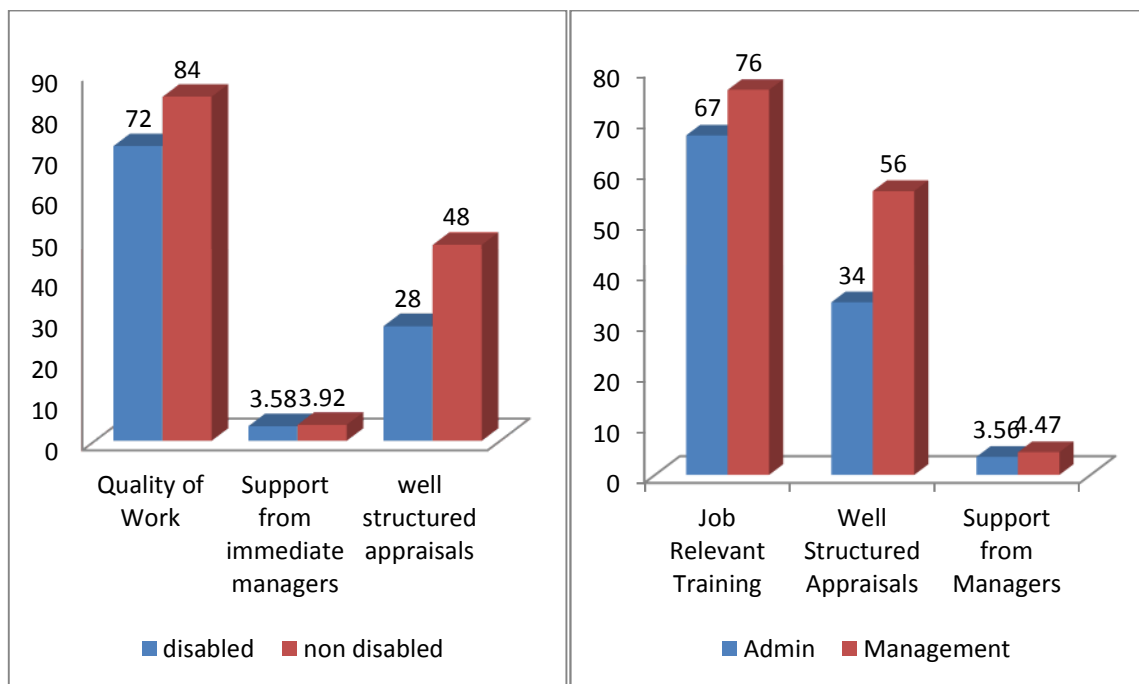
Action

The Trusts actual return rates for personal development plans and appraisals in 2013 were over 90%. This is similar to the return rate this year which is closer to 95%. This does not therefore seem congruent with the staff survey results. One possible explanation for this discrepancy is that a higher number of new starters responded to this survey question, a majority of who would not have been employed by the Trust long enough to have been part of the 2013 appraisal process.

Summary results, findings and action plan: 2013 Annual Staff Survey

The Trust will continue to monitor its annual PDP return rates internally to ensure that this does not fall below 90%.
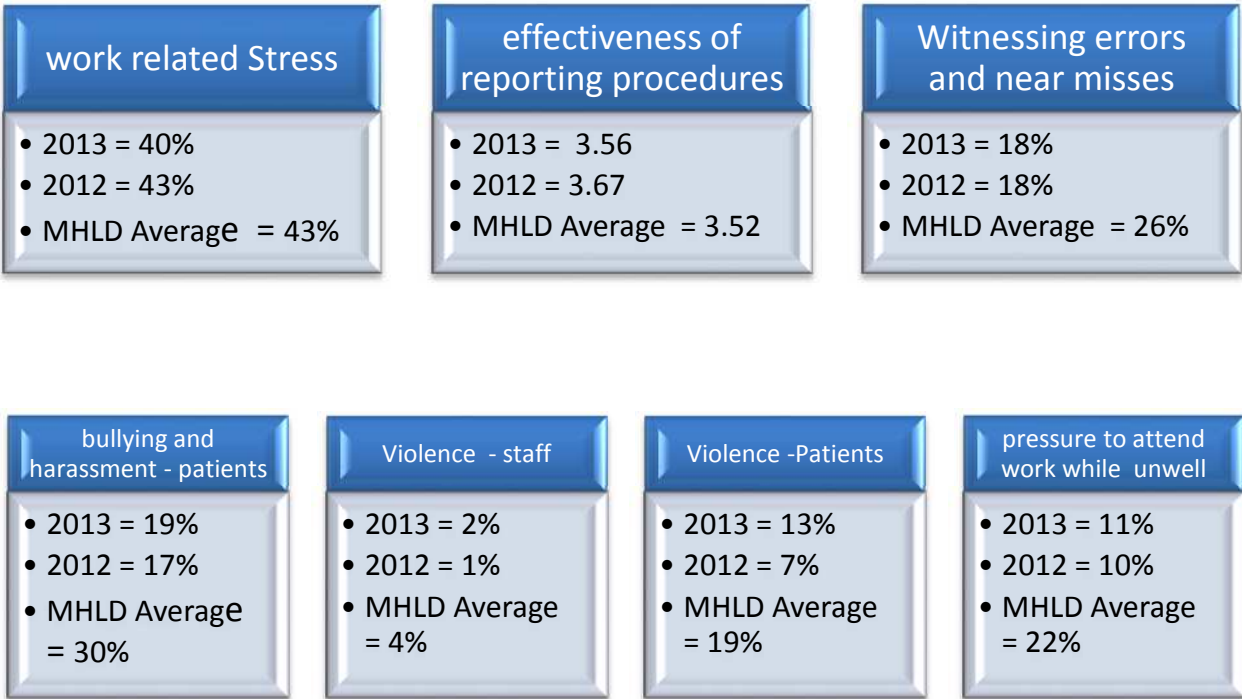
3 Pledge 3 – Maintaining staff health and wellbeing

In 2012, the Trust had good scores in seven out of eleven key areas for this pledge. This year the Trust has also shown good scores in seven areas and rated as having the highest best scores in five of those seven areas. In addition seven areas have improved in comparison with 2012 results.

3.3.1 Positive findings

The areas where the Trust scored extremely well for this pledge and has been rated as having the highest best score are in areas such as the low numbers suffering work related stress (which has improved compared to 2012), the low numbers of staff witnessing errors and incidents the low numbers experiencing harassment, bullying, violence from staff, patients and members of the public and the number agreeing that that the Trust has fair and effective incident reporting procedures. The Trust also scored highly in terms of the numbers of staff feeling pressure to attend work. In terms of positive outcomes when considering demographic statistics, the lowest proportion staff experiencing work related stress and feeling pressure to attend work is in the BME group.

Some of these positive outcomes are shown below

work related Stress	effectiveness of reporting procedures	Witnessing errors and near misses
• 2013 = 40% • 2012 = 43% • MHLD Average = 43%	• 2013 = 3.56 • 2012 = 3.67 • MHLD Average = 3.52	• 2013 = 18% • 2012 = 18% • MHLD Average = 26%

bullying and harassment - patients	Violence - staff	Violence -Patients	pressure to attend work while unwell
• 2013 = 19% • 2012 = 17% • MHLD Average = 30%	• 2013 = 2% • 2012 = 1% • MHLD Average = 4%	• 2013 = 13% • 2012 = 7% • MHLD Average = 19%	• 2013 = 11% • 2012 = 10% • MHLD Average = 22%

Summary results, findings and action plan: 2013 Annual Staff Survey

Staff Survey

3.3.2 Negative Findings

The four main areas where the Trust has not done so well are in relation to the numbers stating that they have undertaken health and safety training in the past year, the numbers stating hand washing materials are available, the numbers reporting errors, near misses or incidents and the numbers experiencing bullying and harassment from staff. It is important to mention that the Trust also had low scores for the percentage of staff reporting errors, near misses or incidents and those undertaking Health and Safety in 2010, 2011 as well as in 2012.

The Trust's score for availability of hand washing materials seems to be on a steady decline from a good above average score of 66% in 2011 to 51% in 2012 and down to 48% this year, with the MHLD average this year being 54%. The Trust also had a good score in 2012 for the numbers experiencing bullying and harassment from staff (18%, which was above the 21% MHLD average), however the Trusts score of 23% this year is below the national average of 20%.

Other areas to consider include a higher proportion of disabled staff suffering work related stress, experiencing bullying and harassment from staff and feeling pressure to attend work while unwell. Additionally a higher proportion of nursing staff stated that they experienced bullying from staff in the last 12 months (45% compared to 10% for other clinical staff groups)

Some of the poorer outcomes for disabled staff in this category are shown below -
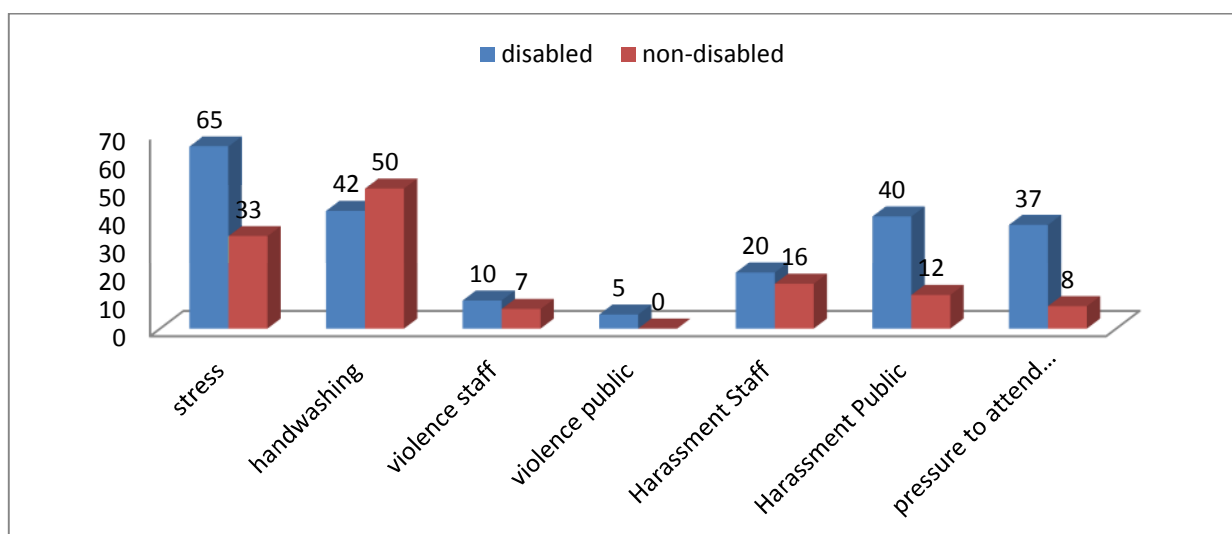
Action

The main areas to focus on relate to hand washing, incident reporting, bullying and harassment by staff and health and safety training.
In terms health and safety training and incident reporting, the Trust provides this via its INSET events which staff are only required to attend every two years. As the question is whether staff have had training in the last year this is bound to affect response rates.

The Trust however should continue providing additional health and safety training updates outside the normal INSET events. This should be done through email alerts,

briefing hand-outs, flyers and health and safety awareness sessions either in teams or at directorate meetings. Incident reporting training should continue to be provided to all staff frequently throughout the year. E-mail notifications with details of incident reporting procedures and Q&As included as information briefings, should also be provided regularly.

The Trust will also need to consider whether further improvements can be made to the existing hand washing provision. The area of bullying and harassment also needs to be looked into and further training provided including how to raise and deal with concerns.

The poorer outcomes for disabled staff which seems to be a theme throughout the survey and in previous surveys also needs to be looked into and it is recommended that this is discussed and analysed further by the Trust's Equality Committee.

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

Completion Date – June 2015

3.4   Pledge 4 – Staff involvement and engagement

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

3.4.1 Positive findings

good communication between senior management and staff	able to contribute towards improvements at work
• 2013 = 49% • 2012 = 52% • MHLD Average = 31% • Best MHLD Score = 49%	• 2013 = 75% • 2012 = 76% • MHLD Average = 72% • Best MHLD Score = 79%

The Trust's score for the percentage of staff reporting good communication between senior management and staff, has been rated as the best score of all MHLD Trusts and much higher than the MHLD average score. The second finding for this category relates to the number of staff stating that they are able to contribute towards improvements at work, which is also higher than the MHLD average. While both areas have dipped very slightly compared to 2012, they are still extremely good.

Looking at the demographic statistics for this area, important points to note, include a higher proportion of BME staff and staff aged between 16 -30 feeling able to contribute to work improvements. Part-time staff also feel more able to contribute towards work improvements than full time staff, as well as staff in central and corporate services functions. Some of these outcomes are shown below -

Summary results, findings and action plan: 2013 Annual Staff Survey
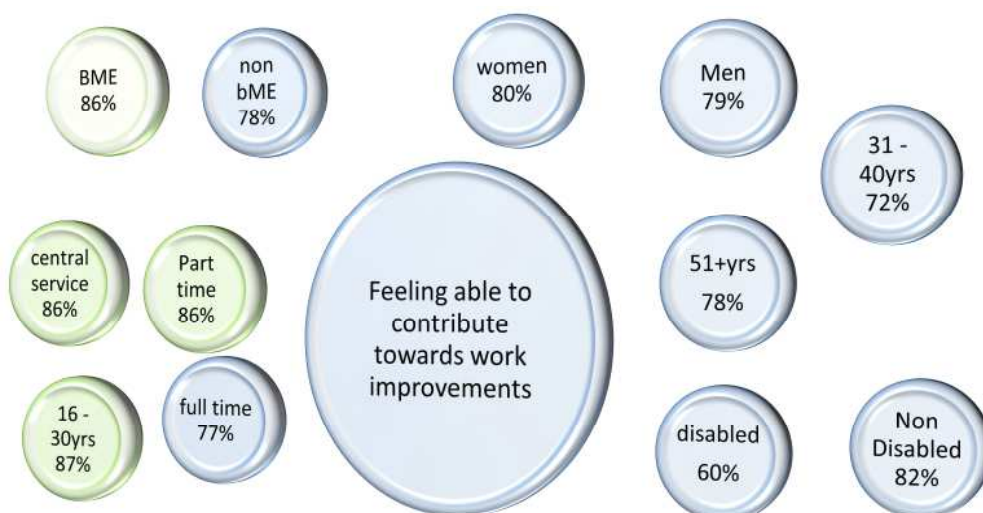
3.4.2 Negative findings

Once again with this pledge, some areas for further improvement relate to the slightly lower outcomes for disabled staff in comparison with other groups. 35% of disabled staff indicated that there is good communication between management and staff, compared with 49% for non-disabled staff. The figure for BME staff for this question at 40% is also lower than other groups. Additionally non-clinical staff scored much lower than clinical staff for both questions in this pledge and administrative staff reported the lowest outcomes (28%) in terms of good communication between staff and management.

The negative findings by demographic group is illustrated below-
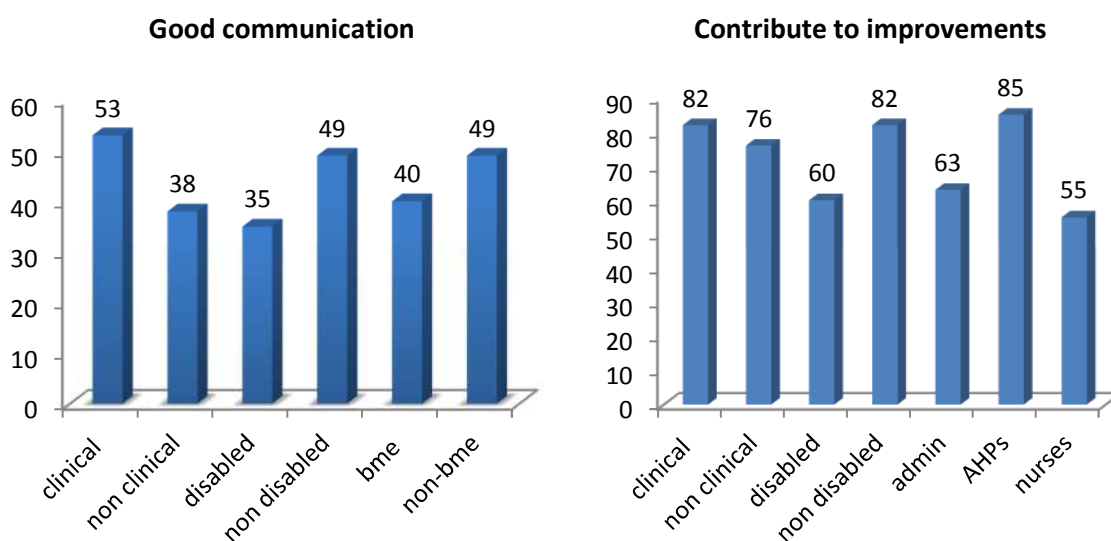
Action

The Trust's overall results for this pledge are very good, however it is important that the Trust continues to work on improving its communication and staff involvement groups to ensure that they are much more inclusive and accessible and understood by all levels of staff. Improved methods of ensuring that all levels of staff feel engaged and are able to contribute to the Trust's work should be considered by the management committee and the Board. The Human Resources department will continue to work with the Trust's communications team in this area.

3.5   Additional Theme 1: Staff Satisfaction

In 2012, the Trust was rated as being in the highest best for one area and above average for two areas of this pledge. This year the trust has improved on this outcome and is rated as highest best for two areas and one area has been rated as above average.

3.5.1 Positive findings

job satisfaction	recommending the Trust	Motivation at work
• 2013 = 3.84 • 2012 = 3.73 • MHLD Average = 3.67	• 2013 = 4.02 • 2012 = 3.99 • MHLD Average = 3.55	• 2013 = 3.88 • 2012 = 3.87 • MHLD Average = 3.85

The Trust is ranked as being in the highest best category for job satisfaction and staff recommending the Trust as a place to work and receive treatment and better than average for staff motivation at work. All three areas have also improved when compared with 2012 results.

Demographic and occupational findings for this pledge are also good, with a higher proportion of BME staff reporting staff satisfaction, motivation, and that they would recommend the Trust to others. Motivation was also highest in the 41 – 50 and 51+ age group. Clinical staff scored better than non-clinical staff in all three areas, once again showing that while clinical staff work the most additional hours they also seem the most motivated with high levels of job satisfaction.

Staff in management and administrative functions are the most satisfied and are more likely to recommend the Trust to others, while CAMHS staff are the most motivated, when comparing occupational groupings.

The Trust's demographic results are shown below and while there are no major negative findings to report for this pledge, the lower outcomes for disabled staff should once again be noted.

non BME 3.90

BME 4.01

mgt &admin 4.12

Non Disabled 3.96

job satisfaction

non-clinical 3.88

disabled 3.52

clinical 3.94

CAMHS 3.97

non-BME 3.89

Mgt &admin 3.87

Motivation

51+ yrs 4.05

SAMHS 3.88

non-clinical 3.77

clinical 3.94
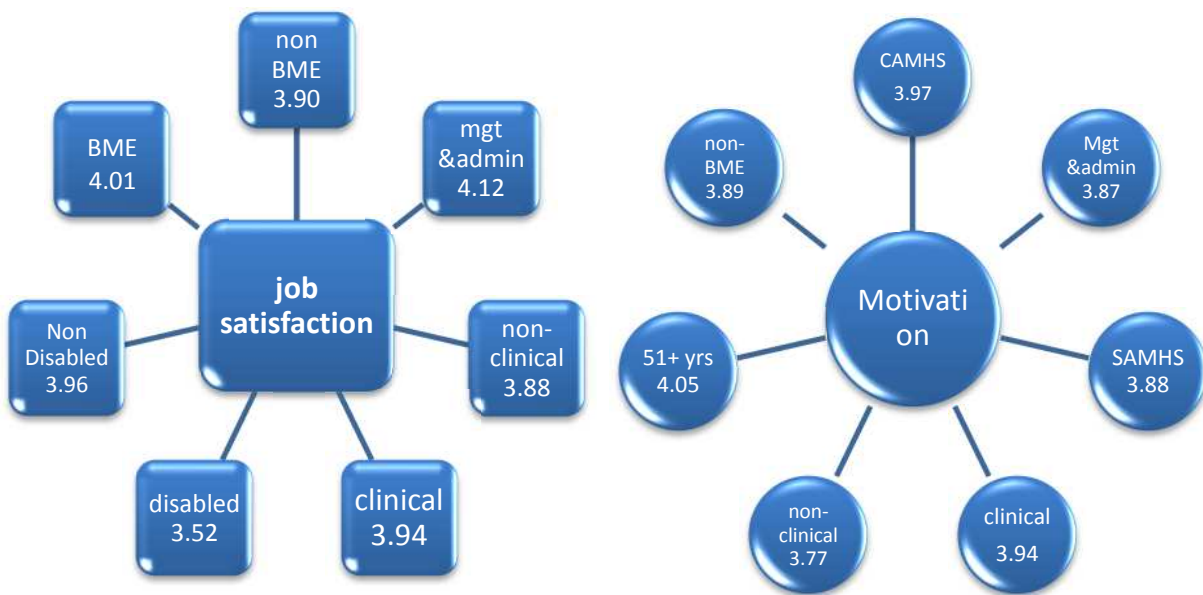
3.6 Additional Theme 2: Equalities and Diversity

This area seems to be showing a steady decline. In 2011, the Trust did well in all three areas of this pledge and was rated in highest best for all three categories. In 2012, one area was rated as being below average, with the other two areas rated as average and better than average respectively. This year two areas have been rated as below average and one area as average.

Staff receiving equalities training	believe the Trust provides equality in career progression	Experiencing discrimination
• 2013 = 50% • 2012 = 61% • MHLD Average = 67%	• 2013 = 86% • 2012 = 85% • MHLD Average = 89%	• 2013 = 12% • 2012 = 10% • MHLD Average = 13%

3.6.1 Positive Findings

The Trust has been rated as average this year for the number of staff experiencing discrimination at work in the last 12 months. The Trust's score for this area has increased slightly from 2012 and while it just below the MHLD average this year, it is quite some way above the best MHLD score of 6%.

Some positive areas to mention in terms of demographic and occupational statistics are the better outcomes for BME staff in all areas of this pledge, when compared to non-BME staff, with the highest proportion of staff stating that the Trust provides equal opportunities in career progression coming from the BME group.

Summary results, findings and action plan: 2013 Annual Staff Survey

The overall percentage stating that they believe the Trust provides equal opportunities in career progression has also gone up this year, however it is still below the MHLD average.

3.6.2 Negative Findings

Overall, the Trust has not done well in terms of the numbers believing the Trust provides equal opportunities for career progression or promotion and in the area of equalities training. Equalities training similar to health and safety training is mainly provided at the Trust's INSET day and staff are only required to attend every two years, though the Trust does provide additional equalities sessions throughout the year, however these are poorly attended.

In terms of demographic and occupational data, there are no major differentials when looking specific statistics for this pledge.

Action

The numbers attending equalities training needs to be improved upon. A number of diversity training events take place throughout the year across the Trust, staff need to be encouraged to attend these events. Consideration should also be given to providing training sessions at team meetings and team events.

Responsibility for Action – HR Director, Trust Equalities Chair

Completion Date – June 2015

4. Conclusion

The survey results this year are good. A number of areas noted as requiring improvements in the 2012 survey have shown improvements this year. As in previous years, there still remain number of areas that require further work such as the numbers of staff working extra hours, the numbers undertaking health and safety training and the numbers reporting incidents, errors and near misses. Additionally, the poorer outcomes for disabled staff for a number of key areas needs to be addressed.

The overall response rate in terms of the numbers completing the survey has improved this year, though it could be better. This year the Trust gave staff the opportunity to win five Kindles as an added incentive to participate in the survey. The trust should consider continuing with this for the next survey as well as improving communications and encouraging staff to complet the survey. The Trust should also consider online surveys in the next survey round and the HR department is looking how best to implement this.

This year, as in previous years, unadjusted or unweighted scores <u>have not</u> been used in this report when making comparisons. Using raw unadjusted scores to analyse this Trust's data has usually improved the Trust's outcomes for most questions.

Summary results, findings and action plan: 2013 Annual Staff Survey

Staff Survey

Notwithstanding this, our results this year, without unweighted scores, still show that the Trust continues to improve and outperform many other Trusts in its sector. Additionally, once again the Trust has been rated as being in the highest best category for overall staff engagement, when compared with Trusts of a similar type. This is an extremely good result.

Namdi Ngoka,
Associate Director of HR,
May 2014

The Tavistock and Portman **NHS**
NHS Foundation Trust

Board of Directors : May 2014

Item : 9

Title : CQSG Report, Q4, 2013/14

Purpose:

The purpose of this report is to give an overview of performance of clinical quality, safety, and governance matters in the opinion of members of the CQSG. The Board of Directors is asked to confirm whether this paper is accepted as adequate assurance, and where not, whether the Board of Directors is satisfied with the action plans that have been put in place.

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

- Clinical Quality, Safety, and Governance Committee
- Management Committee, 15th May 2014

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

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

This report focuses on the following areas:
- Quality
- Patient / User Experience
- Patient / User Safety
- Risk

For : Discussion

From : Rob Senior, CQSG Chair

Page 1 of 20

CQSG Report, Q4, 2013/14

1.   Introduction

1.1   The overview summary of areas already considered by the CQSG is set out in Appendix 1; the Board of Directors is reminded that ratings are not given in the same way as for the Risk Register.

1.2   The focus in this narrative is on areas of concern and interest to which the board should pay particular attention; it is not simply an amplification of red and amber rated elements.

2.   Findings

2.1   Appendix 1 sets out the detail by reporting line, the expected rating in column on the right of the table may change over that reporting period.

2.2   Having considered and discussed the reports, the committee set the level of assurance as demonstrated; this is recorded below.

2.3   Corporate Governance and Risk

2.3.1   Substantial assurance was demonstrated

2.3.2   All areas green

2.3.3   The committee commended the estates team in delivering much improvement to the décor over the year

2.3.4   Was pleased to note the positive outcome of the CQC inspection but was disappointed that a proactive media initiative did not follow

2.4   Clinical Outcomes

2.4.1   Adequate assurance was demonstrated

2.4.2   Trust systems are fully functional; the committee was disappointed that the Trust could not yet tell what percentage of clinical staff were actually using the system

2.4.3   The Trust fell just short of some CQUIN targets

2.4.4   20,000 forms have now been collected and this data will be analysed

2.4.5   The Trust appears to be doing as well as its peers in OM activity

2.4.6　More work on data integrity was indicated; this will be taken up by the Clinical Information Management Group

2.5　Clinical Audit

2.5.1　Adequate assurance was demonstrated

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

2.6　Patient Safety and Clinical Risk

2.6.1　Substantial assurance was demonstrated

2.6.2　Good data validation processes had identified a data reporting error; this had been corrected

2.6.3　The committee directed that a group be formed to review clinical supervision arrangements

2.6.4　The committee was concerned that the Trust was still unable to fully reconcile the Trust and local authority records of children subject to child protection plans. Audit activity is ongoing to resolve this issue.

2.7　Quality Reports

2.7.1　Adequate assurance was demonstrated

2.7.2　Extant patient record systems do not support efficient collection and processing of data; until the replacement is in place this remains a challenge

2.7.3　Some clinicians are too reliant on administrators to complete their outcome monitoring processes; this is not efficient

2.7.4　The draft Quality Report had been approved by the Board

2.8　Patient and public involvement

2.8.1　Substantial assurance was demonstrated

2.8.2　140 people had come forward as potential volunteers to support the Trust's work on clinical service development

2.8.3　Following a positive start, comprehensive proposals were being developed to implement extensive user involvement in recruitment processes; the committee felt that the Trust was lagging behind other Trust's in this area

2.9　Information Governance

2.9.1	*Adequate assurance was demonstrated*
2.9.2	Overall improvements were noted; a small number of long-standing issues remained an area of work
2.9.3	The Trust had met at least the minimum level required externally, but remained ambitious to achieve higher levels
2.9.4	That it was inconsistent to report problems in other work streams, e.g. data quality, yet rate them green in the IG report; adjustments from green to amber on several lines

3. Conclusion

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

3.2 A number of key –priority areas for the year ahead can be identified:

- Clinical Outcomes, particularly further work on clinician engagement and the development of patient determined outcomes of relevance to people using our services.
- Preparation for the IDCR migration in May 2015 ensuring maintenance of clinical safety and addressing other risks associated with the migration
- The effective engagement of people who use our services in the design, delivery and evaluation of our services including their more specific roles in the appointment of staff and outcome monitoring

Corporate Governance and Risk Work stream ■

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
To maintain CQC registration without qualification	G	G	G	G	The latest risk profile published by the CQC shows no areas of significant concern. The recent CQC visit confirmed that the Trust is fully compliant with all relevant standards.	
To maintain a green governance rating with Monitor	G	G	G	G	Monitor's rating of the Trust remains green.	
To maintain a highly effective workforce	G	G	G	G	All training targets achieved or exceeded. Support for staff reporting concerns is in place.	
Estates and Facilities infrastructure improvements and CQC and	G	G	G	G	All estates projects were completed on schedule; estates team commended for delivering high volume of work.	

					Comments
NHSLA compliance					
Managing responses to recommendations and requirements of external bodies	G	G	G	G	Schedule up to date; no deadlines missed.
Maintain compliance with current NHSLA rating	G	G	G	G	Standards are being maintained pending the external introduction of a new system.
Non-clinical incident reports	G	G	G	G	Monitoring via work streams working well.
Specific case reports (serious incidents / SUIs)	G	G	G	G	No issues to report.
Central alert broadcast advice	G	G	G	G	No issues to report.
Operational Risk Register	G	G	G	G	No issues to report.
Relocation of Day Unit	G				This is on hold pending further consideration by the Board of Directors of the options for the Tavistock site and of the revised day unit business case
CGR IG compliance	G	G	G	G	Targets met.

Clinical Outcomes Work Stream ▪

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
Implementation of OM project plan	A	A	A	A	This project will be incorporated as business as usual	
Local ownership of outcome monitoring	A	A	A	A	SAMHS and CAMHS directors need to find out what proportion of their staff are fully engaged and using the system	
Processes for data collection are robust.	A	A	A	A	Clinical Governance and Informatics Managers have systems in place to examine data quality and will report from Q4.	
CQUIN targets CAMHS and SAAMHS			A	A	Targets were again missed in Q4 and a plan is in place to improve performance.	
Data collection and data quality monitoring systems effective				A	Limited at present but development work ongoing	

Clinical Audit work stream ■

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
NICE compliance	A	A	A	A	Monthly support meeting were put in place	(orange)
National audit requirements	G	G			Reporting line discontinued	
Compliance with plan	A	A	G	G	Detailed plans are being developed for delivery at team level.	(green)
Audit tracking	G	G	A	A	An effective register is in place	(orange)
Implementing improvements recommended in audit reports			G	G	Development work is ongoing	(green)

Patient Safety and Clinical Risk Work stream ■

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
Clinical incidents	G	G	A	A	No incidents rated 9+ were reported. A data reporting error was identified and corrected.	
Specific case reports (serious incidents / SUIs)	G	G	A	A	The final reports on the two suicides have been drafted and will be considered by the Board in May.	
Hospital acquired infection	G	G	G	G	No incidents reported.	
New Clinical claims	G	G	G	G	None.	
Complaints responses	G	G	G	G	1 complaint (clinical) was made in Q4; all open cases were resolved by the end of the quarter. 1 complaint is being considered by the ombudsman.	
PSCR NHSLA compliance	G	G	G	G	See entry in CGR report.	
PSCR CQC compliance	G	G	G	G	No areas of concern noted.	

Central Alert Broadcast advice	G	G	G	G	No areas of concern noted.
Supervision of clinicians	G	A	A	G	Having found that all clinicians are receiving supervision, future audits will look at the quality of supervision. The committee suggested that OM be considered in supervision.
Revalidation	G	G	G	G	All doctors have been revalidated.
PSCR risk review	G	G	G	G	There are no 9+ risks
Safeguarding children	A	A	A	A	The committee was concerned that the Trust and Camden Council had been unable to reconcile child safeguarding register data mis-matches and expected that this matter be escalated if progress was not made to resolve the matter
Safeguarding adults	G	G	G	G	The procedure was updated

Quality reports work stream ■

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
CQUINS and KPI targets are agreed for 2013/14	A	A	G	G	Agreed; 2014/15 awaited	
Arrangements in place to report on CQUINs and KPIs for SAAMHS	A	A	A	G		
Arrangements in place to report on CQUINs and KPIs for CAMHS	A	A	A	G		
Meeting Quality Priorities listed below at **	G	G	G	G		
Meeting quality reporting requirements of CCG	G	G	G	G	This is an area of ongoing development with the lead CCG.	

Quality report Recommendations from 2012-13	A	A	A	R	Data quality evidence is limited.
Preparation for Quality Report 2013-14	-	-	G	G	

PPI work stream ▪

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
CQC compliance	G	G	G	G		
Providing assurance that the Trust adheres to all PPI related policies and procedures	G	G	G	G	Departmental PPI leads promote procedures to teams	
Discussing PPI issues arising from PALS, complaints or other forms of PPI input and making recommendations	G	G	G	G	These are analysed annually.	
Discussing the findings of the experience of service questionnaire	G	G	G	G	Findings and action plans considered quarterly.	`

Objective					Status
and ensure delivery of action plans	G				
To ensure 3 issues identified at stakeholder meetings were addressed by March 2014	G	G	G	G	Completed
To hold 3 patient forums	G	G	G	G	Completed
To audit accessibility of modality leaflets	G	G	G		Reporting line discontinued
To produce further 4 leaflets on modalities	G				Reporting line discontinued
Ensure that quality is continually improved through the development of patients centred services and within the organisation's culture [with QR lead and others]	G	G	G	G	Five public constituency members help oversee this work.

Information Governance Work Stream : Q4 2013/14

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
101 Governance Overview	G	G	G	G	A strong area for the Trust.	(green)
105 Policy overview	R	R	R	G	All policies in date	(green)
110 Contractor compliance	A	R	R	G	A temporary solution was adopted at the last minute; audits will verify its effectiveness.	(green)
111 Employee contract compliance	G	G	G	G	The use of national terms and conditions saves the Trust from the expense of developing its own compliance regime.	(green)
112 IG training	A	A	A	G	Several members of the clinical teams and the Council of Governors did not complete their training.	(green)
200 Data protection compliance	A	R	R	G	Overall, the Trust complies, but DET and IT need to complete a project to provide secure storage for student research data; in the meantime, this risk remains on the register at a high level.	(orange)
201 Confidentiality compliance	A	A	A	G	A revised Code of Confidentiality is to be published	(green)

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
202 & 203 Consent compliance	A	A	R	A	The procedure relating to this is overdue for renewal; this and the accompanying leaflet are with the Caldicott Guardian for approval.	(green)
205 Access request compliance	G	G	G	G	The Trust receives very few requests. One request was challenged and the Trust was found to be in breach, but the matter was considered minor and no further action was taken.	(green)
206 Confidentiality audit compliance	A		R	G	A short report from the Caldicott Guardian found no problems.	(green)
207 Sharing protocol compliance	G	A	G	G	This is covered in contracts; though as most partners are NHS the Trust can be assured, we are all working to the same high standards. However, more work to ensure good contract management is indicated (see also 210).	(green)
209 processing outside UK	A	A	G	G	(The EU Commission has expressed serious concerns about the failure of US firms to protect EU citizens' data. Until this has been resolved to the satisfaction of the Commission, US based storage systems for data storage are not suitable for consideration when procuring new systems.)	(green)
210 New systems compliance	R	R	R	A	Commercial Directorate completed a temporary protocol setting out how compliance will be incorporated into due diligence and implementation processes; this will be reviewed in Q1. Meanwhile, the process to procure a new patient records system is addressing the pertinent issues as part of a wider collaboration across directorates and functions (see 209); however, permanent IG engagement is indicated.	(orange)

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
300 Information security skills compliance	G	A	G	G	The 2013 audit was completed and no areas of concern were identified	
301 Risk assessment of Information Assets	A	A	G	G	A small number of tasks were outstanding, but overall the Trust has no concerns.	
302 Incident Reports	G	G	G	G	Reporting is monitored at the IG work stream; no concerns apparent.	
303 Registration Authority compliance	G	G	G	G	An audit indicated good compliance.	
304 RA monitoring compliance	G	G	G	G	An audit indicated good compliance.	
305 access control compliance	G	G	G	G	Access to Trust systems is multi-layered.	
307 Risk management	R	R	G	G	No new risks added this quarter; Relocation Programme IG risks are to be assessed by the IG Manager/Programme Assistant in 2014/15.	
308 Data mapping	A	G	G	G	All known assets have been mapped.	

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
309 Business continuity assurance	A	A	G	G	This is addressed as part of the risk assessment process; no concerns apparent.	
310 Disruption preparation assurance	A	A	G	G	This is addressed as part of the risk assessment process; no concerns apparent.	
311 Protection of IAs	A	A	G	G	This is addressed as part of the risk assessment process; no concerns apparent.	
313 Network assurance	G	G	G	G	Access to Trust systems is multi-layered.	
314 Teleworking assurance	G	G	G	G	Access to Trust systems is multi-layered.	
323 Protection of IA assurance	G	G	G	G	A comprehensive programme of assessment is monitored and reported to the IG work stream.	
324 Pseudonymisation assurance	G	G	G	G	This is monitored and reported to the IG work stream.	
400 IG quality, skills and experience assurance	G	G	G	G	A review of an external archive is underway. A reorganisation of the Trust's basement archive was completed. Extra capacity to cope with more and thicker patient files has been provided.	

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
401 NHS number assurance	G	G	G	G	This is rather obsolete as 'RiO' only functions with NHS numbers, the Trust is therefore compliant.	
402 Accuracy of data input	A	R	A	G	This is being monitored through the Clinical Governance Office.	
404 Audit assurance	A	G	G	G	This complements 206 and is managed by the Governance and Risk Adviser with support from the Clinical Governance Office and Governance Manager.	
406 Monitoring paper records assurance	G	G	G	G	Tracking records is well managed; spot checks have been introduced.	
501 Data definitions compliance assurance	G	G	G	G	This is rather obsolete as 'RiO' only functions with national definitions.	
502 External data feedback reports	A	A	A	A	The Trust has met this requirement to the extent that it is possible to do so, the Trust having atypical data sets that do not lend to external comparison.	
504 Benchmark reports	A	A	A	A	Early reports indicated that the work led by the Clinical Governance and Informatics managers is providing evidence of compliance.	
506 Service user data accuracy validation	A	A	A	A	Early reports indicated that the work led by the Clinical Governance and Informatics managers is providing evidence of compliance.	

Task	Q1	Q2	Q3	Q4	Comment and action plan for amber and red risks	Predicted position for end of Q4, 14/15
507 Data completeness validation	A	A	A	A	Early reports indicated that the work led by the Clinical Governance and Informatics managers is providing evidence of compliance.	
508 Clinical data input validation	G	G	G	A	Early reports indicated that the work led by the Clinical Governance and Informatics managers is providing evidence of compliance.	
514 Clinical coding audit validation		A	A	A	This was considered not relevant but will be addressed as the Trust prepares to report on clustering.	
516 Clinical coding training programme assurance		A	A	A	This was considered not relevant but will be addressed as the Trust prepares to report on clustering.	
601 Corporate record management assurance	A	G	G	G	The Trust is undertaking a small project to ensure compliance with the Public Records Act 1958.	
603 FOI compliance assurance	G	A	G	G	No concerns to note.	
604 Records lifecycle management assurance	A	G	G	G	The Trust is considering whether to replace its archive with electronic copies of records.	

Board of Directors: May 2014

Item : 10

Title : Equalities Committee Annual Report 2013-14

Purpose:

The purpose of this report is to update the Board of Directors of the work of the Equalities Committee during 2013/14 and inform them of the Committee's objectives for the forthcoming year.

This report was discussed at the Management Committee on May 15th 2014. All members of the Management Committee expressed their commitment to promoting equality and diversity throughout the Trust and in all areas of our work.

This report focuses on the following areas:

- Quality
- Patient / User Experience
- Equality
- Risk

For : Discussion

From : Louise Lyon, Trust Director and Interim Chair, Equalities Committee

Equalities Committee Annual Report 2013-14

1. Introduction

1.1 Under the Equality Act 2010, the Trust is required to develop and publish equality objectives, and set clear plans as to how these will be achieved during the course of the year. Besides meeting the general equality duty and ensuring that we are making progress against the objectives on an annual basis, this also ensures that the equalities agenda is embedded in how we conduct Trust business.

A recent HSJ special report on Diversity (May 2014) stated:

There is increasing evidence that there is a strong link between having a diverse NHS workforce, in which all staff members' contributions are valued, and good patient care.

Diverse teams have been found to outperform teams in which people are more similar, both in terms of productivity and creativity. This is because diverse teams bring different skills, experience and knowledge to the table.

Active attention to equalities throughout all Trust activities and stakeholder relationships is therefore vital to our delivery of good patient care, education and training and staff well-being.

As NHS providers we need to attend not only to the 9 protected characteristics but also to discrimination and social exclusion arising from deprivation and destitution; for example the access problems arising from homelessness would fall into this category.

The Equalities Committee leads on all aspects of equality and diversity and besides setting the equalities objectives, it also leads on setting the strategic direction for the Trust in the field of equalities. It is responsible for ensuring that the Staff Training Committee is aware of and makes provision for training in relation to equality and diversity.

The Committee consists of representatives from the Council of Governors and the Board of Directors, the Dean, the Director of Corporate Governance and Facilities, representatives of HR, CAMHS, SAAMHS, PPI, Communications and Staff Side. The former Chair, Trudy Klauber, stepped down upon retirement in September 2013 having very ably and actively led the committee. It is currently chaired on an interim basis by the Trust Director, Louise Lyon. The CEO will make a substantive appointment on the completion of the current 'Shaping the Future' consultation. The Committee has continued with the work set in motion under the previous Chair and

will continue to work actively on a defined and limited number of objectives each year. The Committee remains lively, active and committed to making a difference with the limited resources available within a small Trust. Currently, available resourcing comprises 0.1 WTE for leadership and 0.2 WTE Band 5 Equalities Officer, neither of which is permanently appointed at present which has somewhat hindered the work of the Committee over recent months. The annual Equalities Report 2013-14 demonstrates the work we have undertaken so far and our plans for the coming months.

2. Progress on Equalities Objectives 2013/14

2.1 Sexual Orientation

Throughout 2013-14, the Committee actively debated the most effective approaches to ensuring that all staff wishing to provide education and training, including clinical supervision within the Trust understood that they must agree with the Trust's stated view that sexual orientation is not a pathology. The Committee remains committed to addressing both the historic legacy and any current practice not in line with the Trust's position. INSET day presentations, discussions at the Clinics Committee, the Education and Training Executive and the JSCC raised debate within the Trust and contributed to the discussion of how best to address the issues.

The Interim Chair arranged to meet a Stonewall representative, along with staff side representatives to explore the potential helpfulness of consultation from Stonewall on issues in relation to sexual orientation in March 2014. Following this meeting, we applied to take part in the Stonewall Healthcare Champions programme funded by the Department of Health. We are pleased to have been successful in our application which will provide us with advice and support in tackling health inequalities faced by lesbian, gay and bisexual people. A first meeting with the allocated Stonewall Health Officer is scheduled for May 22nd 2014.

2.1.1　CAMHS and SAAMHS Management have actively supported initiatives in relation to sexual orientation.

2.1.2　Gill Rusbridger, CAMHS Equalities Committee representative, and Trudy Klauber visited many of the CAMHS clinical teams to raise awareness of LGBT issues for the young people, parents and families we work with. This was met with interest and enthusiasm, with staff keen to share their experiences and a request to continue to engage in dialogue with the Equalities Committee and each other.

This led to two staff members coming forward wanting to carry out some further research into our clinical practice with the LGBT client group, both through staff and service user experiences.

Staff were also particularly concerned about working with schools, where homophobic bullying was seen as often going unchallenged. As part of her enquiry into local resources for LGBT young people, GR was put in touch with the manager of a local youth club (Mosaic) and as a result, GR and LL have been liaising with him about how to make our services more accessible to LGBT adolescents and to consider organising further training for staff in being aware of, and sensitive to, the needs of LGBT service users.

There has been evidence of a general rising of interest amongst staff through exchange of information. Staff have also been pleased to hear about the ongoing work in DET on this subject.

2.1.3   In SAAMHS, regular discussion has taken place at the SAAMHS Clinical Quality, PPI and Equalities meetings. Consideration has been given to how best to ensure our services are clearly welcoming for LGBT patients and from these discussions clear support for contacting Stonewall emerged, as well as local groups, in order to explore how confident LGBT patients feel in approaching our services. The issues have also been taken back to clinical teams for further discussion in order to increase awareness of issues raised in our staff survey which indicated that many staff across the trust were unsure whether or not the Trust was welcoming to LGBT people.

2.2   Communications and website development

A standardised translation statement to be included on all of our Trust literature was agreed by the Committee. It was acknowledged by the Committee that there may be a potential future need for our patient information to be translated via statements written in our patients' native language.

This standardised translation statement included the ten most widely spoken languages in the London Borough of Camden (see appendix 1). The statement informs patients how to access information in their preferred language. The standardised translation statement will be gradually introduced to Trust literature and leaflets.

If a patient requires a leaflet to be translated into their preferred language, the Communications team will be contacted and are responsible for ensuring the information is translated and forwarded to the patient. Communications will co-ordinate requests for translated information and keep a centralised spread sheet of requests, which would be shared with service managers as appropriate.

The former chair, Trudy Klauber, was involved in the development of the new website. Careful consideration was given as to how best to communicate our commitment to equalities. This was discussed at the Equalities Committee and an approach agreed whereby equalities are woven into all our communications rather than through equalities statements.

2.3 HR and Staff Side

Following robust discussions at the Equalities Committee on staff health and wellbeing, HR and Staff Side have considered the NHS guidance on supporting workplaces and effected changes to the Stress Management policy to facilitate open and meaningful conversations between staff and managers on stress and wellbeing. Use of a structured approach, i.e. frameworks such as Health & Safety executive management standards for work related stress are being used to identify stressors with a view to managing them proactively. Well implemented policies for managing staff sickness are being invoked by managers by way of offering early intervention to a problem. Onsite Stress management training programmes are also being offered to staff. The annual disability meetings with staff have been effective in that access and support needs are addressed and discussed more fully in addition to any regular meetings disabled staff may have with their managers during the course of the year.

3. Equalities Objectives for 2014/15

3.1 The objectives for 2014-15 listed below have been agreed by the Equalities Committee. Our aim is to consolidate and complete work in progress on areas of particularly salience to the Trust whilst providing a firm basis for keeping the broad range of equalities concerns under review.

    3.1.1 Sexual Orientation: in addition to ensuring compliance with general equality duty, the Trust will prioritise an agreed plan of work in relation to sexual orientation with staff, and with users of our clinical and education and training services. The Committee will formalise an action plan with milestones for

work in education and training, staff support and clinical services. This work will include the Health Champions work with Stonewall but a separate work stream on education and training will continue.

3.1.2   <u>Staff Mental Health and Mental Health in the Workplace</u>: a working group is already established to scope and understand Staff Mental Health matters as confirmed in last year's report to the Board. This group, including a Non-Executive Director, the Trust Director, HR Manager and Staff Side representatives, in consultation with the Chair, will consider reviewing best practice in creating appropriate staff behaviour and attitudes to colleagues with mental health problems, and may result in a Trust-led conference on mental health and wellbeing in the workplace. The Committee recognises the sensitivity and complexity in addressing these issues. This piece of work will be linked with the Trust wide ''Time to Change'' Pledge to reduce the stigma of mental illness, that is being led by the Director of Human Resources.

3.1.3   <u>Protected characteristics</u>: develop a system for monitoring our performance in relation to all 9 of the protected characteristics in order to identify where further work is needed and to prioritise the work in relation to the Committee's annual objectives.

As the Trust continues to grow and change, equitable representation will always be an area that requires monitoring. The Committee hopes to explore and develop a work plan which continues work around all of the protected characteristics. In the past the committee has led on work related to raising staff awareness on disability support and entitlements. The Committee has also looked at measures to promote workforce diversity, inclusion and equality at all levels of the organisation through its work of the Race Equality in Employment. As we are no longer required to provide a single equalities scheme report covering all areas, we have decided to develop our own means of examining whether we have maintained our performance across all areas. This information will then contribute to work planning and prioritisation.

3.1.4   <u>Communications</u>: to ensure that the new website is regularly updated on equalities.

Additionally, to produce an Equalities Newsletter based on the successful Newsletter published in 2012-13 and to explore

other means of communicating to educate, inform and seek the views of all relevant stakeholders.

Louise Lyon
Interim Chair, Equalities Committee
May 2014

Translation Panel

The text on the panel below is in Bengali, French, Spanish, simplified Chinese, Italian, Somali, German, Arabic, Albanian and Portuguese; the ten most popular languages spoken in the London Borough of Camden.

If you need this information in a different language or format please contact the communications team, communications@tavi-port.nhs.uk

Nese ky informacion ju duhet ne nje gjuhe ose format tjeter, ju lutemi kontaktoni grupin e komunikimit ne communications@tavi-port.nhs.uk

"اذا اردت أن تحصل على هذه المعلومات بلغة اخرى نرجو الاتصال بالفريق الفنى فى : **communications@tavi-port.nhs.uk**

উক্ত তথ্য ভিন্ন ভাষা অথবা আকারে প্রয়োজন হইলে নিম্ন অনুসন্ধান দলের সাথে যোগাযোগ করুন : communications@tavi-port.nhs.uk

如 果 您 需 要 这 资 料 不 同 的 语 言 或 版 面 格 式 ， 请 联 系 通 讯 小 组 ， communications@tavi-port.nhs.uk

Si vous désirez recevoir ces informations dans une autre langue, prière de contacter l'équipe technique à : communications@tavi.port.nhs.uk

Wenn Sie diese Information in einer anderen Sprache oder in einem anderen Format benötigen, kontaktieren Sie bitte das Kommunikationsteam, communications@tavi-port.nhs.uk

Se hai bisogno di queste informazioni in una lingua o formato diverso, contatta il team comunicazioni, communications@tavi-port.nhs.uk

Se precisar desta informação numa língua ou formato diferente, solicitamos que contacte a equipa de comunicações: communications@tavi-port.nhs.uk

Si necesita tener esta información en otra lengua o formato, contacte con el equipo de comunicación: communications@tavi-port.nhs.uk

Haddii aad macluumaadkaan u baahan tahay luqad ama qaab kale, fadlan la xiriir kooxda is-gaarsiinta, communications@tavi-port.nhs.uk

Board of Directors : May 2014

Item : 11

Title : Workforce Statistics Report 2013-14

Summary:
This report fulfils the Trusts Obligation to publish workforce monitoring data. The report includes quantitative data on recruitment & leaver's activity, sickness and 9 protected characteristics within the Equalities Act 2010.

There are some areas which need further exploration and analysis. These will be taken forward under the auspices of the Trusts Equality Committee and are noted in the report.

This report has been reviewed by the following Committees:
- Management Committee – 15/05/2014

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 plans that have been put in place i.e. further exploration by the Equalities Committee.

This report focuses on the following areas:
(delete where not applicable)

- Equality

For : Approval

From : Director of Human Resources

Workforce Statistics

Introduction & Purpose

The workforce statistics report 2013-14 fulfils the Trusts obligation in relation to equality duties which require public sector organisations to publish annually a range of staff monitoring data. The report provides statistics on some of the protected characteristics within the Equalities Act 2010.

We have used Electronic Staff Data (ESR) & NHS jobs website to collect data that monitors workforce information provided in this report.

This report also links to the CQC Outcomes and is relevant in the suitability of staffing section.

Staffing overview

The Trust employed 556 substantive staff as at 31st March 2014. The Trusts skills mix between clinical & non – clinical & specialist posts along with robust recruitment practices ensure we have a fit for purpose workforce delivering range of services.

Departments	Staff No.
CAMHS	272
CEO office/ Trust Wide Management	6
Chair and Non-Executive Directors	6
Clinical Governance/ Medical Director	6
Commercial/Communications	16
Corporate Governance and Facilities	24
DET	25
Finance	11
Human Resources	10
ICT	11
Library	12
Research and Development	1
SAMHS	150
TCS	6
Grand Total	**556**
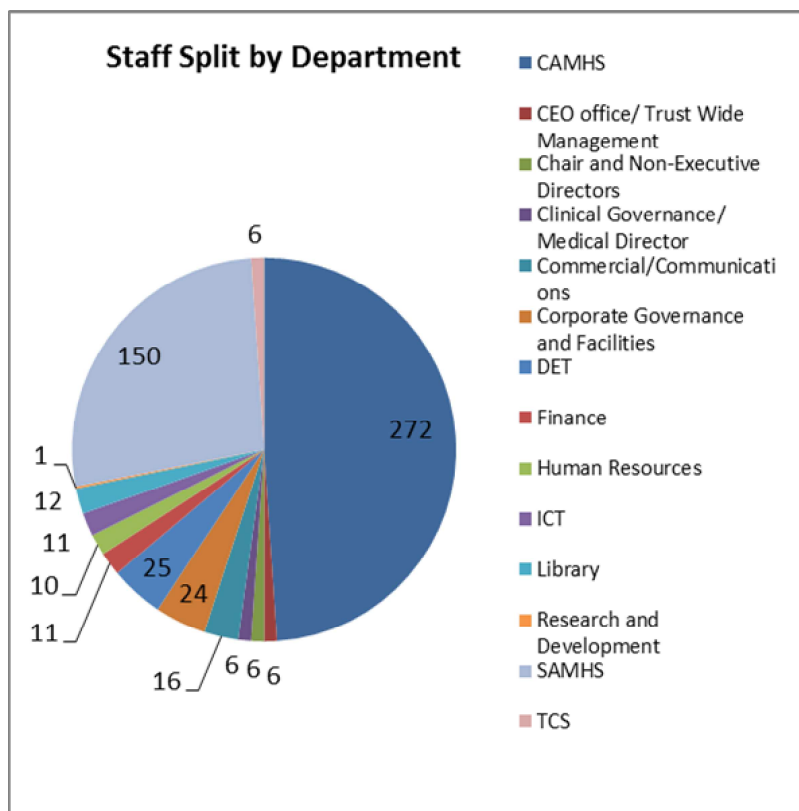
CAMHS employs the largest workforce in the Trust at 266 (headcount) followed by SAAMHS at 150 (headcount).

In addition:-
1. Majority of the Trusts employees are females 417 to 139 males (headcount)
2. 21% of Trusts workforce is made up of BME Staff, White staff is 79%
3. 1.8% of workforce (10 headcount of the total workforce of 556) have declared themselves as disabled

Trust Board

1. There is an equal split of male and female Board members
1. Majority of the Board is within the average age of 59
2. There is no BME representation in the Trust Board

Workforce: Recruitment

Ethnic Description	Applied	Shortlisted	Appointed
WHITE - British	947	141	47
WHITE - Irish	75	10	4
WHITE - Any other white background	539	68	17
ASIAN or ASIAN BRITISH - Indian	299	21	7
SIAN or ASIAN BRITISH - Pakistani	100	9	4
ASIAN or ASIAN BRITISH - Bangladeshi	157	10	0
ASIAN or ASIAN BRITISH - Any other Asian background	99	9	1
MIXED - White & Black Caribbean	40	4	1
MIXED - White & Black African	27	1	0
MIXED - White & Asian	19	3	2
MIXED - any other mixed background	47	5	2
BLACK or BLACK BRITISH - Caribbean	196	23	3
BLACK or BLACK BRITISH - African	560	37	2
BLACK or BLACK BRITISH - Any other black background	56	2	1
OTHER ETHNIC GROUP - Chinese	23	2	0
OTHER ETHNIC GROUP - Any other ethnic group	97	12	3
Undisclosed	**96**	**6**	**2**
Total number of applications received : 3377 **Total number of posts advertised : 126**			

Note :

From the data above it is noted that the BME applicants shortlisted & interviewed based on the job criteria do not necessarily get selected for the job.

This may link to the larger training issues for the recruiting managers & may be explored for further investigation by the Equalities Committee.

Recruitment Ethnic Origin between 1/04/2013- 31/03/2014
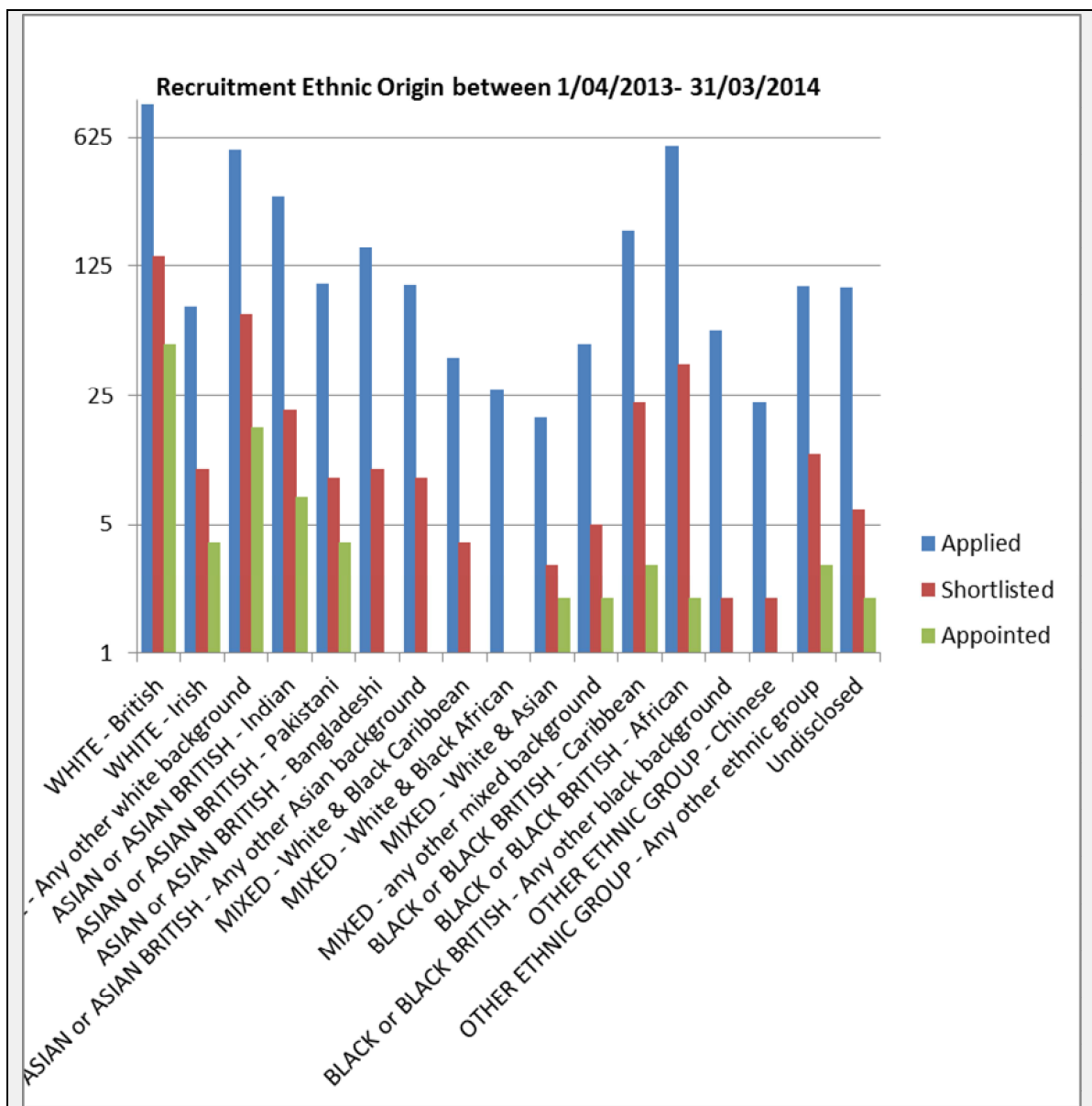
For the period 1st April 2013 to 31st March 2014, the total number of jobs Advertised was 126 and total number of application received was 3377.

The breakup of applications by ethnicity indicates that the largest group of applicants have described themselves as ''White British'' (947 applied, 141 were shortlisted and 47 were appointed) the second largest group of applicants appointed to posts described themselves from ''any other white background'' (539 applied, 68 were shortlisted and 17 were appointed) and the third largest group appointed to posts described themselves as ''Asian or Asian British – Indian'' (299 applied, 21 were shortlisted and 7 were appointed).
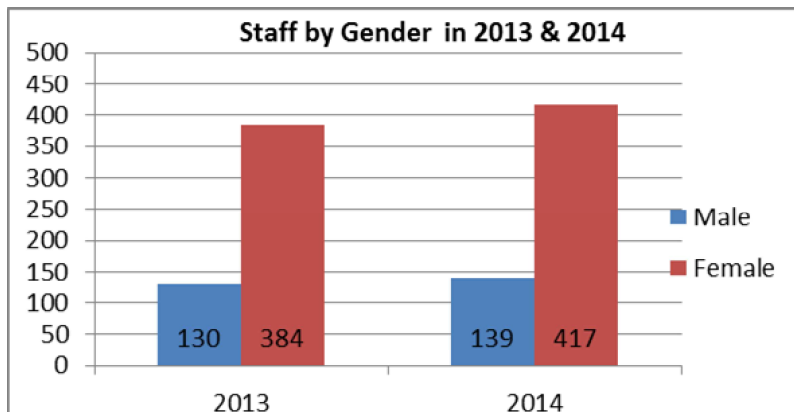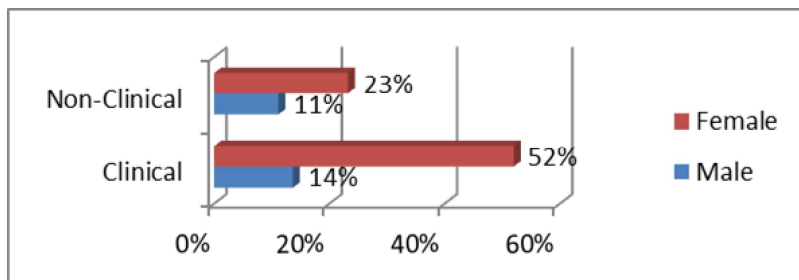
The Trust workforce profile according to gender is predominantly Females

The split between male and female staff across the Trust over last 2 years confirms an increase in number of female employees by 33 (headcount) in 2014.

The chart below shows the gender profile of the workforce by pay band. Band1-3 staff group is more fairly gender balanced as opposed to the other bands which are predominantly represented by female employees.

The majority of staff who have declared themselves as white is represented across all bands from 1 to 9 and also in the Medical, Teachers and spot salary appointments.

Workforce Statistics
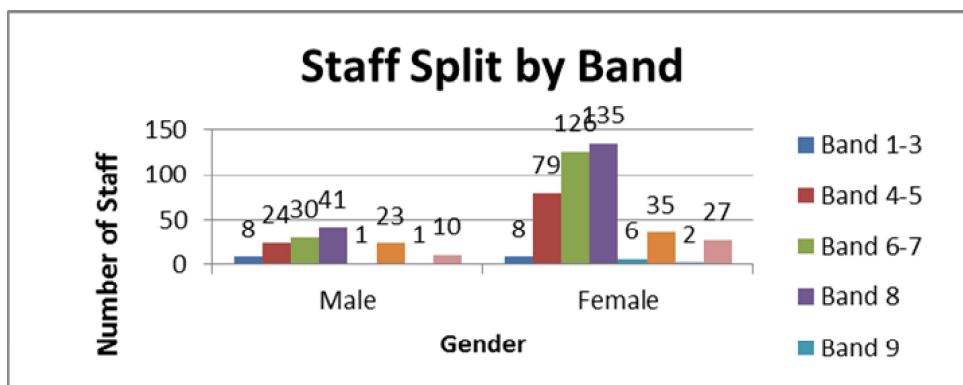
Workforce: Ethnicity by Group & Band

	Band 1-3	Band 4-5	Band 6-7	Band 8	Band 9	Medical	Teacher	Spot Salary	Total
A White - British	6	51	76	108	7	22	2	29	301
B White - Irish	1	5	3	4		4	1	1	19
C White - Any other White background	2	15	40	30		20		2	109
D Mixed - White & Black Caribbean		2	2	2					6
E Mixed - White & Black African				2					2
F Mixed - White & Asian		1	1						2
G Mixed - Any other mixed background			3	2					5
H Asian or Asian British - Indian		8	5	4		5		1	23
J Asian or Asian British - Pakistani		1	3	1		1			6
K Asian or Asian British - Bangladeshi	1			1					2
L Asian or Asian British - Any other Asian background		1		2		3			6
M Black or Black British - Caribbean	1	5	3	10				2	21
N Black or Black British - African	1	10	6	4				1	22
P Black or Black British - Any other Black background		1							1
R Chinese			2						2
S Any Other Ethnic Group	2	1	6	2		1		1	13
Undefined	2	2	3	4					11
Z Not Stated			2			2			4
A Black Somali			1						1
Grand Total	16	103	156	176	7	58	3	37	556

The largest 3 BME groups in the Trust (clinical & non-clinical posts) are as follows:

The 3 Largest BME Group by Staff Group
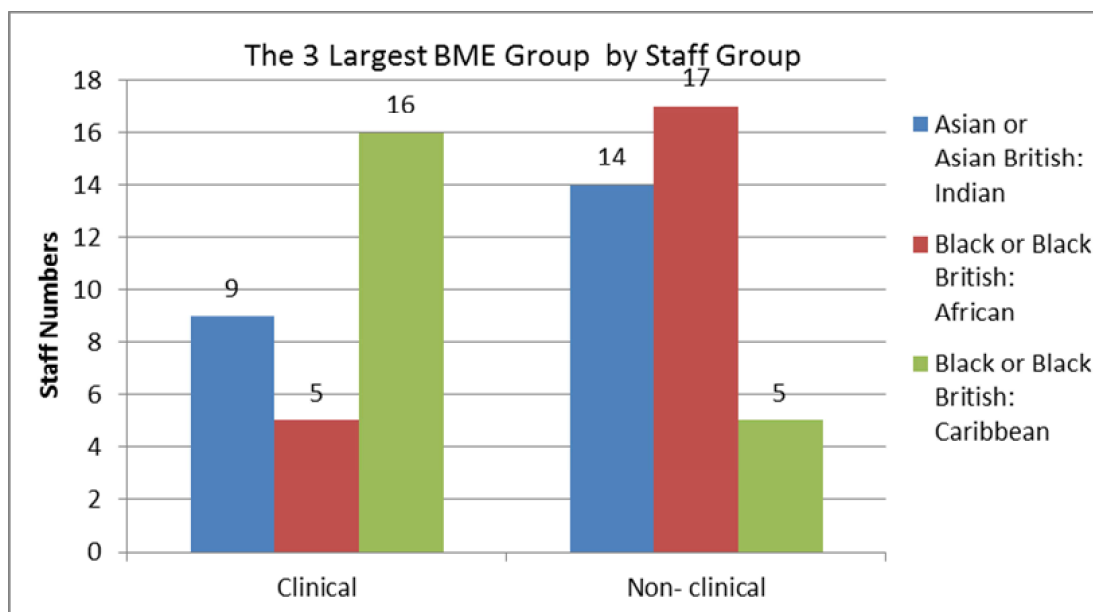
The breakup according to the bands for these 3 largest BME Groups is as follows:

The 3 Largest BME Group by Band

## Workforce: Disability
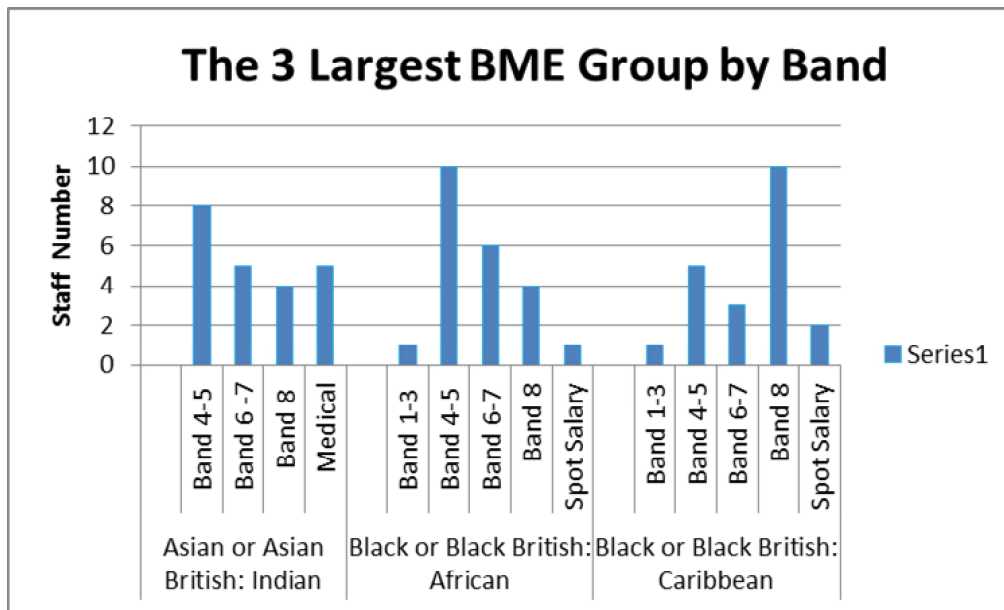
Staff Profile by Disability
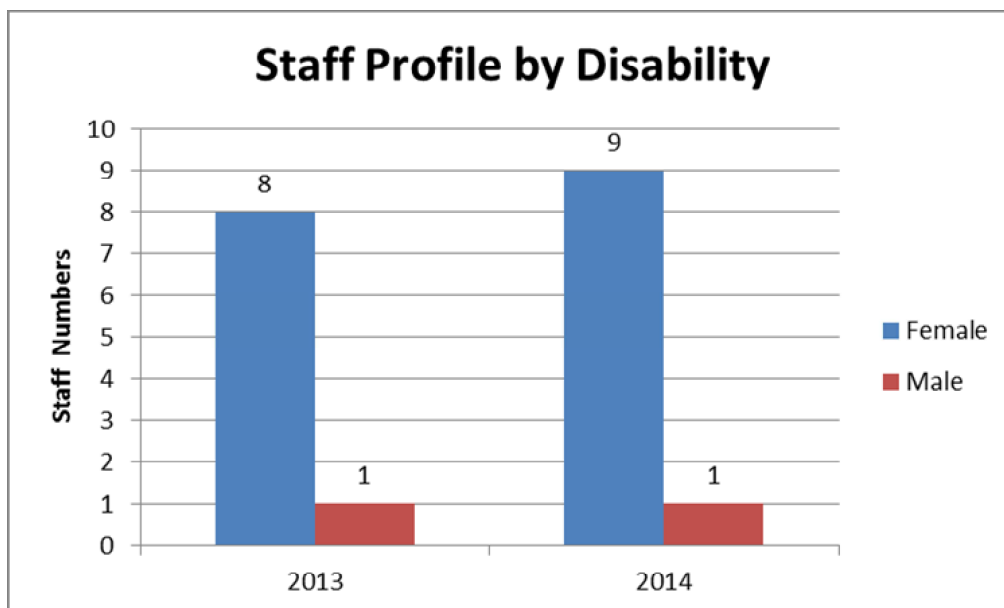
Only 1.8 % (10 headcount of the total workforce of 556) of staff has declared a disability (2013-14), whilst the majority have not declared any information. Please be aware that data regarding disability is largely dependent upon an individual's perception of whether they have a disability and whether they choose to declare a particular disability.

Trusts Equality Committee and Human Resources had launched an awareness campaign to encourage staff to disclose disability in a confident and confidential

manner so we may consider their support and access needs. The Trust is a ''Two Tick'' employer.

Workforce: By Age & Band
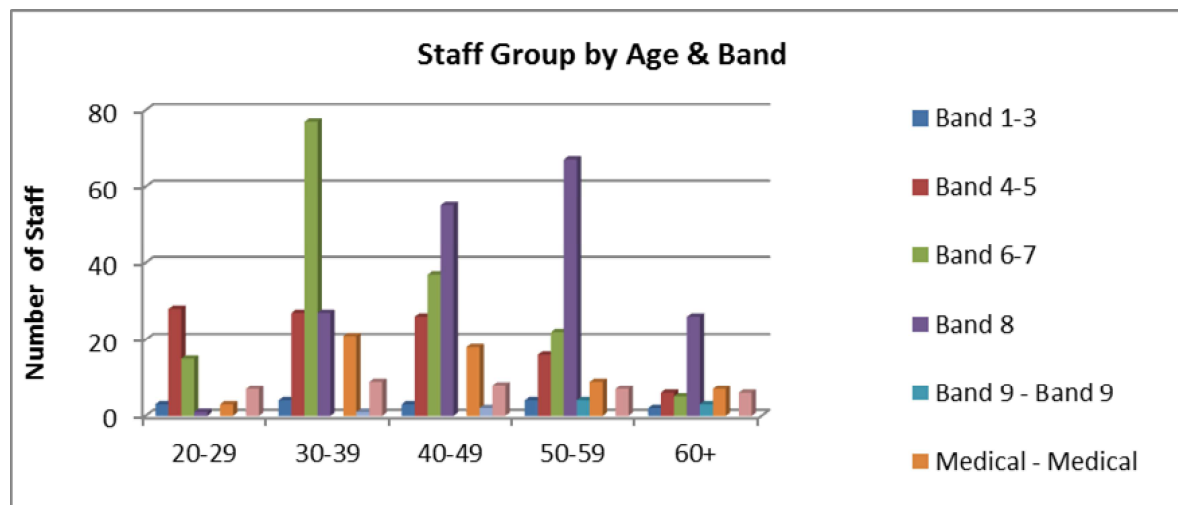
From the data above table the largest number of staff are between ages of 30 to 39 in bands 6-7 followed by staff in age band 50 to 59 in Band 8(a,b,c,d)

Sexual Orientation & Religion & Belief, Gender Re-assignment, Pregnancy & Maternity, Marriage & Civil partnership :

The ESR data on these protected characteristics is dependent on the responses from the candidates. We still do not know about these characteristics for many employees and hope to carry out work to increase the number of employees who complete this monitoring information. For all staff recruited through the NHS jobs; it is mandatory to complete the relevant equality monitoring fields even if the applicants choose to not disclose the information. The Trust is working to improve the quality of data on these characteristics and will ensure that information is updated for existing staff at the point of joining the Trust.

Workforce: Staff Sickness Absence

| Staff Sickness Absence for Last 3 Financial Years			
	2013/14	2012/13	2011/12
	Number	Number	Number
Days Lost (Long Term) *	478	1,086	913
Days Lost (Short Term)	516	661	766
Total Days Lost	994	**1,747**	**1,679**
Total Staff Years	426.9	411	426
Average working Days Lost	2.3	4.3	3.9
Total Staff Employed In Period (Headcount)	632	620	621
Total Staff Employed In Period with No Absence (Headcount)	443	388	368
Percentage Staff With No Sick Leave	**70.1%**	**62.6%**	**59.3%**

Note: 2013/14

- Total staff employed = Staff in post (556)+ Leavers (76)=632
- Total staff no absence - total staff employed minus staff with a sickness episode = 632-189=443
- WTE= 426.9
- Total staff with sickness episode =189

The data shows an increase in number of staff 443 (headcount) for 2013-14 with no period of sickness absence as opposed to the previous year's figures of 338.

Workforce: Leavers
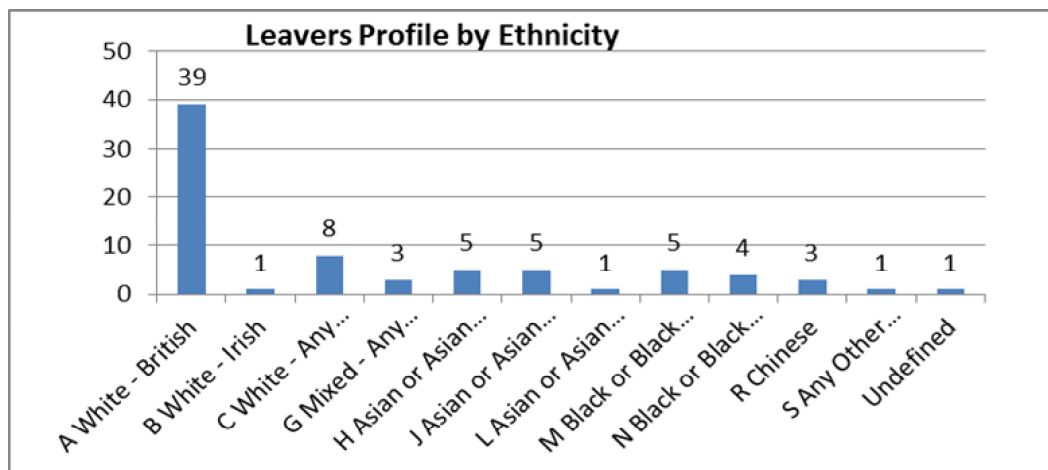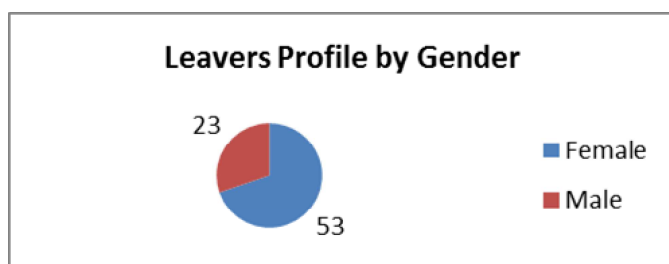
Leavers by Ethnicity	Headcount
A White - British	39
B White - Irish	1
C White - Any other White background	8
G Mixed - Any other mixed background	3
H Asian or Asian British - Indian	5
J Asian or Asian British - Pakistani	5
L Asian or Asian British - Any other Asian background	1
M Black or Black British - Caribbean	5
N Black or Black British - African	4
R Chinese	3
S Any Other Ethnic Group	1
Undefined	1
Staff Group Total	76

Leavers Profile by Reason
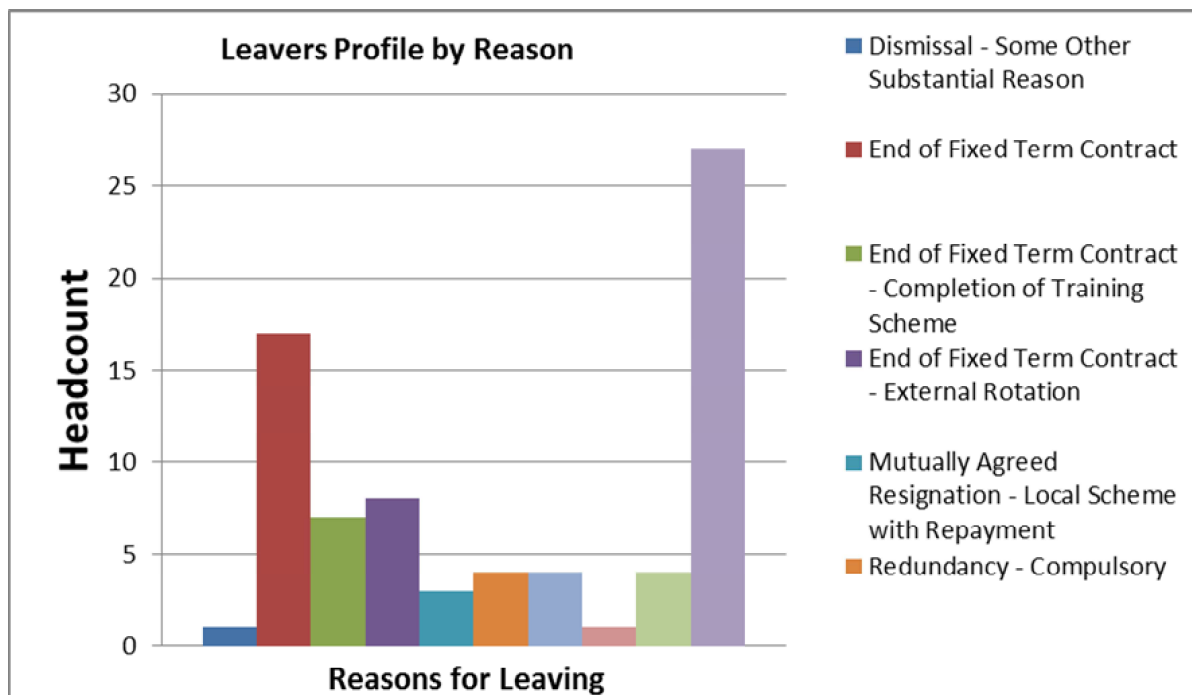
Leaving Reason	Headcount
Dismissal - Some Other Substantial Reason	1
End of Fixed Term Contract	17
End of Fixed Term Contract - Completion of Training Scheme	7
End of Fixed Term Contract - External Rotation	8
Mutually Agreed Resignation - with Repayment	0
Redundancy - Compulsory	4
Redundancy - Voluntary	4
Retirement - Ill Health	1
Retirement Age	4
Voluntary Resignation	30
Staff Group Summary Total	76

Total staff leaving the Trust in 2013-14 is 76

1. Majority of the Staff who left described themselves as White British. (39 headcount or 51.3% of total leavers.

2. Majority of leavers were female employees at 53 to 23 (headcount).

3. End of Fixed term contracts was the main reason for staff leaving the Trust.

Human Resources
May 2014

Board of Directors : May 2014

Item: 12a & 12b

Title : Annual Report

Note:
As the Annual Report and Accounts are to be laid before Parliament, the Trust is not allowed to publish them until this has happened. They are therefore not included in this publicly available set of papers, but will be published separately on our website once they have been reviewed by Parliament in July.

Purpose:
The Annual Report and Accounts have been compiled in accordance with the *NHS Foundation Trust Annual Reporting Manual 2013/14*, issued by Monitor.

The report has been reviewed by the management committee on 15th May and will have been seen by the audit committee on the 21st May, as well as having been reviewed

Annual Report & Accounts

by our external auditors.

The accounts have been reviewed by the external auditors and will have been seen by the audit committee.

The Board of Directors is asked to approve the text of the Annual Report, and to approve the annual accounts.

This report focuses on the following areas:
- Quality
- Communications
- Finance

For : Approval

From : Gervase Campbell, Trust Secretary; Simon Young, Deputy Chief Executive and Director of Finance.

Board of Directors : May 2014

Item : 12c

Title : Letters of Representation

Summary :

The Board of Directors is asked to approve two letters of representation, to be sent to KPMG to enable them to conclude their work.

The Audit Committee will have reviewed the drafts attached (Annexes 1 and 2), and their recommendation will be reported to the meeting.

For the first letter, the Trust Director has sent me confirmation that she is confident of the three statements a, b and c regarding the compilation of the 2013/14 Quality Report.

For the second letter, I confirm that I believe all the statements to be true. I am happy to respond to any queries about them at the meeting.

Annex 3 deals with the specific point that the financial statements have been prepared on a going concern basis.

For : Approval

From : Deputy Chief Executive and Director of Finance

Philip Johnstone
KPMG LLP
Public Sector Audit
12th Floor
15 Canada Square
London
E14 5GL

27 May 2014

Dear Sirs,

This representation letter is provided in connection with your limited assurance engagement regarding the Quality Report of Tavistock and Portman NHS Foundation Trust ("the Trust"), for the year ended 31 March 2014, for the purpose of forming a conclusion, based on limited assurance procedures, on whether anything has come to your attention that causes you to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified in the Monitor Guidance; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*

The Board confirms that:

a) The Quality Report has been prepared in line with the guidance set out in the *NHS Foundation Trust Annual Reporting Manual*;
b) The information presented in the Quality Report is consistent with underlying data held by the Trust and is sourced from reliable sources;
c) The Quality Report is consistent with the performance of the Trust in achieving quality over the period.

Yours faithfully,

Simon Young
Deputy Chief Executive and Director of Finance

Paul Jenkins
Chief Executive

    cc: Audit Committee

Annex 2

Philip Johnstone
KPMG LLP
Public Sector Audit
12th Floor
15 Canada Square
London
E14 5GL

27 May 2014

Dear Sirs,

This representation letter is provided in connection with your audit of the financial statements of Tavistock and Portman NHS Foundation Trust ("the Trust"), for the year ended 31 March 2014, for the purpose of expressing an opinion:

    i.   as to whether these financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2014 and of its income and expenditure for the financial year/then ended; and

    ii.   whether the financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

These financial statements comprise the Statement of Financial Position, the Statement of Comprehensive Income, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Board confirms that the representations it makes in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Board confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing itself:

Financial statements

1.   The Board has fulfilled its responsibilities, as set out in the terms of the audit engagement dated 14 March 2014, for the preparation of financial statements that:

    i.   give a true and fair view of the state of the Trust's affairs as at 31 March 2014 and of its income and expenditure for that financial year; and

    ii.   have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

    The financial statements have been prepared on a going concern basis.

2.   Measurement methods and significant assumptions used by the Board in making accounting estimates, including those measured at fair value, are reasonable.

3.   All events subsequent to the date of the financial statements and for which IAS 10 *Events after the reporting period* requires adjustment or disclosure have been adjusted or disclosed.

Information provided

4. The Board has provided you with:

    - access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
    - additional information that you have requested from the Board for the purpose of the audit; and
    - unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

5. All transactions have been recorded in the accounting records and are reflected in the financial statements.

6. The Board confirms the following:

    i.   The Board has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

    ii. The Board has disclosed to you all information in relation to:

    a) Fraud or suspected fraud that it is aware of and that affects the Trust and involves:
        - management;
        - employees who have significant roles in internal control; or
        - others where the fraud could have a material effect on the financial statements; and

    b) allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

    In respect of the above, the Board acknowledges its responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

7. The Board has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

8. The Board has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets*, all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

9. The Board has disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with IAS 24 *Related Party Disclosures*.

10. The Board confirms that all intra-NHS balances included in the Statement of Financial Position (SOFP) at 31 March 2014 in excess of £250,000 have been disclosed to you and that the Trust has complied with the requirements of the Intra NHS Agreement of Balances Exercise as set out in 4.11 to 4.14 of the FT Annual Reporting Manual 2013/14. The Board confirms that Intra-NHS balances includes all balances with NHS counterparties, regardless of whether these balances are reported within those SOFP classifications formally deemed to be included within the Agreement of Balances exercise.

11. The Board confirms that:

d) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the Trust's ability to continue as a going concern as required to provide a true and fair view.

e) Any uncertainties disclosed are not considered to be material and therefore do not cast significant doubt on the ability of the Trust to continue as a going concern.

12. From 2013/14 the Trust is required to consolidate any NHS charitable funds which are determined to be subsidiaries of the Trust. The decision on whether to consolidate is dependent upon the financial materiality and governance arrangements of the charitable funds. The Board confirms that, having considered these factors, it is satisfied that the charitable funds do not require consolidation as they are not material to the Trust's financial statements.

This letter was tabled and agreed at the meeting of the Board of Directors on 27 May 2014.

Yours faithfully,

Simon Young

Deputy Chief Executive and Director of Finance

Paul Jenkins
Chief Executive

cc: Audit Committee

Appendix to the Board Representation Letter of Tavistock and Portman NHS Foundation Trust: Definitions

Financial Statements

IAS 1.10 states that a complete set of financial statements comprises:

- a statement of financial position as at the end of the period;
- a statement of comprehensive income for the period;
- a statement of changes in equity for the period;
- a statement of cash flows for the period;
- notes, comprising a summary of significant accounting policies and other explanatory information;
- a statement of financial position as at the beginning of the earliest comparative period when an entity applies an accounting policy retrospectively or makes a retrospective restatement of items in its financial statements, or when it reclassifies items in its financial statements.

Material Matters

Certain representations in this letter are described as being limited to matters that are material.

IAS 1.7 and IAS 8.5 state that:

"Material omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions that users make on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or a combination of both, could be the determining factor."

Fraud

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and
b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to "management" should be read as "management and, where appropriate, those charged with governance".

Related parties

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in IAS 24 *Related Party Disclosures* as the "reporting entity").

a) A person or a close member of that person's family is related to a reporting entity if that person:
   i. has control or joint control over the reporting entity;
   ii. has significant influence over the reporting entity; or
   iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.
b) An entity is related to a reporting entity if any of the following conditions applies:
   i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
   ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
   iii. Both entities are joint ventures of the same third party.
   iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
   v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
   vi. The entity is controlled, or jointly controlled by a person identified in (a).
   vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).

A reporting entity is exempt from the disclosure requirements of IAS 24.18 in relation to related party transactions and outstanding balances, including commitments, with:

a) a government that has control, joint control or significant influence over the reporting entity; and
b) another entity that is a related party because the same government has control, joint control or significant influence over both the reporting entity and the other entity.

Related party transaction

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

Going Concern

The NHS Foundation Trust Annual Reporting Manual 2013/14 (the "ARM") published by Monitor states:

Going concern

3.20. IAS 1 requires management to assess, as part of the accounts preparation process, the NHS foundation trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

3.21. Where management are aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the NHS foundation trust, these should be disclosed.

The International Accounting Standard (IAS) does not make any specific statement about how far ahead the management should look in order to assess the position. As members are aware, the Board approved a budget for 12 months, with a small surplus and adequate contingency reserve. Savings have been identified and allowed for in the budget; there is no requirement to identify additional CIPs in-year. The Board also approved an operational plan for 2 years which includes the Trust's financial plans and projections.

On this basis, and in view of the guidance in the ARM and the IAS, the Trust has prepared financial statements on a going concern basis.

Board of Directors : 27 May 2014

Item : 13

Title : Directors' responsibilities in respect of Quality Report

Summary:

We are asking the Board to approve the Quality Report on behalf of the Chief Executive and Chairman, in order that the Chief Executive and Chairman can 'sign off' the Quality Report. For Directors to decide whether they are in a position to provide this assurance, it will be necessary for Directors take steps to satisfy themselves on the criteria included on the attached paper, which they need to consider when reviewing the Draft Quality Report (Appendix 1).

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

The draft report has been previously reviewed by the management committee.

This report focuses on the following areas:

- Quality
- Patient / User Experience
- Safety

For : Approval

From : Quality Standards and Reports Lead

Statement of Directors' Responsibilities in Respect of the Quality Report

1.   Introduction

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

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

Monitor has issued guidance to NHS foundation trust boards 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.

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

2.1   The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14.

The Quality Report contains Part 1, 2, 3 and 4 as required. It includes all the mandatory sections, with the section on Achievements in Quality included by the Trust.

2.2   The content of the Quality Report is not inconsistent with internal and external sources of information, including:

-   Board minutes and papers for the period April 2013 to May 2014.

-   Papers relating to Quality Reported to the Board over the period April 2013 to May 2014.

-   Feedback from the commissioners, dated 15/05/2014.

-   Feedback from governors, dated 12/05/2014.

-   Feedback from local Healthwatch organisations, dated 9/05/2014.

-   The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. We have produced an annual complaints report dated April 2014 covering 2013/14, which was presented to the Board in April 2014.

- The 2013 national staff survey, received by the Trust in February 2014.

- The Head of Internal Audit's annual opinion over the trust's control environment, dated 21/05/2014.

- Care Quality Commission quality and risk profiles. [The Board does not receive the Quality Risk Profiles but has received assurance via the Clinical Quality, Safety and Governance Committee (CQSG) and via the Director of Corporate Governance and Facilities Report to CQSG that no issue had been highlighted for the period covering 2013/14].

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

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

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

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

2.5 There are proper internal controls over the collection and 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.

Data validation forms, which form part of the Framework for Data Quality and Reporting have been completed for each data entry in the Quality Report, and signed off by the relevant Director. These forms outline the systems for recording the data; process for obtaining the data; data validation processes, where relevant; assurances over data quality; gaps/risks in data assurance, and action plans to address risks and/or provide assurance, where required. These data validation forms have been reviewed by the internal Data Quality Assurance Group (Management Committee) which undertakes the internal quality assurance process for the data reported in the Quality Report, identifying gaps and risks in data assurance and providing recommendations for improving data quality. The Trust has fully implemented its assurance process via the CQSG, which has been in operation since July 2010. We

consider therefore that there are proper controls in place, which are subject to review and which work effectively in practice.

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

To the best of our knowledge the data underpinning the measures of performance is robust and reliable, and conforms to data quality standards and meets the requirements for reporting. For example, for patient safety incidents (which are reported to the NPSA), complaints received, monitoring of adult safeguard alerts, waiting times, and other quality indicators. However, in those areas where the data is seen to fall below an acceptable standard, action plans are in place to address this. For example, we have explained the difficulties we have experienced with the DNA data and the steps we have taken to validate this data, where we continue to impress on staff the importance of making a record in the paper file for each appointment whether or not the patient attends.

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

The Tavistock and Portman **NHS**

NHS Foundation Trust

Quality Report

2013/2014

Contents

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.

Part 1: Statement on Quality from the Chief Executive

Embedded within the Trust is a genuine desire to improve each year the quality of our services across a number of broad headings, including:

- The experience that our patients have of the way they are dealt with by our administrative teams and by our clinical staff.

- The way we collect, report and use information about the outcome of patients' treatment.

- The effectiveness of the wide variety of treatments our patients receive from us.

- The experience patients and students have when they visit us, including the accessibility, lay-out, condition and décor of our buildings and rooms and the facilities we offer.

- The way we communicate information about our clinical and educational services to patients and students and to organisations which purchase those services from us.

- The way we collect, protect and store information about our patients.

- The way we engage with patients, students, our Members, the general public, our Governors and all our stakeholders in order to keep them informed and to take their views into account.

- The way we keep all members of our workforce highly motivated, well trained and effective in order to deliver the best possible services.

How are we doing?

Our continued effort and commitment to improve quality has resulted in positive outcomes.

Demonstrating the effectiveness of our clinical services is one of our key priorities, so we are pleased that we exceeded three of our four targets in 2013/14 for the goals we set for evaluating clinical effectiveness. Specifically, for our Child and Adolescent Mental Health Service (CAMHS), where 79% of patients and their parents/carers completed the Goal-Based Measure at both Time 1 and Time 2. Although we fell short for our second target of 75%, by achieving 65%, for an improvement from Time 1 and Time 2 for at least two of the goals (agreed by

patients/service users in conjunction with clinicians), we still consider this achievement significant as it represents a reasonably high percentage of patients/service users. In addition, for adult patients, we exceeded both our targets. Sixty-two% of patients who completed the CORE forms at time 1 and Time 2 showed an improvement in their Total CORE score from the pre- to the post-assessment stage and by achieving a return rate of 35% for the CORE forms completed and returned by patients/service users at end of their treatment.

We have been successful in achieving most of our targets for Improving Access to Information. We have developed four modality leaflets this year, two which were developed by children and young people; our mystery shoppers were able to access information relevant to their needs; the language and content has been changed in the modality leaflets, where applicable, in response to feedback from mystery shoppers; patients also have provided feedback about the modality leaflets on the monthly membership stand days and a random selection on case files was audited to identify if treatment options were documented as discussed.

We have also been successful in achieving all our targets for Patient and Public Involvement. We have developed a protocol for the payment of service users on interview panels and includes guidance on the selection and training of service users on interview panels and Bid for Better was expanded to encourage young people to participate.

In March 2014 the Trust underwent a routine inspection by the Quality Commission (CQC). The inspectors spent some time in different departments across the Trust over a number of days; they met with clinical staff and spoke with some of the service users. The inspectors considered feedback that we had received from patients and their carers/parents and reviewed a number of key policies and procedures. Whilst on site they focused their assessment on 5 of the core standards and found us to be fully compliant with each of these. This was an announced inspection and focused on care to children and young people. We continue to hold full registration with the CQC without restriction. The full report is available on the CQC website www.cqc.org.uk.

How we monitor our performance

The Board of Directors is ultimately responsible for ensuring that we continue to raise the bar on all our quality initiatives and they receive regular reports from a committee we created during 2010 to oversee all the most important quality initiatives.

The Clinical Quality, Safety and Governance Committee (CQSG) is a Board appointed committee with Trust and Non-Executive Director members and

Governors which meets quarterly to receive and consider assurance of progress against requirements and action plans across the core of our quality improvement agenda, and to review work stream reports submitted to this committee. These key work streams, which are at the heart of our quality commitment, cover areas such as clinical effectiveness, patient experience, safety and staff training, with quarterly reports to the Board of Directors. These work streams are:

- Patient Safety and Clinical Risk.
- Corporate Governance and Risk [including CQC and NHS Litigation Authority (NHSLA) compliance].
- Clinical Outcomes and Clinical Audit.
- Patient and Public Involvement.
- Information Governance.
- Quality Reports.

Our commitment and impetus for continuous quality improvement does not end here, it operates through all levels of the organisation, with employees aware of the importance of the need to challenge the ways in which we work, with an on-going effort to improve quality across all aspects of our services. We work closely with our many stakeholders to ensure that they have every opportunity to contribute to our plans, and to monitor our progress.

Our Council of Governors is fully committed to our quality agenda.

One of the major roles of the Council of Governors during 2013/14 has been to ensure that they are fully involved in both contributing to and monitoring the Trust's quality agenda. The influence of the Council of Governors is interwoven in all the key decision making processes and they do this in a variety of ways:

- By Governors' attendance at key committee meetings and fora including:

  o CQSG
  o PPI Meeting
  o Equalities Committee
  o Quality Stakeholders Meeting
  o Governors Clinical Quality Meeting

- By considering the quality agenda at all of their Council meetings.

- By visiting and where possible observing the work of the different departments and services and attending Trust Board Meetings.

- In particular, the Governors Clinical Quality Meetings continue to provide an important forum for Governors and key Trust staff to focus on the quality agenda for the Trust and ways for improving quality.

Our priorities for 2014/15

We continue to be fully committed to improving quality across every aspect of the Trust's work, building on what we have achieved this year. Our on-going consultation throughout the year with a variety of stakeholders has provided us with valuable feedback and ideas both for establishing our priorities for next year and for exploring the ways we can raise the bar on the targets we set.

Our Quality Priorities for 2014/15 will focus on:

- Continuing to demonstrate further positive changes for patients, as a consequence of the psychological intervention/treatment they receive from the Trust.
- Including service users on interview panels.
- Arranging for members of the board to 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.
- Creating a patient's stories section on the Trust website, where video and written transcripts will be available and promoting access to this section of the website.

In this report you will find details about our progress towards these priority areas as well as information relating to our wider quality programme.

Some of the information is, of necessity, in rather complex technical form, but I hope the glossary will make it more accessible.

However, if there are any aspects on which you would like more information and explanation, please contact Justine McCarthy Woods (Quality Standards and Reports Lead) at JMcCarthyWoods@tavi-port.nhs.uk, who will be delighted to help you.

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

Signature Mr Paul Jenkins

Chief Executive

May 2014

CQC Care Quality Inspection
Inspection Report

Why was the CQC inspection carried out?

This was a routine inspection to check that essential standards of quality and safety referred to below were being met. CQC sometimes describe this as a scheduled inspection.

This was an announced inspection and focused on care to children and young people.

How the CQC carried out this inspection

CQC carried out visits on 3, 5 and 6 March 2014, observed how people were being cared for and talked with people who use the service. CQC talked with staff and reviewed information provided to them by the Tavistock & Portman NHS Foundation Trust.

Outcomes

The CQC inspected the following standards as part of their routine inspection.

This is what they found:

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

> " We found that people's views and experiences were taken into account in the way the service was provided and delivered in relation to their care. "

> " People experienced care, treatment and support that met their needs and protected their rights. "

> " People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider in cooperation with others. "

> " The provider had an effective system to regularly assess and monitor the quality of service that people receive. "

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 (See Glossary). 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) (See Glossary) 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) (See Glossary) 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.

1.2 Overview of Quality Indicators 2013/14

The following table includes a summary of some of the Trust's quality priority achievements with the RAG status*, along with the page number where the quality indicator and achievement are explained in greater detail.

Target	RAG Status*	Achievement	Page Number
Child and Adolescent Mental Health Service Outcome Monitoring Programme			
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).		79%	16
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).		65%	16
Adult Outcome Monitoring Programme			
For the total CORE scores to indicate an improvement from pre-assessment (Time 1) to post-assessment (Time 2) for 61% of patients over the age of 25 years.		62%	18
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.		35%	18
Access to Clinical Service and Health Care Information for Patients and Public			
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.		Achieved	19
To demonstrate that 90% of mystery shoppers are able to access a leaflet relevant to their needs including young people.		Achieved	19
To modify leaflets content and availability in light of feedback from mystery shoppers.		Achieved	19
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.		Partially achieved	19
To audit a random selection of case files to identify if treatment options were documented as discussed.		Achieved	19
Patient and Public Involvement			
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.		Achieved	23

To continue to expand and promote Bid for Better and to target engagement with our younger members.		Achieved	23
Patient Safety Indicators			
NHS Litigation Authority Level		Level 2 achieved Feb 2011	39
Patient Safety Incidents	n/a	42	40
Monitoring of Adult Safeguard Alerts	n/a	0	41
Safeguarding of Children – Level 1 Training Safeguarding of Children – Level 2 Training Safeguarding of Children – Level 3 Training	n/a n/a n/a	94% 88% 89%	43
Clinical Effectiveness Indicators			
Monitor number of staff with PDPs		96%	46
Patient Experience Indicators			
Complaints received	n/a	12	48
Patient Satisfaction			
Percentage of patients that rated the overall help they had received as good: Quarter 1 Quarter 2 Quarter 3 Quarter 4		94% 97% 93% 93%	48
Did Not Attend Rate			
Trust Wide – First Attendances		10.3%	51
Trust Wide – Subsequent Appointments		8.7%	51
Waiting Time Breaches			
Trust Wide – Number of patients waiting for first appointment for 11 or more weeks Internal Causes External Causes Unknown Causes		65 18 47 N/A	53
Trust Wide – Percentage of patients waiting for first appointment for 11 or more weeks Internal Causes External Causes Unknown Causes		4.1% 1.1% 2.9% N/A	53
Other Achievements			
Maintaining a High Quality, Effective Workforce			
Attendance at Trust Wide Induction Days		94%	41
Completion of Local Induction		97%	42
Attendance at Mandatory INSET Training		95%	42

*Traffic light system for indicating the status of the target using Red (remedial action required to achieve target), Amber (target not achieved but action being taken or situation being monitored) and Green (target reached).

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%	65%

*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 to 75%. Unfortunately, we fell short of the target of 75%, by achieving 65%. 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. In addition, there were some patients only interested in working on one particular goal and therefore who only agreed one goal with the clinician at Time 1.

    However, while 65% of patients achieved an improvement in their GBM score from Time 1 to Time 2 on at least two targets (goals), as indicated above, a number of patients in this cohort only rated one goal at Time 1, making it impossible for them to achieve this target. When those patients with only one goal at Time 1 are excluded from the cohort, 73% achieved an improvement in their GBM score from Time 1 to Time 2 on at least two targets.

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 targets, which also represent the CQUIN (see Glossary) target we had agreed with our commissioners for 2013/14. Although we had exceeded our first target in 2012/13, our commissioners recommended that we continue with this target for 2013/14:

2. Adult Outcome Monitoring Programme			
Targets for 2013/14	2011/12	2012/13	2013/14
1. For the total CORE scores to indicate an improvement from pre-assessment (Time 1) to post-assessment (Time 2) for 61% of patients over the age of 25.	*	63%	62%
2. 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.	*	*	35%

*No comparable targets existed for the previous years, so therefore cannot be compared.

How have we progressed?

1. For the Adult Service, Time 1 refers to the pre-assessment stage, where the patient is given the CORE form to complete before they are seen for the first time. Then, the patient is asked to complete this form again at the post-assessment stage (Time 2).

   We are pleased to report that we achieved our target, as 62% of patients who completed the CORE forms at time 1 and Time 2 showed an improvement in their Total CORE score from the pre to the post-assessment stage, which suggests that they benefitted from this clinical intervention, although the percentage of patients who improved was slightly lower than last year.

2. 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 four 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 because patients told us on the previous phone survey that they found it very difficult to answer questions over the phone without seeing the leaflets. 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 (2012/13) 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

The purpose of this target was 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. Initially, we planned to undertake another telephone survey. However, a more comprehensive review of our feedback from patients from the 2012/13 telephone survey indicated that patients would have liked to have seen the leaflets to be able to comment. Therefore, based on patient feedback, we decided that 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.

How have we progressed?

Therefore, although we changed the methodology for obtaining this information from the time that we set this target, we believe that we were able to obtain more useful feedback from patients regarding their awareness of these leaflets and their satisfaction with the level of information contained in 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 (2012/13) to ascertain whether treatment options were documented as discussed. Theses 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% 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. This is a two year target, therefore implementation of training for staff on including service users on interview panels will be progressed over 2014/15 with at least two staff trainings planned.

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. The Governors Clinical Quality Group has played a key role in helping us to think about some our quality priorities for next year. In addition, this year Camden Healthwatch has also made a useful contribution to this process.

Clinical Effectiveness (Clinical Outcome Monitoring)

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

As we fell short of achieving one of our CAMHS target in 2013/14, we agreed with our commissioners to continue with one of these CQUIN (see Glossary) targets for 2014/15, which we have also set as one of our Quality Priority targets.

This target requires 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). Although, we appreciate that this target may not be appropriate for the group of patients/service users who only wish to focus on one particular goal.

However, in order to have a representative sample of patients, we think that it is also important to include the first target from 2013/14 (which we achieved last year) where we expect 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).

1.	**Child and Adolescent Mental Health Service Outcome Monitoring Programme**

Targets for 2014/15
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).
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).

Measure Overview

For our Child and Adolescent Mental Health Services (CAMHS), we plan to use the Goal-Based Measure again this year. This is a commonly used measure in CAMHS and we will be building further 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 want 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.

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

For 2014/15, we plan to focus on evaluating the change for adult patients from the pre-assessment phase to the End of Treatment phase as a way of evaluating our clinical effectiveness for the group of adult patients who qualify for the CQUIN (see glossary). This follows on from one of our targets from last year, where we worked to try to increase the percentage of patients who completed and returned the End of Treatment CORE form.

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

2. Adult Outcome Monitoring Programme
Target for 2014/15
1. For the Total CORE scores to indicate an improvement from pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.

Measure Overview

As described in Part 2.1, the CORE Clinical Outcomes for Routine Evaluation system was designed to provide a routine outcome measuring system for psychological therapies. The 34 items of the measure covers four dimensions: subjective well-being, problems/symptoms, life functioning and risk/harm.

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:

3. Access to Clinical Service and Health Care Information for Patients and Public
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:

4. Patient and Public Involvement
Targets for 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 Team 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 four of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 79% 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

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. This individual 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.
- re-audit 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 http://www.tavistockandportman.nhs.uk/about-us/governance/commissioning-quality-and-innovation-cquin.

The total financial value for the 2013/14 CQUINs was £268,261 (£180,473 in 2012/13) and The Tavistock and Portman NHS Foundation Trust expects to receive £257,775. (The Trust received £183,043 in 2012/13.)

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.

In March 2014 the Trust underwent a routine inspection by the Quality Commission (CQC). The inspectors spent some time in different departments across the Trust over a number of days; they met with clinical staff and spoke with some of the service users. The inspectors considered feedback that we had received from patients and their carers/parents and reviewed a number of key policies and procedures. Whilst on site they focused their assessment on 5 of the core standards and found us to be fully compliant with each of these. This was an announced inspection and focused on care to children and young people. We continue to hold full registration with the CQC without restriction. The full report is available on the CQC website, www.cqc.org.uk.

Specifically, at the assessment the CQC looked for evidence of compliance with the following standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Co-operating with other providers
- Supporting workers
- Assessing and monitoring the quality of service provision

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 88% and was graded Green.

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:

- We are still in the process of completing training the clinicians, including new clinicians and trainees on courses to complete and monitor their patients' outcome monitoring progress electronically. This is part of the larger preparation we are making for the introduction of a new electronic patient administration system in 2015 which will be used by clinicians for direct entry of information.

- In line with new CQUIN targets, we have taken the next step with our collected data, which is to begin to interrogate the data in a meaningful way to inform clinical work. Part of this interrogation will be done by the newly organized evidence based practice clinical working groups which have been set up to begin to look at the progress and risks highlighted by the many outcome measures used with patients.

2.3 Reporting against core indicators

Since 2012/13 NHS foundations have been required to report performance against a core set of indicators using data made available to the trust by the Health and Social Care Information Centre (HSCIS). When reporting on these indicators, the trust is required to use two prescribed 'assurance' statements. Most of the indicators included in this section are not relevant to the Trust.

However, one of the indicators which is relevant to the Trust is Core Indicator number 21, *'the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as provider of care to their family or friends'.*

To report on our performance for this indicator, we used the data from the 2013 National NHS staff survey. *The Tavistock and Portman NHS Foundation Trust considers that this data is as described (in the tables below) for the following reason* specifically, as the 2013 National NHS staff survey was conducted by NHS England.

The data provided for the 2013 Staff Survey Key Findings was for the question: 'Staff recommendation of the trust as a place to work or receive treatment' (Key Finding 24).

Staff who would recommend the trust as a place to work or receive treatment					
	TPFT 2012	TPFT 2013	National Average	Best 2013 score	Lowest score
Staff who would recommend the trust	3.99	4.02	3.55	4.04	3.01

This data is presented as a score from 1-5 where 1 is a low score and 5 is a high positive score (not presented as a percentage)
The question numbers used to calculate these figures were Q12a, 12c-d.

All figures reported for the Staff Survey were taken from the Annual published findings of the 2013 staff survey. The data in the above table is presented as a score out of 5, rather than as a percentage as indicated in the Core Set of Indicators.

As indicated above, for this financial year we have performed above the National average and were very close to achieving the Best 2013 score for this indicator.

Below are the Trust's performance given as percentages for the 3 questions used to calculate the scores given above.

Question No	Questions	TPFT 2013	Average for the Mental Health Trusts	TPFT 2012
Q12a	Care of patients/service users is my organisations top priority.	80	63	83
Q 12c	I would recommend my organisation as a place to work.	73	53	70
Q 12d	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	85	59	80

As reported in Part 3 (pages 44-45), the Trust's results from this year's staff survey are good once again and indicate that staff still consider the Trust to be a good employer. Specifically, 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 which demonstrates an improvement on the Trust's performance. In relation to indicator 21, the trust received the best scores for the following:

o The percentage of staff reporting good communication between senior management and staff.
o The percentage of staff feeling pressure to attend work while feeling unwell.
o Staff job satisfaction.

Notwithstanding the above, *The Tavistock and Portman NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services.* Specifically, 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.

Regarding the Core Indicator 25, concerning the rate of patient safety incidents reported within the Trust during 2013/14, the data for this indicator can be found elsewhere in the Quality Report at page 40.

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	*	*	94%
Safeguarding of Children – Level 2 Training	**	**	88%
Safeguarding of Children – Level 3 Training	86%	82%	89%

*All staff receives 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, 94% of staff received Level 1 training and 88% of staff attended Level 2 training.

We are particularly pleased to report that 89% of staff requiring Level 3 training had attended this training, which is an 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 the 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/ 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 <u>annual training</u> 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 31 March 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.

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 31 March 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 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 http://www.tavistockandportman.nhs.uk/about-us/governance/commissioning-quality-and-innovation-cquin to review the Portman CQUIN 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
Patient rating of help received as good	94%	97%	93%	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 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) and 93% of patients in Quarter 4 (January to March, 2014) 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 who 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.

YPCS The Young People's Consultation Service (YPCS)

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 (1,2,3,4)

Indicator	2011/12	2012/13	2013/14
Trust Wide			
First Attendance	11.4%	9.6%	10.3%
Subsequent Appointments	10.7%	8.9%	8.7%
Adolescent and Young Adult			
First Attendance	13.1%	9.5%	7.7%
Subsequent Appointments	14.1%	13.7%	14.3%
Adult			
First Attendance	11.1%	7.3%	7.5%
Subsequent Appointments	9.1%	7.6%	9.1%
Camden Child and Adolescent Mental Health Service (Camden CAMHS)			
First Attendance	17.9%	13.6%	14.1%
Subsequent Appointments	20.2%	10.1%	8.1%
Developmental (including Learning and Complex Disability Service)			
First Attendance	9.9%	3.0%	2.0%
Subsequent Appointments	7.4%	7.4%	6.9%
North Camden Child and Adolescent Mental Health Service			
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
Portman			
First Attendance	2.8%	4.6%	7.9%
Subsequent Appointments	10.2%	11.0%	9.1%
South Camden Child and Adolescent Mental Health Service			
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
Other Child and Adolescent Mental Health Service (Other CAMHS)			
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%
Vulnerable Children			
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

1. 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.
2. 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.
3. 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.
4. 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 minimising where possible wasted NHS time.

Targets and Achievements

There has been an increase in DNA rates for first attendances (10.3%), compared with 2012/13 (9.6%). However, we 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%.[5]

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.

However, it is important to note that the Trust reports DNAs that are recorded on our electronic administrative data base Rio. Information is uploaded onto Rio by administrators who rely on clinicians to inform them of the outcome for each patient. During the year the trust has undertaken a number of data validation audits and these on occasions have demonstrated that we were unable to review a paper entry that linked to the Rio record of DNA. This is as a result of a number of different paper sources of data being used (eg clinical records; diary sheets; emails to administrators). We have added this comment to our report to show the steps we take to validate data. We continue to impress on staff the importance of making a record in the paper file for each appointment whether or not the patient attends. In 2015 the Trust will be moving to a fully electronic clinical records system which will reduce the number of steps to recording DNA (ie the clinician will record outcome directly) and we anticipate that our data reliability will be increased.

5. Mental Health Benchmarking Club, April 2010, Audit Commission: http://www.audit-
    commission gov uk/SiteCollectionDocuments/Events/201 0/mental-health-benchmarking-club-presentations- april-201 0.pdf

Waiting Times ([6,7])

Indicator	2011/12	2012/13	2013/14
Trust Wide – Number of patients waiting for first appointment for 11 or more weeks	74	118	65
Internal Causes	28	27	18
External Causes	46	88	47
Unknown Causes	N/A	3	N/A
Trust Wide – Percentage of patients waiting for first appointment for 11 or more weeks	4.7%	6.1%	4.1%
Internal Causes	1.8%	1.4%	1.1%
External Causes	2.9%	4.5%	2.9%
Unknown Causes	N/A	0.2%	N/A

6. The figures for 2012/13 exclude the Gender Identity Disorder Service, as this Service has a Department of Health Referral to Treatment target (RTT) of 18 weeks.
7. For 2012/13, the 3 cases falling into the category of 'unknown causes' originated from Quarter 1 and Quarter 2. However, since Quarter 3, the responsibility for collating and interrogating the waiting time data has been transferring to the CAMHS and SAAMHS managers, which has helped to improve the accuracy of the waiting time data as these managers work more closely with the clinical teams within their directorates.

What are we measuring?

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait, especially those who are close to our target time of eleven weeks.

Prior to their first appointment, patients will be contacted and offered two possible appointments, and invited to choose one of these appointments. If neither appointment is convenient for the patient, they will be offered an alternative appointment with the same therapist where possible. This system on the whole helps to facilitate patients engaging with the service. The majority of patients are seen within eleven weeks of the Trust receiving the referral.

During 2013/14, 65 (4.1%) patients had to wait for eleven weeks or longer. Although clinical and administrative staff work hard to minimise the length of time that patients have to wait before they are seen, this is an improvement on the 118 (6.1%) figure from 2012/13. There were both factors external to the Trust, concerning 47 (2.9%) patients, and internal to the Trust, for 18 (1.1%) patients, which contributed to these delays. The Trust waiting times, will continue to be monitored and improved where possible, especially for internal delays.

To help address the breaches of the eleven week target, at the end of each quarter a list is drawn up for each service of those patients who had to wait eleven weeks or longer for their first appointment, together with reasons for this. The services where the breach has occurred are requested to develop an action plan to address the delay(s) and to help prevent further breaches.

GIDS — The Gender Identity Development Service

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.   By achieving 99% data completeness for these mental health identifiers, the Trust exceeded 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.

Comments from Camden Clinical Commissioning Group (CCG)

NHS Camden Clinical Commissioning Group are the lead commissioner for the commissioning for Tavistock and Portman NHS Foundation Trust on behalf of the population of Camden and associated commissioners.

NHS Camden Clinical Commissioning Group welcomes the opportunity to provide this statement on Tavistock and Portman NHS Foundation Trust's Quality Accounts. We confirm that we have reviewed the information contained within the Account and checked this against data sources where this is available to us as part of existing contract/performance monitoring discussions and confirm its accuracy in relation to the services provided.

We have reviewed the content of the Account and confirm that this complies with the prescribed information, form and content as set out by the Department of Health. We believe that the Account represents a fair and balanced overview of the quality of care at Tavistock and Portman NHS Foundation Trust. We have been given the opportunity to discuss the development of priorities taken forward in this Quality Account with Tavistock and Portman NHS Foundation Trust over the year and have been able to contribute our views on content and quality priorities for 2014/15.

We have taken particular account of the identified priorities for improvement for:

Priority 1: Children and Adolescent Mental Health Service Outcome Monitoring Programme (CQUIN, targets not set yet as in negotiation).
Priority 2: Adult Outcome Monitoring Programme (CQUIN, targets not set yet as in negotiation).
Priority 3: Access to clinical service and health care information for patients and the public.
Priority 4: Public and Patient Involvement (PPI).

And how this work will enable real focus on improving the quality and safety of health services for the population they serve.

Overall we welcome the vision described within the Quality Account, agree on the priority areas and will continue to work with Tavistock and Portman NHS Foundation Trust to continually improve the quality of services provided to patients.

Trust Response: *We appreciate the comments provided by Camden Clinical Commissioning Group (CCG) and look forward to working closely in 2014/15 with our colleagues in the CCG and the commissioners representing other boroughs in our shared effort and commitment to improving the quality of our services.*

Comments from our Governors

The Governors Clinical Quality Meetings have given us an excellent opportunity to focus exclusively on the quality agenda with Governors from all constituencies and senior leaders in the Trust. We feel we have been fully consulted, particularly in the selection of priorities and the local indicators. We are once again delighted that this report shows that the Trust is continuing not only maintain but to go forward in improving the quality of its wide range of services in these challenging times**.**

Trust Response: *We greatly value the contribution of our Governors and the role they have played in helping us to take forward the quality agenda for the Trust, with their on-going commitment to exploring different ways for evaluating and improving quality.*

Comments from Camden Healthwatch

There is clearly a lot of good work going on at the Tavistock and Portman. We will not be commenting on the clinical aspects of the Trust's work. We want to comment on just a few brief points, all related to patient involvement.

- We think the targets and (some) performance on patient accessibility and involvement are disappointing. In relation to the performance for 2013/14, the targets on patient access are about the number of information leaflets produced. Whilst this is a response to patient requests, it is not clear that the leaflets the Trust has produced actually help nor how many patients have seen them. In 2012/13 the Trust did a telephone survey about the leaflets but too few had seen them to make a meaningful response possible. In 2013/14 they abandoned the survey and interviewed some patients with the leaflets in front of them to ask about whether they were helpful. So there is no information about how accessible the leaflets are or how helpful.

Trust Response: *The telephone survey was replaced with face to face questions because this was patient preference, clear feedback was that patients could not*

comment on the patient leaflets without having them to hand. We also used the mystery shopper approach to understand accessibility. Of the 20 people questioned, only 50% had previously seen the leaflets, but when shown them, 17 (85%) felt the leaflets were helpful. From the accessibility perspective, of the mystery shoppers involved 100% were positive about the leaflet contents, however, 66% felt they were difficult to access on the website. We have since reviewed the website and our new website was launched in April. We will be following up with a further mystery shopper's project to see if the accessibility of these leaflets has improved.

- The 2014/15 targets on patient access are all about patient stories being accessible. We are not clear what having this available achieves and it would have been helpful to know. On public and patient involvement, the focus is on training staff on having service users on PPI panels, interviewing at least 3 service users on the panel and taking patient stories to the board. Again, we are not clear what the outcome of all this is supposed to be.

Trust Response*: There is a clear evidence base on the benefit of hearing about other people's experiences with services (see for example, making the board room the place to improve patient experience, Health Service Journal (HSJ) November 2011), this methodology also gives us more detailed feedback about user experience which will be fed into the quality stakeholders group who review all the feedback the Trust receives so it is likely to have positive benefits in more than one way. In relation to having service users on panels, again there is a clear evidence base that this method of co-production is valued by patients and staff alike, when we asked the PPI Forum (which consists of 12 mental health trusts across London and the home counties) all the PPI leads described how having users on panels had improved their selection processes. Patients are given the opportunity to shape the future staffing of the Trust and to influence the selection of particular traits they value in staff.*

- The Trust reports 12 complaints last year. But there is no analysis of what they were about or what the Trust did in response.

Trust Response: *During 2013/14 the Trust received 12 formal complaints. All complaints related to clinical care. The Trust received no complaints about environment or facilities during 2013/14. The complaints from patients covered a number of issues. However, in order to maintain confidentiality of the complainants, given the small numbers of complaints, the Trust does not provide the details of these complaints. Each complaint was investigated under the Trust's complaints procedure and a letter of response was sent by the Chief Executive to each complainant.*

- In terms of patient involvement, the Trust undertook two random case file audits to check whether the files had notes about treatment options (which

might indicate that patients had a discussion about those options). Only 58% had such a note, which we do not think is a good outcome.

Trust Response: *It is worth noting that the Trust has only in the last two years developed a written log of consent, which is not strictly required for psychotherapy as the patient's participation is considered consent. However, in line with best NHS practice ensuring that patients know what is planned, the risks and benefits and the alternatives, is good practice and therefore we have introduced a place on the assessment form to record this. Moreover, medico legal training has been delivered by the Governance and Risk Adviser, covering most of the clinical services in the Trust. In addition, the action plan arising from the case note audit includes further training on consent, including discussion of choice of treatment and the use of the form to record that discussions with patients have taken place.*

- We have been pleased to learn over the year about the Trust's work on patient involvement and we have enjoyed taking part in some engagement activity at the Trust. As part of the programme it is right that there are targets for patient involvement, but we think they could be made clearer (and therefore stronger) for the future.

Trust Response: *We appreciate the feedback on the PPI targets and have endeavoured to be clearer about the significant gains this work will bring the trust. We will take this feedback into account when describing further work in this area.*

Comments from Camden Overview and Scrutiny Committees

We invited feedback from the Camden Overview and Scrutiny Committee on our Draft Quality Report and were advised that they would consider the Quality Report but no longer provided formal comment for inclusion in reports.

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 2013/14*;

- 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 May 2014.

- Papers relating to Quality reported to the Board over the period April 2013 to May 2014.

- Feedback from the commissioners, dated 13/05/2014.

- Feedback from governors, dated 12/05/2014.

- Feedback from local Healthwatch organisations, dated 9/05/2014.

- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. We have produced an annual complaints report dated April 2014 covering 2013/14, which was presented to the Board in April 2014.

- The 2013 national staff survey, received by the Trust in February 2014.

- The Head of Internal Audit's annual opinion over the trust's control environment, dated 21/05/2014.

- Care Quality Commission quality and risk profiles. [The Board does not receive the Quality Risk Profiles but has received assurance via the Clinical Quality, Safety and Governance Committee (CQSG) and via the Director of Corporate Governance and Facilities Report to CQSG that no issue had been highlighted for the period covering 2013/14].

- 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) 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).

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

Barnet Young People's Drug and Alcohol Service (YPDAS) - This service operates in the London Borough of Barnet to provide support to young people relating to drug and alcohol misuse. They provide counselling, drug treatment, family therapy and health assessments, following NHS confidentiality and patient care guidance.

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 31 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.

City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) - The City and Hackney Primary Care Psychotherapy Consultation Service offers talking therapies to adults aged 18 or over living in the City of London or London Borough of Hackney. Clinicians typically see patients who are experiencing problems such as depression, anxiety, stress, panic, isolation, loss of sleep or persistent physical pain or disability. It is an inclusive service, seeing people from a diverse range of backgrounds. Depending on the individual needs clinicians will work with the individual, a couple, and a family or in a group of 8-12 others.

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, adolescent 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.

Family Nurse Partnership National Unit (FNP NU) - The Family Nurse Partnership is a voluntary home visiting programme for first time young mothers, aged 19 or under. A specially trained family nurse visits the young mother regularly, from early in pregnancy until the child is two. Fathers are also encouraged to be involved in the visits if mothers are happy for them to be. The programme aims to improve pregnancy outcomes, to improve child health and development and to improve the parents' economic self-sufficiency. It is underpinned by an internationally recognised evidence base, which shows it can improve health, social and educational outcomes in the short, medium and long term, while also providing cost benefits.

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.

Mystery Shoppers – These are service users or volunteers who make contact with the trust via phone, email or who visit the building or our website, in order to evaluate how accessible our services are, the quality of our information and how responsive we are to requests. The mystery shoppers then provide feedback about their experiences and recommendations for any improvements they consider we could usefully make.

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, GIDS, Portman Child and Adolescent Service and the Adolescent and Young Adult Directorate to be trained in Safeguarding of Children Level 3, where staff are required to attend Level 3 training every 3 years. (In addition, all other Trust staff regularly attend Safeguarding of Children Training, including Level 1 and 2 training.)

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 : May 2014

Item : 14

Title : Corporate Governance – Register of Interests

Purpose:

Please find attached the register of interest. This register ensures there are no material conflicts of interest within the board of directors, and is for the board to approve

For : Approval

From : Gervase Campbell, Trust Secretary

Register of Directors' Interests 2014/15

1. Introduction

All existing Directors shall declare relevant and material interests forthwith and the Trust shall ensure that those interests are noted in the *Register of Directors' Interests*. Any Directors appointed subsequently shall declare their relevant and material interests on appointment.[1] At the time the interests are declared this shall be recorded in the minutes of the Board of Directors meeting as appropriate. Any changes in interest shall be officially declared at the next meeting of the Board of Directors following the change occurring. It is the obligation of the Director to inform the Trust Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest and the membership.[2] If a Director has a doubt about the relevance or materiality of any interest this should be discussed with the Trust Chair.[3]

2. Declaration

Please complete the table below, stating all relevant and material interests. If none are applicable, put "none". Interests which shall be regarded as "relevant and material" and which for the avoidance of doubt should be declared and should be included in the Register of Directors' Interests are:

Disclosure Requirement	Disclosure[4]
Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those directorships of dormant companies)	**Martin Bostock:** • Director, Nelson Bostock Group Ltd, a wholly owned subsidiary of Creston PLC **Caroline Rivett:** • NED, Patient Information Forum • Director, Unthank Consulting **Angela Greatley:** None **Rob Senior:** None **Louise Lyon:** None

---

[1] Tavistock & Portman NHS Foundation Trust, *Constitution, Election Rules, Standing Orders*, February 2010, Annex 5, Paragraph 9.1
[2] Ibid, Paragraph 9.4
[3] Ibid, Paragraph 9.3
[4] A lack of disclosure from any Director indicates a nil return on the Declaration of Interest

Register of Interests

Disclosure Requirement	Disclosure[4]
	Rita Harris: None
	Paul Jenkins: None
	Simon Young: None
	Malcolm Allen: None
	David Holt: • Director, Urban Patch Ltd (Consultancy) • Director, Circle Living Ltd (Circle) • Director, Invicta Telecare Ltd (Circle)
	Lis Jones: None
	Joyce Moseley: None
	Ian McPherson: • Non-Executive Clinical Director, Mental Health Division of Care UK
Ownership, part-ownership or directorships of private companies, businesses or consultancies likely or possibly seeking to do business with the National Health Service	**Martin Bostock:** None
	David Holt : None
	Angela Greatley: None
	Rob Senior: None
	Louise Lyon: None
	Rita Harris: None
	Paul Jenkins: None
	Simon Young: None
	Malcolm Allen: None

Disclosure Requirement	Disclosure[4]
	Lis Jones: • Lis Jones Associates, Consultancy **Caroline Rivett:** • Director and shareholder in Synodex **Joyce Moseley:** None **Ian McPherson:** None
Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the National Health Service	**Martin Bostock:** None **David Holt:** None **Angela Greatley:** None **Rob Senior:** None **Louise Lyon:** None **Rita Harris:** None **Paul Jenkins:** None **Simon Young:** None **Malcolm Allen:** None **Lis Jones:** None **Caroline Rivett:** None **Joyce Moseley:** None **Ian McPherson:** None
A position of authority in a charity or voluntary organisation in the	**Martin Bostock:** None

Register of Interests

Disclosure Requirement	Disclosure[4]
field of health and social care	**David Holt:** • NED, Circle Housing, Centra Board • NED & Chair of Audit Committee, Barnet and Chase Farm Hospital NHS Trust **Angela Greatley:** None **Rob Senior:** None **Louise Lyon:** • Chair of Tavistock Clinic Foundation **Rita Harris:** None **Paul Jenkins:** None **Simon Young:** None **Malcolm Allen:** None **Lis Jones:** • Trustee, North London Hospice **Caroline Rivett:** • NED, Patient Information Forum • Member, eHealth and Telemedicine Council for Royal Society of Medicine **Joyce Moseley:** • A trustee of the Social Research Institute, Dartington **Ian McPherson:** • Trustee/Director, Centre for Mental Health • Trustee/Director, Mental Health Provider Forum • Trustee/Board Member, International Initiative in Mental Health Leadership

Disclosure Requirement	Disclosure[4]
Any connection with a voluntary or other organisation contracting for National Health Service services or commissioning National Health Service services	**Martin Bostock:** None
	David Holt: • Married to member of CQC
	Angela Greatley: None
	Rob Senior: • Married to City & Hackney Clinical Commissioning Group Chair
	Louise Lyon: None
	Rita Harris: None
	Paul Jenkins: • Member and previous CEO of Rethink Mental Illness
	Simon Young: None
	Malcolm Allen: None
	Lis Jones: None
	Caroline Rivett: • Member of National Autistic Society
	Joyce Moseley: • Chair of the Board of Directors of HCT Group, a community social enterprise which runs the transport service for NHS organisations (St Thomas & Guys Hospital)
	Ian McPherson: • Chair, Improving Health and Wellbeing UK, Community Interest Company • Chair, Ki Group, Community Interest Company • Executive Chair, E-Health Alliance, Community Interest Company • Director, 121 Support, Community Interest Company

Disclosure Requirement	Disclosure[4]
Any connection with an organisation entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to lenders or banks	**Martin Bostock**: None
	David Holt: None
	Angela Greatley: None
	Rob Senior: None
	Louise Lyon: None
	Rita Harris: None
	Paul Jenkins: None
	Simon Young: None
	Malcolm Allen: None
	Lis Jones: None
	Caroline Rivett: None
	Joyce Moseley: • the social research Unit at Dartington is in a consortium with the Trust to run the Family Nurse Partnership. The Unit is a sub-contractor of the Trust.
	Ian McPherson: • Non-Executive Clinical Director, Mental Health Division of Care UK • Advisor, Ultrasis plc • Advisor, Handle my Health

Board of Directors : May 2014

Item : 15

Title : Scheme of Delegation of Powers Review 2014

Summary:

This document outlines amendments made to the Scheme of Delegation of Powers. The Scheme was reviewed by the Trust Secretary, with advice from the deputy finance director, the HR director, and the CGF director.

This report has been reviewed by the following Committees:
- Management Committee, 15th May 2014

This report focuses on the following areas:
(delete where not applicable)

- Risk

For : Approval

From : Gervase Campbell, Trust Secretary

Delegation of Powers

The Tavistock and Portman **NHS**

NHS Foundation Trust

Scheme of Delegation of Powers Review 2014

1.   Names of those with delegated authority

1.1.1   No changes were made to the names of those to whom powers have been delegated.

2.   Delegated matters

2.1   (3c) Invoices not covered by a purchase order

2.1.1   "Any individual authorised by Budget Holder and Deputy Director of Finance" have been given green delegated authority (must authorise) in line with part (3a) Requisitions, to reflect the functioning of the Trust's procurement system.

2.2   (5e(i)) Retaining records

2.2.1   "Retaining the Register of Interests" has been corrected to read "Retaining the Register of Tenders".

2.3   (9) Letting of premises to, or renting of premises from, outside organisations

2.3.1   This section was previously titled "Letting of premises to outside organisations", but this has been re-titled to cover renting of premises for the Trust.

2.4   (19d) Banding, rebanding and other remuneration matters

2.4.1   This section was previously titled "Grading…", but this has been re-titled to reflect Agenda for Change terminology.

2.5   (19g(iii)) Annual leave – approval of carry over in excess of 5 days

2.5.1   The Chief Executive was previously listed as having delegated authority, but this has been changed to the Director of Human Resources.

2.6   (19h(ii)) Return to work part-time on full pay to assist recovery, phased return to work advised by Occupational Health

2.6.1   This was previously titled "Return to work part-time on full pay to assist recovery"

2.6.2   The Chief Executive was previously listed as having delegated authority, but this has been changed to the Director of Human Resources to reflect the Trust's policy.

2.7   (19j) Removal expenses and house purchase etc.

2.7.1   This provision has been removed to reflect our current policy which does not grant any removal expenses.

2.8   (19l) Authorised mobile devices users

2.8.1   This was previously titled "Authorised mobile phone users", but this has been retitled to reflect the use of other mobile devices such as tablets.

2.8.2   The Human Resources director was previously listed as having delegated authority, but this has been changed to the budget holder to reflect current practice.

2.9   (19n) Staff retirement policy

2.9.1   This has been removed as there is no longer a retirement age, and so no requirement to authorise extension of contract beyond the retirement age.

2.10 (42b) Governance declaration

2.10.1 The Director of Finance has been given green delegated authority in place of the Director of Corporate Governance and Facilities.

Gervase Campbell
Trust Secretary
7th May 2014

Delegation of Powers

Delegated plan of authority table (roles across columns; green = "Must authorise", blue = "Must jointly authorise"):

Delegated Matter	Reference documents & notes	Chief Executive	Finance Director	Medical Director	Trust Director	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Dir. of Service Dev & Strat	Trust Secretary	Clinical Director	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
1. Management of budgets — Responsibility of keeping expenditure within budget	SFI 3													green		
2. Maintenance / operation of bank accounts	SFI 5	green														
3. Non-pay revenue and capital expenditure / requisitioning / ordering / payment of goods and services — a) Requisitions	SFI 9												green			Any individual authorised by Budget Holder and Deputy Director of Finance
b) Purchase orders													green	green		
c) Invoices not covered by a purchase order	SFI 9															Any Individual authorised by Budget
4. Capital schemes — a) a selection of architects, quantity surveyors, consultant engineers, and other professional advisors, within EU regulations							green	green								Estates Officer
b) financial monitoring and reporting on all capital scheme expenditure		green					green									
5. Quotation and Tendering Procedures (see also 3(e) above) — a) Obtaining 3 written quotations on the basis of a written specification for goods / services from £10,000 to £60,000	SFI Appendix 6;	blue											blue			Other originating Officer
b) Obtaining at least 3 written competitive tenders for goods/services above £60,000	SFI Appendix 4; SFI Appendix 5												green			
c) Waiving of the requirements to obtain quotations or tenders subject to SFIs	SFI Appendix 4.3; SFI Appendix 6.3	blue		blue	blue											
d) Opening Tenders	SFI Appendix 5.3; Note: Any two Executive Directors, in presence of Trust Secretary			blue	blue	blue			blue							
e) Retaining records — (i) Retaining the Register of Tenders	Constitution Annex 5								green							
(ii) Retaining detailed records of each tender	SFI Appendix 5.3															
(iii) Retaining records of competitive quotations obtained	SFI Appendix 6.2; SFI Appendix 6.3											green				Originating Department
6. Contracts for NHS Clinical Services — a) Setting prices	SFI 7; SFI 6.2	blue						blue								

Must authorise Must jointly authorise May authorise with approval

Legend: **Must authorise** (green) · **Must jointly authorise** (blue) · **May authorise with approval** (purple)

Delegated Matter	Reference documents & notes	Chief Executive	Finance Director	Medical Director	Trust Director	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Dir. of Service Dev & Strat	Trust Secretary	Clinical Director	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
(6. Contracts for NHS Clinical Services continued…) b) Signing agreements		Must authorise														**CAMHS Director**
7. Setting of Fees for Training courses, Consultancy work and other services — a) New training courses	SFI 6.2					Must jointly authorise										
b) Annual review of fees for all courses			Must jointly authorise			Must jointly authorise										**Management Committee**
c) Daily fee rates (range) to be charged for all consultancy work			Must jointly authorise													**Director of Tavistock Consulting**
d) Approval of fees for other services including the Tavistock Children's Day Unit and the Monroe Family Assessment Service			Must jointly authorise													**Unit Directors**
8. Expenditure of Charitable Funds — a) From grants received for specific purposes (e.g. research grants; donations for specific services)	SFI 16; Charitable Fund Cttee ToR		May authorise with approval										Must authorise			
b) From staff earnings funds										Must authorise						
c) From all other funds: (i) Up to £20,000		Must authorise														
(ii) Above £20,000																**Charitable Fund Committee**
9. Agreements/Licences — a) Letting of premises to, or renting of premises from, outside organisations	SFI 6.2.4	Must jointly authorise	Must jointly authorise				Must jointly authorise									
b) Approval of rents to be charged	SFI 9.2.7.1 **Note**: to be based on professional assessment and subject to competitive tendering requirements		Must jointly authorise				Must jointly authorise									
10. Condemning & Disposal - items which are obsolete, redundant, irreparable or which cannot be repaired cost effectively — a) with current / estimated purchase price under £200	SFI 13; SFI Appendix 11											Must authorise	Must authorise			**Head of IM&T**
b) with current purchase new price over £200 but expected sale value and current book value (where applicable) both under £1,000		Must authorise	Must authorise				Must authorise									
c) with expected sale value or current book value (where applicable) both over £1,000		Must authorise	Must authorise				Must authorise									
d) with expected sale value or current book value (where applicable) both over £5,000	**Note**: Subject also to competitive quotations or tendering	Must authorise	Must authorise				Must authorise									

Must authorise **Must jointly authorise** **May authorise with approval**

Delegated Matter		Reference documents & notes	Chief Executive	Finance Director	Medical Director	Trust Director	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Dir. of Service Dev & Strat	Trust Secretary	Clinical Director	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
11. Losses, Write-offs & Compensation	a) Losses due to theft, fraud, overpayment & others Up to £50,000	SFI 13.2; HM Treasury "Managing Public Money"															
	b) Fruitless Payments (including abandoned Capital Schemes) Up to £50,000																
	c) Bad Debts and Claims Abandoned up to £50,000																
	d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use, up to £50,000																
	e) Compensation payments made under legal obligation (no limit)																
	f) Extra Contractual payments to contractors, up to £50,000																
	g) Ex-gratia payments to patients and staff for loss of personal effects: (i) Less than £100 (ii) Between £100 and £50,000																
	h) Ex-gratia payments for clinical negligence up to £50,000 (including plaintiff's costs) for negotiated settlements following legal advice and in compliance with guidance																
	i) Ex-gratia payments for personal injury claims involving negligence, up to £50,000 (including plaintiff's costs), where legal advice has been obtained and guidance applied																

Must authorise Must jointly authorise May authorise with approval

Delegated Matter	Reference documents & notes	Chief Executive	Finance Director	Medical Director	Trust Director	Dean	Director of Human Resources	Dir. of Corp. Gov. & Strat	Dir. or Service Dev & Strat	Trust Secretary	Clinical Director	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
(11. Losses, Write-offs & Compensation continued…) j) Other ex-gratia payments, up to £50,000 (but note that the Trust has no delegated authority to make any payments in cases of maladministration where there was no financial loss by the claimant)		Must authorise														
12. Reporting of Incidents to the Police a) Where a fraud is suspected	SFI 13.2; Counter Fraud Policy	May authorise with approval														Governance & Risk Lead or Receptionist
b) Violence, theft or any other offence or suspicion	SFI 13.2						May authorise with approval									Governance & Risk Lead or Receptionist
13. Petty Cash Disbursements a) Expenditure up to £50	SFI 9.2.8; Note: Items which cannot be covered from petty cash floats are to be submitted as cheque requests (e.g. for long distance patient fares) or invoices approved for payment)													May authorise with approval		
b) Expenditure above £50 and up to £100 per item															Must authorise	Financial Controller
14. Ensuring that Internal and External Audit, and Local Counter Fraud Specialist recommendations are implemented	SFI 2	May authorise with approval														Relevant Director
15. Maintenance & Update of Trust Financial Procedures	SFI 3.3	May authorise with approval														
16. Investment of Funds a) The Trust's Exchequer funds.	SFI 10.2; Operating Cash Management Policy	May authorise with approval														
b) Charitable funds	SFI 16; Charitable Fund Cttee ToR	Must authorise														Charitable Fund Committee
17. Application to the Department of Health for Advance of Public Dividend Capital	SFI 10.1; Operating Cash Management Policy; Note: Any two Executive Directors are required	Must authorise	Must authorise	Must authorise	Must authorise	Must authorise										

Must authorise Must jointly authorise May authorise with approval

Legend: **MA** = Must authorise (blue); **JA** = Must jointly authorise (green)

Delegated Matter	Reference documents & notes	Chief Executive	Finance Director	Medical Director	Trust Director	Dean	Director of Human Resources	Dir. of Corp. Gov. & Strat	Trust Secretary / Dir. of Service Dev & Strat	Dir. of Service Dev. & Facilities	Clinical Director	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
18. Borrowing	SFI 10.1; Trust's Operating Cash Management Policy	MA	MA													
19. Human Resources & Pay																
a) Authority to fill funded post on the establishment with permanent staff.	Policy & Procedure for Recruitment & Selection						MA						MA			
b) Authority to appoint staff to long-term post not on the formal establishment.	SFI 8.2.3; Policy & Procedure for Recruitment &	JA														
c) Additional Increments - The granting of additional increments to staff within budget *on appointment.*	Agenda for Change Conditions of Service	JA	JA				JA									
d) Banding, rebanding, and other remuneration matters - All requests shall be dealt with in accordance with Trust Procedure: (i) Staff listed in "Duties (1)" of the Remuneration Committee Terms of Reference	Remuneration Cttee ToR															Remuneration Committee
(ii) All other staff	Policy & Procedure for Recruitment &										JA					
e) Establishments: (i) Additional staff to the agreed establishment with specific external funding	SFI 8						JA						JA			
(ii) Additional staff to the agreed establishment without specific external funding		JA														
f) Pay: (i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	SFI 8						JA									
(ii) Authority to authorise overtime																HR Officer
(iii) Authority to authorise travel & subsistence expenses																
(iv) Approval of Performance Related Pay Assessment	Remuneration Cttee ToR	JA														Remuneration Committee
g) Leave: (i) Approval of annual leave	NHS Terms and Conditions of Service Handbook; Other relevant terms & conditions of service; Leave Policy										JA					

Legend: **MA** = Must authorise (green) · **MJA** = Must jointly authorise (blue)

Delegated Matter	Chief Executive	Finance Director	Medical Director	Trust Director	Dean	Director of Human Resources	Dir. of Corp. Gov. & Strat	Dir. of Service Dev & Facilities	Trust Secretary	Clinical Director	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other	Reference documents & notes
(19 Human Resources & Pay continued…) **(g) Leave continued…)**																
(ii) Annual leave - approval of carry forward (up to 5 days or in the case of Ancillary & Maintenance staff as defined in their initial conditions of service).										MA						
(iii) Annual leave - approval of carry over in excess of 5 days.						MA										
(iv) Compassionate leave						MA				MA						
(v) Special leave	MA									MA						
(vi) Leave without pay										MA						
(vii) Time off in lieu (to be documented)																
(viii) Maternity Leave - paid and unpaid															HR Officer	
h) Sickness Absence:																
(i) Extension of sick pay on half pay up to three months	MJA					MJA										Trust Sickness Absence & Rehabilitation Policy & Procedure
(ii) Return to work part-time on full pay to assist recovery, phased return to work advised by OH						MA										Trust Sickness Absence & Rehabilitation Policy & Procedure;
(iii) Extension of sickness absence on full pay	MJA					MJA										
i) Study Leave:																
(i) Medical staff study leave			MJA													Leave Policy
(ii) All other study leave						MA				MA						
j) Grievance Procedure - All grievances cases must be dealt with strictly in accordance with the Grievance Procedure																Grievance Policy & Procedure
k) Authorised Mobile Device Users - Requests for new posts to be authorised as mobile telephone users												MA				Mobile Phone & PDA Agreement
l) Renewal of Fixed Term Contract						MA										

Delegated Matter	Reference documents & notes	Chief Executive	Finance Director	Medical Director	Trust Director	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Dir. of Service Dev & Strat	Trust Secretary	Clinical Director	Line / Dept Director	Procurement Officer	Budget Holder	Petty Cash Holder	Other
n) Redundancy	Redundancy & Redeployment Policy & Procedure	Must authorise					Must authorise									Chief Executive and Remuneration Committee for senior staff
o) Ill Health Retirement - Decision to pursue retirement on the grounds of ill-health							Must jointly authorise									
p) Dismissal	Disciplinary Policy & Procedures															Dismissal Officer
20. Authorisation of Sponsorship deals		Must authorise														Management Committee
21. Authorisation of Research Projects				Must jointly authorise												Director of Research & Development
22. Authorisation of Clinical Trials				Must jointly authorise												Director of Research & Development
23. Insurance Policies and Risk Management	SFI 18	Must authorise					Must authorise									
24. Patients & Relatives Complaints a) Overall responsibility for ensuring that all complaints are dealt with effectively	Trust Policy and Procedure for the Management of Formal Complaints															Complaints Officer
b) Responsibility for ensuring complaints relating to a department are investigated thoroughly						Must jointly authorise			Must jointly authorise							Department Director
c) Management of the legal aspects of complaints							Must jointly authorise									
25. Relationship with the media	Media Policy	Must authorise / May authorise with approval														Communications Lead
26. Patient Services — Variation of clinic sessions						Must authorise			Must authorise							
27. Facilities for staff not employed by the Trust to gain practical experience a) Professional Recognition, Honorary Contracts, & Insurance of Medical Staff.							Must jointly authorise									
b) Work experience students							Must jointly authorise									
28. Review of fire precautions	Fire Safety Procedures															
29. Review of all statutory compliance with legislation on health and safety	Health & Safety Policy			Must jointly authorise												
30. Review of *Medicines Inspectorate Regulations*																

Must authorise   Must jointly authorise   May authorise with approval

Legend (colour key): **G** = green (Must authorise) · **B** = blue (Must jointly authorise / May authorise with approval)

Delegated Matter	Reference documents & notes	Chief Executive	Finance Director	Medical Director	Trust Director	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Trust Secretary	Dir. of Service Dev & Strat	Clinical Director	Line / Dept Manager	Procurement Officer	Budget Holder	Petty Cash Holder	Other
31. Review of compliance with environmental regulations							G									
32. Review of Trust's compliance with the *Data Protection Act*	Data Protection Policy						B									**Information Governance Lead; Senior Information Risk Owner**
33. Review the Trust's compliance with the *Access to Records Act*	Trust Procedure for the Management of Health Care Records						G									
34. Membership management and Governor	Constitution															
35. The keeping of registers for the *Declaration of Interests*, the register of members and the *Declaration of Independence*	Constitution, Annex 5							G								
36. Attestation of sealings in accordance with Standing Orders	BDSO 9	B														
37. The keeping of a register of sealings, and reporting to the Board of Directors	BDSO 9							G								
38. The keeping of the *Gifts and Hospitality Register*	SFI 20							G								
39. Information Governance	SFI 17; Information Governance Policy															**Information Governance Manager; Senior Information Risk Owner; Caldicott Guardian**
40. Clinical Governance					G			G								
41. Review of the Trust's compliance with Monitor's *Code of Governance*	Monitor's Code of Governance							G								
42. Review of the Trust's compliance with Monitor's *Compliance Framework* a) Financial matters	Monitor's Compliance Framework	G														
b) Governance declaration							G									
c) Membership matters								G								
43. Review of the Trust's compliance with the *Codes of Conduct for the Board of Directors and the Board of Governors*	Board of Directors' Code of Conduct; Board of Governors' Code of Conduct			G				G								
44. The review and keeping of the *Assurance Framework* and *Risk Register* a) Strategic Risk Register		G														**Or Officers nominated by CEO and FD**
b) Operational Risk Register							G									

Must authorise Must jointly authorise May authorise with approval

Board of Directors : May 2014

Item : 16

Title : Corporate Governance Statement – declaration of compliance with conditions G6 and CoS7 of our licence from Monitor.

Summary:

Monitor require us to complete an annual self-certification declaring whether the Trust is compliant with two conditions of our licence:
- general condition 6, systems for compliance with licence conditions, and
- continuity of service condition 7, availability of resources.

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

This report focuses on the following areas:
- Quality
- Risk
- Finance

For : Approval

From : Simon Young, Deputy Chief Executive and Director of Finance

Monitor self-certificate

Page 1 of 4

Corporate Governance Statement

1. Introduction

1.1 For submission to Monitor by the end of May, the Board of Directors is required to consider three statements covering compliance with our licence conditions and continuity of services; and to confirm or not confirm each of the statements.

2. Statements in declaration

2.1 Appendix 1 of the report sets out the text of each of the 3 statements. The Board of Directors is invited to confirm all 3 statements.

2.2 The first statement refers to condition G6 of the licence, which requires the Trust to take all reasonable precautions against the risk of failure to comply with the conditions of the licence, requirements imposed on it under the NHS Acts, and the requirement to have regard to the NHS Constitution in providing healthcare services. It further refers to paragraph 2(b), which requires that the Trust regularly reviews the processes and systems implemented to ensure we comply with the licence conditions.

2.3 The second statement is a declaration that the Trust meets the criteria for holding a licence.

2.4 The board of directors is invited to confirm these two statements on the basis of:
2.4.1 Regular reports on quality, performance, finance and governance received throughout the year, including the quarterly declarations
2.4.2 The annual quality report and annual accounts presented to this meeting, together with the reports of the external auditors on both of them.
2.4.3 The annual reviews of the risk register and board assurance framework.

2.5 The third statement is that the Trust has the Required Resources available for the period of 12 months from the date of this declaration.

2.6 The board of directors is invited to confirm this statement on the basis of the budget approved by the Board in March.

3. **Views of the Governors**

3.1 In approving the statements, we can confirm that we have taken the views of the governors into account. The Board has consulted the Council of Governors during the development of the annual plan. The Council of Governors also receives reports on the matters covered by these statements; and representative members of the Council take part in the governance processes of the Trust.

Simon Young
Deputy Chief Executive and Director of Finance
13 May 2014

Page 3 of 4

Monitor self-certificate

Completed Template – Draft for Approval

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions

1   Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed

AND

2   The board declares that the Licensee continues to meet the criteria for holding a licence.

Confirmed

3   Continuity of services condition 7 - Availability of Resources

EITHER:

3a   After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

OR

3b   After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Not Confirmed

OR

3c   In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Not Confirmed

Statement of main factors taken into account in making the above declaration
In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Budget approved by the Board, with small surplus and adequate contingency reserve. Savings identified and allowed for in the budget; no requirement to identify additional CIPs in-year. Contract income largely secured; other areas of variable income to be managed in-year.

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

Signature _____   Signature _____

Name Paul Jenkins   **Name** Simon Young

Capacity Chief Executive   **Capacity** Deputy Chief Executive and Director of Finance

Date 28th May 2014   **Date** 28th May 2014

Page 4 of 4

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 27th May 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 Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.19
8.	**Staff Survey 2013 Report and Action Plan** Mr Namdi Ngoka, Deputy Director of Human Resources	To approve	Enc.	p.26
9.	**CQSG Quarter 4 Report** Dr Rob Senior, Medical Director	To note	Enc.	p.44
10.	**Equalities Report** Ms Louise Lyon, Trust Director	To note	Enc.	p.64
11.	**Workforce Information** Ms Shilpi Sahai, Human Resources Manager	To note	Enc.	p.72
12.	**Annual Report and Accounts** Mr Simon Young, Deputy Chief Executive & Director of Finance and Mr Gervase Campbell, Trust Secretary a) **Annual reports** b) **Annual Accounts** c) **Letters of Representation**	To approve	Enc.	p.82 p. 146 p.207

Agenda Pullout

CORPORATE GOVERNANCE			
13.	**Annual Quality Report** Ms Justine McCarthy Woods, Quality Standards and Reports Lead	To approve	Enc.	p.215
14.	**Register of Interests** Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.289
15.	**Scheme of Delegation of Powers** Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.296
16.	**Monitor Annual self-certification Governance Statement** Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.307
CONCLUSION			
17.	**Any Other Business**		Verbal	
18.	**Notice of Future Meetings** • Tuesday 10th June 2014: Directors' Conference, 12pm-5pm, Lecture Theatre • Tuesday 24th June 2014: Board of Directors, 2pm-5pm, Board Room, Tavistock Centre • Thursday 26th June: Council of Governors, 2pm-5pm, Board Room, Tavistock Centre		Verbal	