

Board of Directors Part One

Agenda and papers
of a meeting to be held in public

2.00pm–4.20pm
Tuesday 24th February 2015

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

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 24th February 2015, 14.00 – 16.20
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.10
4.	Matters arising Ms Angela Greatley, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	Trust Chair's and NED's Report Non-Executive Directors as appropriate	To note	Verbal	-
6.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To note	Enc.	p.11
7.	Finance & Performance Report Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.14
8.	Training and Education Programme Board Report Mr Brian Rock, Director of Education & Training, Dean	To note	Enc.	p.24
9.	CAMHS Service Line Report – Westminster & FDAC Dr Rita Harris, CAMHS Director	To discuss	Enc.	p.30
10.	Clinical Quality, Safety and Governance Report – Quarter 3 Dr Rob Senior, Medical Director	To approve	Enc.	p.51

11.	Clinical Quality, Safety and Governance Report – Terms of Reference Dr Rob Senior, Medical Director	To approve	Enc.	p.59
12.	Draft Operational Plan Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	late	-
13.	Duty of Candour/Fit and Proper Person Test Mr Gervase Campbell, Trust Secretary	To discuss	Enc.	p.76
PATIENT STORY				
14.	Patient Story – Review and Discussion Ms Clare Shaw, Patient Stories Lead for PPI	To discuss	Verbal	p.88
CONCLUSION				
15.	Any Other Business		Verbal	-
16.	Notice of Future Meetings <ul style="list-style-type: none"> • Wednesday 4th March 2015: Joint Board Meeting, 2.00pm – 4.30pm, Lecture Theatre, Tavistock Centre • Tuesday 10th March 2015: Leadership Group Conference, 9.00am – 1.00pm, Lecture Theatre, Tavistock Centre • Tuesday 31st March 2015: Board of Directors Meeting, 2.00pm – 5.00pm, Board Room, Tavistock Centre • Tuesday 28th April 2015: Board of Directors Meeting, 2.00pm – 5.00pm, Board Room, Tavistock Centre 		Verbal	-

Board of Directors

Meeting Minutes (Part One)
Tuesday 27th January 2015, 2.00 – 4.30pm

Present:			
Ms Angela Greatley Trust Chair	Prof. Dinesh Bhugra NED	Ms Jane Gizbert NED	Dr Rita Harris CAMHS Director
Mr David Holt Non-Executive Director	Mr Paul Jenkins Chief Executive	Ms Lis Jones Nurse Director	Ms Louise Lyon Director of Quality, Patient Experience and Adult Services
Dr Ian McPherson Non-Executive Director & Vice Chair of Trust	Ms Edna Murphy NED	Mr Brian Rock Director of Education and Training, Dean	Dr Rob Senior Medical Director
Mr Simon Young Deputy CEO & Director of Finance			
Attendees:			
Mr Gervase Campbell Trust Secretary (minutes)	Dr Justine McCarthy Woods, Quality Lead (item 11,12)	Ms Rhona Hobday, CQC Project Manager (item 13)	Mr Jonathan McKee, Governance Manager (item 15)
Dr Claire Shaw, PPI Lead (items 16)	Mr D, Patient Story (item 16)	Dr Jessica Yakeley, Consultant Psychiatrist (item 16)	
Apologies:			

Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor changes to be made to the minutes	GC	Immed.
2	4	HR to give advice on taking forward 360 feedback for managers	ST/NN	March
3	8	Updated figures on the Modular Building proposal to be circulated to the Board for final consideration.	SY	Immed.
4	10	Add further details of the Child Safeguarding Training figures to the Quarterly Quality Report	JMW	April
5	13	NED CQC training to be prioritised	LL	Feb.
6	13	NEDs to be invited to link with a KLOE lead, to allow them to get involved more deeply in one area of the preparations	LL	Feb.

1. Trust Chair's Opening Remarks

Ms Greatley welcomed Mr Brian Rock, the Director of Education and Training, to his first board meeting.

2. Apologies for Absence and declarations of interest

Apologies as above. There were no declarations of interest specific to this meeting.

AP1 **3. Minutes of the Previous Meeting**
The minutes were approved with minor amendments.

4. Matters Arising

Action points from previous meetings:

AP2 – (find suitable forum for discussion of integration of mental and physical health) – this was still pending.

AP4 – (arrange an event for board to consider R&D strategy) – this had been arranged for the February board lunch.

AP2 Mr Holt noted that his suggestion that 360 feedback for managers, as part of tackling bullying and harassment, had not been captured as an action point. It was agreed that Ms Susan Thomas would be asked to give the board advice on taking it forward.

5. Trust Chair and NEDs' Report

Ms Greatley noted that the Governors had begun the process of recruiting a new Chair for the Trust, to start in post in November. In addition there would be elections for the Governor seats this year, with those newly elected taking up their roles in November as well.

Dr McPherson noted that he and Mr Holt had attended a Kings Fund talk on Monitor's requirement for Trusts to review their governance arrangements, which related to item 15 on the agenda.

Ms Murphy noted that she had attended a Kings Fund presentation on the CQC, and it had been instructive to hear the questions from other Trusts. In addition she had attended a training event for new NEDs run by the Foundation Trust Network and Monitor jointly.

Ms Gizbert noted that she had arranged an invitation for the Trust to speak at the next NICE conference.

6. Chief Executive's Report

Mr Jenkins highlighted the business development agenda, with the tenders for CAMHS and Hampshire at the dialogue stage, and an important opportunity available to bid for the Camden 'Team around the Practice' project which is modelled on our City and Hackney Service.

Mr Jenkins noted that the Trust Clinics Committee had held its 201st, and final meeting. The committee was being relaunched as the Clinical Professional Advisory Group, and would meet monthly to provide a space for clinicians to engage with issues.

The London Mental Health Chief Executives Group has been working on raising the profile of mental health in London, and would launch the Cavendish Square Group next month with an informal lecture from Minister Norman Lamb. They would also be producing a London Mental Health Fact book which will include authored opinion pieces.

Prof. Bhugra noted that following Simon Stevens' 5 Year Forward View, boards were being set up for various activities including looking at models for mental and physical care integration, and asked how the Trust was involved in these. Mr Jenkins noted that the Forward View was critical, and he would address it in part 2, and they had done a lot of local engagement.

The Board **noted** the report.

7. Finance & Performance Report

Mr Young noted that the Trust continued to have a significant surplus, of £997k, which was a good position, but as it was a result of non-recurrent savings did not affect next year's budget. He noted that the launch of the Voluntary Severance Scheme might increase the restructuring costs if decisions were made before the end of the financial year.

Ms Greatley noted the movement in the Named Patient Agreement (NPA) income. Mr Young explained that one contract, with Waltham Forest, had been terminated and so those cases were now paid by NPA, but there was no movement overall.

Ms Murphy questioned why the surplus was more than expected. Mr Young explained that in part it was due to having taken a cautious view of what should be in the contingency, which had not been used as much as anticipated. As well as this there had been over performance in GIDS, with activity increasing faster than staffing, and some underspend in other departments, especially in Education and Training.

Mr Young tabled background papers on the Modular Building (the Estates paper from the October meeting, and the minutes of the discussion of that paper), and introduced a capital budget item which was not covered in the written paper. He explained that the costs for rental, or purchase, of the modular building were now much higher than anticipated, in part due to increased demand in London. The changes meant that for rental of up to 3 years there was little difference in cost between rental and purchase, but for any longer period rental would be more expensive.

Mr Holt asked whether any of the other options, such as renting existing

AP3

office space, looked more attractive now given these increases. Mr Young explained that he did not have full figures on the rental alternatives. Ms Murphy noted that if the cost increases were due to demand, this would probably affect the rental market too. Dr Harris noted that when they first looked for space for FNP it had been hard to find anything suitable, and that was unlikely to have changed. Dr McPherson asked if the new figures could be circulated by email to allow a detailed consideration of them.

Mr Jenkins agreed with the need to see the figures in detail, and thanked Mr Holt for the reminder that it is important to step back and consider all options when details of a proposal change. He noted that there were various scenarios, and the costs were dependent on the length of time the building would be in place, which was likely to be more than three years. He agreed that it would be operationally advantageous to have FNP on site, and if the cost difference was not significant this would be preferable.

Ms Greatley acknowledged that it would have been preferable for the Board to have received a report in advance of the meeting. She reminded the Board that there had been a full discussion in October and that the matter had now become urgent. She suggested that the board could agree the proposal to construct the modular building at the higher cost in principle now, subject to having full figures on the costs of the buildings, and the alternatives where available, sent round by email for consideration to allow members to raise any further questions and, after consideration, to take a final decision on the proposal.

The Board **agreed** the proposal in principle.

The Board **noted** the report.

8. Training and Education Programme Management Board Report

Mr Jenkins highlighted that they were engaged in some critical work setting targets for 2015/16, and in so doing aimed to increase the capacity of the more successful courses. He noted that UEL had requested a faster transfer of students to the University of Essex, with current students transferring as the courses were validated, which would present challenges but was probably for the best in reducing the period of overlap. With regards to the National Training Contract, they were working on having a more demonstrable presence across the country and developing the associate centres to be more visible whilst maintaining relationships.

Mr Rock added that work on the new structures was proceeding, with Karen Tanner due to move into the new role of Associate Dean for Teaching and Learning in April, and the post of Associate Dean for Academic

Governance having been advertised. He noted that once these posts were filled the portfolio manager posts be recruited to.

Prof Bhugra asked how many students were involved in the move to UEL. Mr Jenkins noted that there were approximately 1000 in the system in total, not all of whom would be moving. He added it would be important to communicate the changes to students carefully, as not only would the University provider be changed, but also some of the validation criteria. Prof Bhugra suggested that it might be helpful to have counsellors available to assist students with anxiety over the changes.

The Board **noted** the report.

9. Tavistock and Portman Charitable Fund Annual Report and Accounts

Mr Young explained that the Board represent the trustees of the fund so are required to approve the annual accounts. He noted that the fund was not large, and page 44 summarised the activity in the year.

Ms Murphy asked whether the activity included funding for research. Mr Young noted that the 'Suicide in Adolescents' item was a research project, and that the Shaw Legacy was used more for student fees than research at present.

Mr Jenkins noted that the limited fund could contribute to useful projects if used cleverly. This year it had supported research sabbaticals and the excellent film the refugee team had produced. An area under consideration was funding further lived experience work, and they would work with Ms Sally Hodges on this.

The Board **approved** the annual report and accounts.

10 Quarter 3 Governance Statement

Mr Young noted that there were no significant changes from previous quarters, and nothing they were aware of that precluded approving the three elements of the governance statement to be submitted to Monitor for Q3.

The Board **approved** the statements.

11 Quality Report, Quarter 3

Dr Justine McCarthy Woods noted that waiting times had gone up in the past quarter, and this was for a combination of reasons including administration errors, and applied across the range of services. In addition there had been some difficulties moving to monthly reporting on the goal

based measures, but these would be resolved. Otherwise indicators were on track.

Ms Greatley asked if it would be possible to look into the waiting times and to identify if it was the start of a trend. Ms Harris commented that after the results were discussed in the management team she had investigated in CAMHS, and additional training for administrators and team managers had been conducted to address the issues. Ms Lyon noted that they must keep an eye on this, but at present as no other indicators were down, it was unlikely to be caused by productivity savings. Dr McPherson noted that waiting times were a clear and important target, and wondered whether our systems for monitoring were sufficiently robust. Dr Senior noted that the quality indicators also came up through the CQSG committee where they were scrutinised in depth and action plans agreed and monitored as required, which was the operational route to addressing quality concerns.

AP4

Dr Holt noted that the Child Safeguarding rate was 97%, but there was no indication in the paper whether this was judged sufficient or what the cause of the 3% gap was. Dr Senior commented that it was due to maternity leave, temporary illness and similar, and was looked at in the Safeguarding committee and the Safeguarding work stream of the CQSG, but agreed that details of the gap would be added to the paper in future.

The Board **noted** the report.

12 Update on Draft Annual Quality Report

Dr McCarthy Woods presented the planning schedule and noted that they had held a positive meeting with KPMG and were waiting for guidance from Monitor on the format, and to agree the CQINN targets with commissioners, which would inform the quality targets for the following year. She invited any NEDs who were interested in the report to engage with her in the planning, and Dr McPherson and Ms Gizbert volunteered jointly for the role.

The Board **noted** the report.

13 CQC Inspection Preparation Update

Ms Lyon noted that we were not expecting an inspection before July at the earliest, but still needed to be prepared now, and that the preparation work was producing some valuable changes and improvements to quality in the Trust. She noted that staff were generally very involved and positive. There would be specific training for board members coming soon.

Ms Hobday explained that there were three strands to the preparations: identifying gaps related to the KLOES, preparing staff, and a communications plan to keep staff informed. Having gone out and met all the teams now the focus was moving to client facing students, and would then move to board assurance through peer reviews and visits conducted by teams including board members.

Ms Gizbert commented that the guide was excellent and a clear read, and questioned what staff should do if there were not able to answer a question from an inspector directly. Ms Lyon confirmed that during a visit there would be a system in place to report such questions centrally so that they could be followed up.

AP5

Mr Holt asked that the NEDs be engaged in the process as soon as possible, so that they could be informed when visiting services as they regularly do, and if their training could be scheduled for the next few weeks, tailored to the committees they sit on. Dr McPherson commented that NEDs would be invited to be involved in our internal team visits, which would educate them on the process and provide assurance to the board. Ms Lyon suggested that in addition a NED could be linked to each of the KLOE leads, so that they could dig deeper into one area of the process. Dr Senior noted that having NED involvement in visits would not only assure the board, but get the message out to staff and encourage more dialogue between the board and staff.

AP6

Mr Jenkins noted that he had held a helpful meeting with the CQC link, and it was important to understand that a visit is an opportunity for a pitch and we should be ready to address the KLOEs in our own way in terms of our organisation and our vision, both at team and board level.

The Board **noted** the report.

14 Corporate Governance Report – Declarations, Sealings

The register of interests was presented to the Board and approved. The board noted the use of the Trust seal in December.

15 Governance Review Proposal

Mr McKee introduced the proposal by noting that the larger external governance review is a substantial undertaking, and the aim of this review is to give the board enough information to make a good decision about how to proceed. The review would be of a light touch, looking at existing governance work and speaking to a few key people.

The Board **approved** the proposal.

16 Patient Story

Dr Jessica Yakeley, Consultant Psychiatrist at the Portman Clinic, introduced 'Mr D', who had been her patient for 18 months in individual and group sessions for antisocial personality disorder, and was now discharged and staying in touch with intermittent follow up visits.

Mr D explained that he had been convicted for possession of offensive weapons and sentenced to two and a half years custodial and two and a half years' probation. On probation he was informed that because of his risk level he was not allowed to work or return to education until he had a psychological assessment. The first assessment did not go well, but the second assessment was with Dr Yakeley and led to him starting at the Portman.

Mr D noted that he had suffered various traumas and abuse in childhood and grew up to feel that forcing people to do things was an acceptable way to behave, and didn't realise that he was violent and aggressive. Life was filled with constant frustration, and he did not know why.

Joining the group allowed him to talk to people he wouldn't have done otherwise, and he came to realise that he could use his brain instead of violence to relate to other people, and was better able to read situations and gain control through knowledge. He stressed that the abused never feel control or power over their lives and so this aspect of life got distorted.

Prof Bhugra asked what aspects of the service he would have liked to receive more of if it had been possible. Mr D replied that the service is as good as the user, and what is important is how the user engages with it.

Mr Holt asked whether 18 months had felt like the right length of time for the sessions. Mr D commented that he felt he had achieved his goal in a year, but kept with the sessions as he continued to learn and could contribute by interpreting and helping express problems other members were sharing.

Dr Harris asked what his friends and family might say about how he had changed. Mr D said they would notice he was a lot calmer, that he hoped they would see a change.

Mr Jenkins asked whether looking back he thought something could have been done earlier, or was it going to jail that made the therapy possible. Mr D commented that he first sought counselling in prison, but it wasn't prison that was necessary, he had started having flashbacks and felt it was a fault to be addressed, and when the opportunity came up he took it.

Ms Greatley thanked Mr D for coming to share his story with the board, and for helping them to think about the service the Trust offered.

17 AOB and notice of future meetings

None.

Part 1 of the meeting concluded at 4.15pm.

Outstanding Action Part 1

Action Point No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
3	Apr-14	8. Annual Complaints Report	Time to respond to be added to future complaints reports	Jane Chapman	April 2015	Confirmed that Ms Chapman is still responsible for the report.
3	Nov-14	11. Follow up to staff survey -action plan	Further update to the staff survey action plan to return to the board	Susan Thomas	May-15	
4	Nov-14	13. Developing a Research and Development Strategy	Arrange an opportunity for the Board to have a more indepth discussion of R&D	Rob Senior	Mar-15	Discussion scheduled for February board lunch.
2	Nov-14	6. CEO's Report	Find suitable forum for further discussion of integration between mental and physical health	Rita Harris/ Louise Lyon	Feb-15	

Board of Directors : February 2015

Item : 6

Title : Chief Executive's Report

Summary:

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

For : Discussion

From : Chief Executive

Chief Executive's Report

1. Financial position

- 1.1 As highlighted in Finance and Performance report, the Trust continues in a positive position in respect of its financial performance in 2014/5.
- 1.2 Work continues in preparing a balanced budget for 2015/6 and a more detailed update has been prepared for Part 2 of the meeting. We have had a number of applications for the Voluntary Severance Scheme and a process is planned to make a decision on these in the first half of March.

2. New Models of Care

- 2.1 We are the lead partner in an expression of interest to be a "forerunner" site for NHS England's new models of care programme. The bid is based on the implementation of the Thrive model for CAMHS across Camden and Islington. Other partners for the bid include: the Anna Freud Centre, Whittington Health, Camden and Islington Foundation Trust, LA and CCG commissioners in Camden and Islington, the Dartmouth Centre, Young Minds and the Integrate Partnership. The bid is strongly supported by UCLP Partners.
- 2.2 The next stage of the process is due to take place in the first week in March.
- 2.3 While we cannot be guaranteed success given the large number of bids submitted, we have been able to submit a good quality bid at short notice building on earlier work.

3. Essex CAMHS

- 3.1 We are entering the last couple of weeks in the development of our tender for CAMHS in Essex. A paper has been prepared for Part 2 setting out the process for agreeing our final bid in the light of the commissioners' timetable for submission.

4. Training and Education

- 4.1 As is highlighted in the Training and Education report we have had very constructive meetings in the last month with representatives of the University of Essex and with the Northern School on Leeds. I

have further meetings on 23rd February with the Chief Executive of Birmingham and Solihull Mental Health NHS Foundation Trust and our associate centre in Birmingham to explore the scope for developing a regional partnership in the West Midlands.

- 4.2 On the 4th February I attended a Chief Executives dinner in Leeds organised by the NHS Confederation Mental Health Network with Ian Cumming, Chief Executive and Sir Keith Pearson, Chair of Health Education England.

Paul Jenkins
Chief Executive
16th February 2015

Board of Directors : February 2015

Item : 7

Title : Finance and Performance Report

Summary:

After ten months a surplus of £1,181k is reported before restructuring and assuming that the FNP underspend is deferred; this is £1,180k above the revised budget surplus of £1k. Income from training and consultancy has fallen below expectations, but this has been offset by Clinical Income and underspends across a number of services.

The current forecast for the year is a surplus of £1,123k before restructuring costs.

The cash balance at 31 January was £5,917k which is above plan due to salary payments being lower than anticipated, in addition to old year payments from commissioners. Cash balances are expected to be lower by the end of the financial year but will remain above plan.

This report has been reviewed by the Management Team on 12 February.

This report focuses on the following areas:

- Risk
- Finance

For : Information.

From : Deputy Chief Executive and Director of Finance

1. External Assessments

1.1 Monitor

1.1.1 The Monitor submission for the third quarter was submitted at the end of January. The continuity of service risk rating (CoSRR) is expected to remain at 4, which is on plan; and governance rating of Green. The CoSRR is expected to remain at 4 by the end of the financial year, which is above plan.

2. Finance

2.1 Income and Expenditure 2014/15 (Appendices A and B)

2.1.1 After January the trust is reporting a surplus of £1,181k before restructuring costs, £1,180k above budget. FNP are currently £683k underspent, but the corresponding amount of income plus an amount reflecting the 2013/14 performance has been deferred. GIDU are currently over their income target due to additional cost and volume plus the release of income from last year. Overall, income year-to-date is £342k below budget (mainly due to the FNP deferral, offset by GIDU), and expenditure £1,516k below budget.

2.1.2 Income is £101k above budget overall for the month which is primarily due to back dated cost and volume for Barnet and Consultancy income from Portman. TC income is cumulatively £80k below target (across Consultancy and Training) and this is offset by an underspend of £32k.

2.1.3 SAMHS Clinical was £53k below target in month due to shortfall on the non-recurrent savings targets for 2014/15 plus GIDU is £28k below are we are waiting for confirmation on cost and volume activity for the second half of the year. These main income sources and their variances are discussed in sections 3, 4 and 5.

2.1.4 For an externally funded Finance project, the £13k under spend to date (within the Finance line) is matched by a £13k adverse variance on Other Income, since the funding is released in line with costs.

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

2.1.6 The favourable movement of £132k on the expenditure budget in month 10 was due mainly to DET Central non pay due to capital items previously being posted to revenue and a number of variances spread across the organisation. The cumulative underspend of £1,516k is primarily due to FNP at £683k and unused reserves totalling £314k.

2.1.7 The service line report is omitted this month.

2.2 Forecast Outturn

2.2.1 The forecast surplus before restructuring of £1,123k is £1,083k above budget. FNP are currently predicting a £667k under spend; we have agreed with the

commissioner to defer the corresponding income to 2015/16, the effect on the Trust's surplus has been removed. In addition we are deferring the equivalent of the FNP 2013/14 surplus of £415k.

2.2.2 Clinical income is currently predicted to show £509k above budget due the following:

2.2.2.1 The release of deferred income from 2013/14 for GIDU and Portman Mentalisation Based Therapy.

2.2.2.2 GIDU have over performed against budget by £320k for the first half of the year. As this performance level is not guaranteed for the remainder of the year no additional income has been forecast.

2.2.2.3 NPA income was budgeted at £131k for the year which was an understatement. The NPA income is £66k above budget at January and is expected to be £86k favourable by year end.

2.2.3 CAMHS Training fees are currently £217k above budget and are expected to be £205k above budget by the end of the financial year.

2.2.4 SAAMHS Training is expected to be £201k adverse, due to student numbers.

2.2.5 TC consultancy income is currently £51k below budget but they expect to be on target at the end of the financial year

2.2.6 Complex Needs are forecasting £130k underspend on vacancies.

2.2.7 SAAMHS budgeted £105k income from Clinical Income growth of which only £14k is expected in 2014/15.

2.2.8 CAMHS budgeted £96k income from Clinical Income growth of which only £35k is expected in 2014/15.

2.2.9 R&D Expenditure is expected to be £151k below budget due to Anna Freud recharge finishing. R&D income is forecast to be £91k above target due to 2013/14 income being invoiced in 2014/15.

2.2.10 The forecast allows for the investment reserve of £120k to be fully released and for £50k of the remaining contingency reserve of £177k to be needed.

2.2.11 Depreciation is expected to be £31k above budget. The dividend is forecast to be £50k below budget, due mainly to our higher cash balances.

2.2.12 The forecast of £80k for restructuring costs only allows for costs already incurred during the year. When applications for the voluntary severance scheme have been considered, this forecast will be reviewed and may increase significantly.

2.3 Cash Flow (Appendix D)

2.3.1 The actual cash balance at 31 January was £5,917k which is an increase of £1,981k in month, due to the HEE funding for the whole quarter having been

paid in advance in January. The position is £2,750k above plan, due to payments for 2013/14 NHS contracts which were excluded from the plan, in addition to the current 2014/15 surplus.

2.3.2 The cash forecast is to be £2.0m above plan. This is due to the additional NHS old year payments and the forecast surplus.

	Cash Flow year-to-date		
	Actual	Plan	Variance
	£000	£000	£000
Opening cash balance	2,757	2,757	0
Operational income received			
NHS (excl SHA)	16,226	14,919	1,307
General debtors (incl LAs)	7,182	6,462	720
SHA for Training	11,794	10,933	861
Students and sponsors	2,634	2,825	(191)
Other	0	0	0
	37,836	35,139	2,697
Operational expenditure payments			
Salaries (net)	(13,424)	(14,125)	701
Tax, NI and Pension	(10,429)	(10,510)	81
Suppliers	(9,569)	(8,176)	(1,393)
	(33,422)	(32,811)	(611)
Capital Expenditure	(1,089)	(1,700)	611
Interest Income	10	4	6
Payments from provisions	0	(11)	11
PDC Dividend Payments	(175)	(211)	36
Closing cash balance	5,917	3,167	2,750

2.4 Better Payment Practice Code

2.4.1 The Trust has a target of 95% of invoices to be paid within the terms. During January we achieved 91% (by number) for all invoices. The cumulative total for the year is 90%.

3. Training

3.1 Income

3.1.1 Training income is £1,060k below budget in total after ten months. Details are below. FNP income is currently being reported as £1,029k below budget, mainly due to £994k being deferred to next year.

3.1.2 If we exclude FNP then training income is £31k below target year to date. This is mainly due to an LCCPD shortfall of £121k which has been offset by HEFCE and short course income.

3.1.3 The National Training Contract was increased in Qtr3 by short term funding of £166k to support development projects to 31st March 2015. The full year budget has been revised accordingly. £90k will now be deferred into 2015/16.

LDA income (lines 4-7 appendix B)	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Forecast £'000
NHS London Training Contract	6,145	6,145	0	0
Child Psychotherapy Trainees	1,790	1,798	8	0
Junior Medical Staff	797	807	9	-92
Postgraduate Medical and Dental (budget incl. study leave)	78	41	-37	0
Sub Total	8,811	8,791	-20	-92
Fees and academic income (lines 8-11 Appendix B)				
DET	1,262	1,191	-71	60
CAMHS	2,521	2,738	217	205
FNP	3,724	2,695	-1,029	-960
SAAMHS	1,407	1,274	-133	-201
TC	195	170	-25	-49
Sub Total	9,109	8,068	-1,041	-945
Grand Total	17,920	16,860	-1,060	-1,037

3.1.4 The Training income forecast excluding FNP is £77k adverse. This is primarily due to fee income. Fee income for the full academic year 2014-15 is currently expected to be £244k below Plan.

3.1.5 The postgraduate medical and dental education income is £37k adverse to budget, as the income for study leave is now incorporated in the junior medical staff tariff.

3.2 Expenditure

3.2.1 Expenditure is currently £329k under spent at the end of January. Pay cost underspend is forecast to be £209k below budget; this is predominantly due to delayed recruitment of new posts. There have also been vacant posts in the Technology Enhanced Learning Unit.

4. Family Nurse Partnership

4.1 We are nearing the end of the second year in which the FNP national unit has been managed by the partnership of the Trust with SRU and Impetus-PEF, following its transfer from DH. The work is commissioned by Public Health England.

4.2 Continued growth of the service nationally is a key objective of the contract. At 31 March 2014, there were 13,150 places available in FNP services

nationally. The current projection is that the target of at least 16,000 places by 31 March 2015 will be achieved.

- 4.3 A successful conference was held for local authority commissioners in November, to support the transition of commissioning in October 2015 for local FNP teams.
- 4.4 The Service Review was completed in summer 2014. Implementation of the recommendations continues, and will deliver significant savings over the remaining three years of the contract, resulting in improvements in the NU service quality and a more scalable model for the future.
- 4.5 The contract value reduces for the remaining three years, in line with our original tender. This reduction will be partly covered by the savings, and partly by other efficiencies.
- 4.6 In March, the partners are taking part in a workshop on the future of FNP after the contract period. Impetus-PEF have provided significant funding for three development posts. The posts of head of finance and head of business development have been filled, and a further communications post is due to be finalised and recruited to shortly.

5. Patient Services

5.1 Activity and Income

- 5.1.1 Total contracted income for the year is expected to be in line with budget, subject to meeting a significant part of our CQUIN[†] targets agreed with commissioners; achievement of these is reviewed on a quarterly basis.
- 5.1.2 Variances in other elements of clinical income, both positive and negative, are shown in the table below. However, the forecast for the year is currently in line with budget in most cases, not in line with the extrapolated figures shown as “variance based on year-to-date.”
- 5.1.3 The income budget for named patient agreements (NPAs) was reduced this year from £196k to £131k. Up to January actual income is £66k above budget and is expected to be £86k favourable by the end of the year.
- 5.1.4 Court report income has a reduced budget from £113k for 2013/14 to £28k in 2014/15. There has been £14k to date, so we are £9k below budget. This income stream is expected to be £10k below budget at the end of the year.
- 5.1.5 Day Unit Income target was reduced by £210k in 2014/15 and is £6k above target after January.

[†] Commissioning for Quality and Innovation

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	11,215	11,322	1.0%	143	27	GIDU and MBT income deferred from 13/14. Offset by new projects
Cost and vol variances	244	638	161.6%	525	420	GIDU and Barnet over performance
NPAs	109	167	53.4%	104	86	
Projects and other	876	998		-	0	Income matched to costs, so variance is largely offset.
Day Unit	539	545	1.0%	6	0	
FDAC 2nd phas	668	568	-15.0%	-116	0	Income matched to costs, so variance is largely offset.
Court report	23	14	-39.2%	-11	-10	
Total	13,675	14,252		651	523	

5.1.6 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.

6. **Consultancy**

- 6.1 TC are £55k net below their budgeted target after ten months. This consists of expenditure £25k underspent, TC training fee income £25k below budget and consultancy income £55k below budget. TC are currently reviewing and revising their forecast income and expenditure for the rest of the year.
- 6.2 Departmental consultancy is £3k below budget after January; SAAMHS are currently £23k above budget and CAMHS have a £26k shortfall. However, CAMHS expect this position to improve by the end of the financial year.

Carl Doherty
Deputy Director of Finance
13 February 2015

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST										APPENDIX A	
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2014-15											
	Jan-15			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	1,363	1,468	105	13,675	14,252	577	16,401	16,910	509		
2 TRAINING	1,766	1,713	(53)	17,920	16,860	(1,060)	21,527	20,489	(1,037)		
3 CONSULTANCY	113	142	29	1,218	1,159	(59)	1,492	1,548	56		
4 RESEARCH	10	35	25	102	203	100	123	214	91		
5 OTHER	86	80	(6)	603	703	100	776	893	117		
TOTAL INCOME	3,338	3,439	101	33,519	33,176	(342)	40,319	40,055	(264)		
OPERATING EXPENDITURE (EXCL. DEPRECIATION)											
6 CLINICAL DIRECTORATES	1,302	1,327	(24)	13,042	12,862	180	15,650	15,549	101		
7 OTHER TRAINING COSTS	1,246	1,126	120	12,521	11,509	1,012	15,011	14,095	915		
8 OTHER CONSULTANCY COSTS	58	61	(4)	647	615	32	787	742	45		
9 CENTRAL FUNCTIONS	668	662	16	6,189	6,166	23	7,468	7,549	(80)		
10 TOTAL RESERVES	33	0	33	314	0	314	397	50	347		
TOTAL EXPENDITURE	3,306	3,166	140	32,713	31,153	1,560	39,313	37,985	1,328		
EBITDA	32	272	240	806	2,024	1,218	1,006	2,070	1,064		
ADD:-											
11 BANK INTEREST RECEIVED	0	1	(1)	4	10	(6)	5	5	0		
LESS:-											
12 DEPRECIATION & AMORTISATION	46	54	(8)	458	502	(44)	550	581	31		
13 FINANCE COSTS	0	0	0	0	0	0	0	0	0		
14 DIVIDEND	35	35	0	351	351	0	421	371	(50)		
SURPLUS BEFORE RESTRUCTURING COSTS	(49)	184	232	1	1,181	1,180	40	1,123	1,083		
15 RESTRUCTURING COSTS	0	0	0	0	80	(80)	0	80	(80)		
SURPLUS/(DEFICIT) AFTER RESTRUCTURING	(49)	184	232	1	1,101	1,100	40	1,043	1,003		
EBITDA AS % OF INCOME	0.9%	7.9%		2.4%	6.1%		2.5%	5.2%			

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST											APPENDIX B
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2014-15											
All figures £000											
	Jan-15			CUMULATIVE			FULL YEAR 2014-15				
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	OPENING BUDGET	REVISED BUDGET	FORECAST	REVISED BUDGET VARIANCE	
INCOME											
1	CENTRAL CLINICAL INCOME	597	738	140	6,019	6,237	219	7,054	7,213	7,504	290
2	CAMHS CLINICAL INCOME	319	337	18	3,248	3,228	(20)	3,987	3,886	3,776	(111)
3	SAAMHS CLINICAL INCOME	446	393	(53)	4,409	4,787	378	4,398	5,302	5,631	330
4	NHS LONDON TRAINING CONTRACT	638	638	0	6,145	6,145	0	7,254	7,420	7,420	0
5	CHILD PSYCHOTHERAPY TRAINEES	179	174	(5)	1,790	1,798	8	2,148	2,148	2,148	0
6	JUNIOR MEDICAL STAFF	80	44	(35)	797	807	9	1,022	957	865	(92)
7	POSTGRADUATE MED & DENT'L EDUC	8	10	2	78	41	(37)	94	94	94	0
8	DET TRAINING FEES & ACADEMIC INCOME	19	(1)	(20)	1,262	1,191	(71)	1,739	1,362	1,422	60
9	FAMILY NURSE PARTNERSHIP	372	365	(7)	3,724	2,695	(1,029)	4,469	4,469	3,510	(960)
10	CAMHS TRAINING FEES & ACADEMIC INCOME	256	318	62	2,521	2,738	217	2,274	3,033	3,238	205
11	SAAMHS TRAINING FEES & ACADEMIC INCOME	190	145	(44)	1,407	1,274	(133)	1,530	1,787	1,585	(201)
12	TC TRAINING FEES & ACADEMIC INCOME	24	20	(5)	195	170	(25)	282	257	208	(49)
13	TC INCOME	67	63	(4)	742	687	(55)	925	925	925	0
14	CONSULTANCY INCOME CAMHS	6	0	(6)	76	50	(26)	110	87	87	1
15	CONSULTANCY INCOME SAAMHS	40	79	39	400	423	23	492	480	535	55
16	R&D	10	35	25	102	203	100	123	123	214	91
17	OTHER INCOME	86	80	(6)	603	703	100	1,159	776	893	117
	TOTAL INCOME	3,338	3,439	101	33,519	33,176	(342)	39,059	40,319	40,055	(264)
EXPENDITURE											
18	COMPLEX NEEDS	298	297	1	2,979	2,826	152	3,560	3,575	3,476	100
19	PORTMAN CLINIC	127	119	8	1,219	1,142	77	1,225	1,474	1,406	68
20	GENDER IDENTITY	126	136	(10)	1,255	1,179	76	1,253	1,506	1,429	77
21	DEV PSYCHOTHERAPY UNIT	9	12	(2)	94	136	(42)	114	113	165	(53)
22	NON CAMDEN CAMHS	336	347	(11)	3,379	3,446	(67)	4,231	4,052	4,059	(7)
23	CAMDEN CAMHS	361	375	(13)	3,681	3,675	6	4,350	4,404	4,413	(9)
24	CHILD & FAMILY GENERAL	45	42	3	435	457	(22)	503	526	601	(76)
25	FAMILY NURSE PARTNERSHIP	339	320	19	3,388	2,705	683	3,575	4,066	3,399	667
26	JUNIOR MEDICAL STAFF	83	85	(2)	828	784	44	966	993	993	0
27	NHS LONDON FUNDED CP TRAINEES	179	180	(1)	1,790	1,793	(3)	2,148	2,148	2,148	0
28	TAVISTOCK SESSIONAL CP TRAINEES	2	1	0	15	24	(9)	19	19	31	(12)
29	FLEXIBLE TRAINEE DOCTORS & PGMDE	25	23	2	255	236	19	394	306	283	23
30	EDUCATION & TRAINING	246	128	118	3,152	2,748	404	3,447	3,641	3,268	373
31	VISITING LECTURER FEES	125	124	1	979	1,000	(20)	1,229	1,229	1,212	17
32	CAMHS EDUCATION & TRAINING	118	153	(35)	1,182	1,325	(142)	1,429	1,420	1,575	(156)
33	SAAMHS EDUCATION & TRAINING	129	110	19	931	888	43	939	1,189	1,177	13
34	TC EDUCATION & TRAINING	0	2	(2)	0	7	(7)	0	0	9	(9)
35	TC	58	61	(4)	647	615	32	815	787	742	45
36	R&D	20	8	12	200	69	132	169	241	90	151
37	ESTATES DEPT	173	174	(1)	1,727	1,774	(47)	2,078	2,072	2,152	(80)
38	FINANCE, ICT & INFORMATICS	162	158	4	1,618	1,686	(68)	2,326	1,942	2,038	(96)
39	TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	86	113	(27)	816	841	(25)	998	989	1,049	(60)
40	COMMERCIAL DIRECTORATE	90	63	27	714	642	71	738	837	757	80
41	HUMAN RESOURCES	57	57	0	571	606	(36)	632	685	760	(75)
42	CLINICAL GOVERNANCE	80	79	0	543	547	(4)	587	702	702	0
43	PROJECTS CONTRIBUTION	0	0	0	0	0	0	(73)	0	0	0
44	DEPRECIATION & AMORTISATION	46	54	(8)	458	502	(44)	550	550	581	(31)
45	IFRS HOLIDAY PAY PROV ADJ	8	0	8	83	0	83	100	100	0	100
46	PRODUCTIVITY SAVINGS	0	0	0	0	0	0	(134)	0	0	0
47	INVESTMENT RESERVE	10	0	10	100	0	100	120	120	0	120
48	CENTRAL RESERVES	14	0	14	131	0	131	315	177	50	127
	TOTAL EXPENDITURE	3,352	3,220	132	33,171	31,655	1,516	38,603	39,863	38,566	1,297
	OPERATING SURPLUS/(DEFICIT)	(14)	218	232	348	1,522	1,174	456	456	1,489	1,033
49	INTEREST RECEIVABLE	0	1	1	4	10	6	5	5	5	0
50	DIVIDEND ON PDC	(35)	(35)	0	(351)	(351)	0	(421)	(421)	(371)	50
	SURPLUS/(DEFICIT)	(49)	184	233	1	1,181	1,180	40	40	1,123	1,083
51	RESTRUCTURING COSTS	0	0	0	0	80	(80)	0	0	80	80
	SURPLUS/(DEFICIT) AFTER RESTRUCTURING	(49)	184	233	1	1,101	1,100	40	40	1,043	1,003

Board of Directors : February 2015

Item : 8

Title: Training & Education Programme Management Board
January 2015 report

Purpose:

To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 2 February 2015.

This report has been reviewed by the Management Team on 12th February.

This report focuses on the following areas:

- Quality
- Risk
- Finance

For : Noting

From : Brian Rock, Director of Education & Training / Dean of Postgraduate Studies

Training & Education Programme Management Board Report

February 2015

1. Introduction

- 1.1 The Training & Education Programme Management Board (TEPMB) had its fourth meeting on 2 February 2015.

2. MH nursing training

- 2.1 The Director of Nursing made a welcome announcement about the successful bid for the Trust's involvement with undergraduate MH nursing training through the partnership with Buckinghamshire New University (Bucks New University).
- 2.2 This is a modest but significant development for the Tavistock and Portman NHS Foundation Trust as we have successfully contributed to the very first tender of Mental Health Nurse Education contracts in London.
- 2.3 The contract will start in September 2015.

3. New structure for training and education delivery

- 3.1 The Director of Education & Training / Dean provided an update on the implementation of the new education and training structures.
- 3.2 Karen Tanner has been appointed as the Associate Dean (Learning and Teaching). She will take up her new role from 1 April 2015.
- 3.3 The post for the Associate Dean (Academic Governance and Quality Assurance) has been now been successfully appointed to. Elisa Reyes-Simpson, who has been in the interim AD – SAAMHS role, was the successful applicant. ER-S will take up the new role from 1 April 2015.
- 3.4 The confirmation of these two posts will start the process of recruitment for six Portfolio Manager posts from the current group of 11 Cluster Lead roles.
- 3.5 Currently plans are being agreed with the Director of CAMHS and the Director of Quality, Patient Experience, Adult & Forensic Services to effect a transition from the current to the new arrangements, which are planned to take effect from 1 April 2015.

- 3.6 It is expected that there will be a short period of overlap for the new structures to bed down and for people to take up their roles fully.
- 3.7 This work of restructuring the “faculty” is being linked with the work of the directorate so that an integrated service line can be fully established.
- 3.8 The Director of Education & Training / Dean does not think that the restructuring would have an adverse impact on student recruitment. In fact, upward fee revisions had been communicated earlier in the current recruitment cycle than in the previous cycle. Plans were underway to better coordinate our response to initial enquiries, too.

4. Target setting

- 4.1 The work of identifying particular areas for growth in the portfolio was discussed. In the main this involves selecting courses for which there are opportunities through growth by offering the courses at more convenient times for students and/or combining with blended learning options. Marketing certain courses better is also part of the strategy.
- 4.2 The Associate Deans have been working closely with Cluster Leads in this process to not only identify courses where growth can be expected but also identify an operational plan to make it happen and, where required, to unblock any logistical obstacles.
- 4.3 Considerable work has also gone into looking more closely at those courses that do not recruit sufficient student numbers to turn a profit. It was noted that the discontinuance of courses would only make financial sense if it were possible to redeploy staff to deliver in other areas of training. The validation process with Essex would also put the viability of certain courses into perspective.
- 4.4 A detailed plan to achieve the expected target of £200k to contribution has been agreed at a recent meeting of the target setting group for education & training. It is through a combination of income generation through the levying of higher fees; increased student numbers for specific courses through the provision of blended learning formats; a more active development effort in relation to our short courses and CPD events; and specific marketing input.

5. ICT update

- 5.1 The ICT project is getting closer to the stage where it will be possible to initiate the procurement of a new system. London Procurement Partners (LPP) have been engaged to work with the Trust in this regard.
- 5.2 The project team is now finalising the Statement of Requirements (SoR) and has involved two key external partners, HE NCEL & Essex, in this process.
- 5.3 The procurement process will be initiated in the week commencing 16 February 2015. There have been some delays due to the transition to the new Director of Education & Training / Dean role, and the arrival of the new Director of IM&T, who is making a very helpful input.
- 5.4 Challenges around the migration of data from the old system to the new system have also been identified due to the fragmented nature of the current systems. Work is being undertaken to find the best solution to these issues but it is likely that this will require the identification of a suitable system vendor.

6. Transformation Programme

- 6.1 An update of the work around organising and creating a framework for the Action Plan for Transformation initiated by the TEPMB was presented by the Director of Education & Training / Dean.
- 6.2 From early work conducted it was agreed that the Programme is in effect a Transformation Portfolio consisting of three programmes in relation to our externally facing services (i.e. curriculum development), our internally facing operations (i.e. business process review), and the work with the Essex University Partnership. It also consists of two projects involving the closer alignment of Tavistock Consulting and the integration of marketing and communications into the education & training service line.
- 6.3 It was proposed that regional strategy is organised as a third project given its significance for the national training contract.
- 6.4 It was agreed that this organising of the portfolio allowed for a greater prioritisation of workstreams and a better understanding of resource implications and the impact on business as usual.
- 6.5 The ongoing work will be presented at the next Training & Education Programme Management Board in March for review.

7. Recruitment: 2014–15 report and proposed new planning and recruitment cycle for 2015–16

- 7.1 Paul Jenkins reported on the visit to the Northern School (NSCAP) on 30 January 2015 with Brian Rock and Associate Director (DET) Will Bannister. The meeting was positive. Colleagues there expressed a wish to be engaged in more of a partnership with the Trust. They have developed good working relationships with some of their LETBs and have established a well regarded training centre.
- 7.2 NSCAP were keen to be engaged as our preferred partner in the North.
- 7.3 We are looking now to establish a partnership board with NSCAP to facilitate these developments. This relationship could provide a template for subsequent developments in other regions.

8. University of Essex Partnership

- 8.1 On 28 January 2015, Paul Jenkins, Brian Rock and Rob Senior Partnership Board meeting at the university. The tone of the meeting was productive and collaborative.
- 8.2 It was decided that a Strategic Partnership Board will be established to oversee the partnership arrangements. It will meet three times each year.
- 8.3 It was agreed that there would be six workstreams with each partner organisation taking the lead in three of the workstreams to progress discussions and negotiation.
- 8.4 UEL have expressed a wish to have a shorter teach-out period. Initially it was discussed that the migration of courses from UEL to UoE would take place over two years. UEL would like all courses to migrate by the start of AY15/16.
- 8.5 While this has not been agreed, active discussions and work between our respective organisations is underway with Essex to establish a timetable for the migration of courses with a corresponding outline of the resource implications. This is expected to be clarified in early March 2015. At this point, a decision will be taken about what is feasible.
- 8.6 There are two implications arising from UEL's request. The first relates to 2015/16 recruitment for any courses not yet transferred to Essex. The second relates possible transfer of existing students, which would be subject to their consent.

8.7 Meetings with Essex and UEL are ongoing to resolve these issues and arrive at a satisfactory position for all parties. The Board will be kept informed of progress.

8.8 Essex approached our requirement for regional centres in a positive way.

9. DBS Clearance

9.1 An update was given about the requirement for Visiting Lecturers (VLs) to comply with DBS Clearance. There is agreement that this should be required. Legal advice is being sought as to whether DBS clearance is transferrable where it has been obtained elsewhere.

9.2 This matter is being actively engaged with by our HR Director and Associate HR Director in discussion with the Director of Education & Training / Dean and the Associate Deans. A paper will be presented by the HR Director at the next TEPMB in March 2015.

10. QAA visit

10.1 The QAA is undertaking an inspection visit on 24 February 2015 for its Review of Educational Oversight (REO).

10.2 Successful REO registration confers Highly Trusted Status and Tier 4 status with the Home Office CAS allocation for the recruitment of overseas students.

10.3 The last Annual Monitoring Visit took place in February 2013. The Trust received a commendable judgment and was this exempted from an Annual Monitoring Visit in 2014.

10.4 The Trust submitted a Self-Evaluation Document together with supporting documentation to the QAA in late November 2014. On the basis of the documentation submitted, the QAA deemed an Annual Monitoring Visit was appropriate rather than a full two-day Review of the Trust as a higher education provider.

10.5 Preparation is being well managed by our Head of Quality, Louis Taussig, in collaboration with the Associate Deans and Associate Director. It also includes representation from our students.

Brian Rock

Director of Education & Training / Dean of Postgraduate Studies

Board of Directors : February 2015

Item : 9

Title: Service Line Report FDAC London and Westminster Family Services.

Purpose:

The purpose of this report is to give an update on the London Family Drug and Alcohol Court service (FDAC) and the Westminster Family Services.

This report has been reviewed by the following Committees:

- Management Team, 12th February 2015

This report focuses on the following areas:

- Quality
- Risk
- Patient Experience

For : Discussion

From: Steve Bambrough, Associate Clinical Director (CAMHS Directorate).

Service Line Report – FDAC and Westminster Family Services, CAMHS

Executive Summary

1. Introduction

- 1.1 The **Family Drug and Alcohol Court (FDAC)** is a specialist clinical team within the Trust, commissioned directly by the London boroughs of Camden, Islington, the Tri-Borough, Lambeth and Southwark. The service model is a radical change to the way normal court proceedings work for children at risk, whose parents are alcohol or substance misusers.
- 1.2 The team consists of 13 multi-disciplinary staff (10 Trust staff and 3 staff employed by Coram under a Service level Agreement) and is delivered under a two year contract with 6 local authorities and the contract lead is the London Borough of Southwark. The total contract value in 2014/15 is £559,084. The unit is contracted to assess and treat a minimum of 46 families per year.
- 1.3 The service has been rigorously independently evaluated by Brunel University and the Nuffield Foundation over 6 years and they reported on their findings in July 2014 - and the evaluation report can be read at http://www.nuffieldfoundation.org/sites/default/files/files/FDAC_evaluation_summary_findings_01_05_14.pdf
- 1.4 In addition to the London FDAC, the Trust were awarded a contract by the Department for Education in 2013 (at £150,000 per year) for two years until March 2015, to develop the FDAC model outside of London. In December 2014, the Trust also applied for funding through the DfE's Innovation Programme to construct a National Unit for FDAC which includes funding for 4 new FDAC consortiums (potentially 11 new local authorities and 11 new FDAC courts in total) outside of London.
- 1.5 The **Westminster Family Services** is a multi-disciplinary team of 18 staff who undertake parenting assessments, interventions and contact supervision for the Tri-Borough, but principally for Westminster City Council.

- 1.6 The contract value is £826,525 for the year (which runs November 2014 to October 2015) and we have operated within budget for the whole of the contract so far.

Service	2014\15 budget	2014\15 expenditure as at January 2015
Westminster Family Services	£826,525	£578,761
FDAC London	£547,639	£410,348

2. Areas of Risk and/or Concern

- 2.1 In the coming financial year, the **London FDAC** may fall short of the 46 referrals which it needs in each year to maintain the full clinical team and model of operation. This is due to austerity measures within the commissioning London Boroughs. Indications are that there may be 7 fewer cases commissioned in 2015/16 which would mean a £85,057 shortfall in income.
- 2.2 **Westminster Family Services** are in the final year of a 4 year contract. We are anticipating that this contract will be re-tendered in March 2015 and there are likely to be significant changes to the Service Specification which the Tri-Borough wishes to commission. It is also indicated by the commissioners that the contract is likely to be significantly higher in scope and value, due to the Tri-Borough joint commissioning.

3. Proposed Action Plan

- 3.1 Regarding **FDAC London**, we are negotiating with other local authorities such as Greenwich, which may want to buy into the London consortium. In addition we are in ongoing discussions with the West London Family Court (in Hatton Cross) and the local

authorities which use this court, as to the options of them either buying into the current consortium or investing in their own FDAC team. The likelihood is that this will not be secured by the beginning of the financial year so it is likely that we will have to begin a consultation process to reduce the staff team proportionate to the financial reduction. There is a contractual complexity to this – the local authorities are contractually bound to a 2 year contract (ending April 1st 2016) on the total (46) number of referrals agreed by the consortium and therefore we are negotiating with the commissioners to hold to the terms of the contract.

- 3.2 Regarding **Westminster FS**, we will wait for the tender and the Service Specification to be advertised (probably March 2015), which will then go to the Business Development Council for consideration.

Main Report; FDAC

4. Overview of the Service

- 4.1 The London Family Drug and Alcohol Court (FDAC) at the Inner London Family Proceedings Court has been running since January 2008 and is the first of its kind outside of the USA. FDAC offers an alternative form of care proceedings for parents and children in those cases where substance misuse is a key factor in the decision to bring proceedings. FDAC uses a problem solving court approach, which aims to help parents control their substance misuse so they can be safely reunited with their children. If that is not possible, we ensure that children are placed permanently with family members or elsewhere as speedily as possible.

It has won awards from the Royal College of Psychiatrists, the Law Society, the British Medical Journal Group, The Guardian newspaper, and others. It has been cited as an example of excellence in the Home Office's Drug Strategy 2010 and the Munro Review of Child Protection 2011. The Family Justice Review praised FDAC and recommended further roll-out. In 2014 the President of the Family Division, Sir James Munby, described FDAC as "a vital component in the new Family Court" and is committing judicial resources to make FDAC available across the country.

- 4.2 The specialist multi-disciplinary team which works closely with the Judges and supports the parents through the process (in partnership with the children's charity Coram). Following positive findings from the first stage of the research, the Family Justice Review recommended wider roll out of FDAC. The Department for Education awarded a grant to the Tavistock & Portman NHS Trust to support new areas to roll out the model in 2013.
- 4.3 The FDAC carry out rapid assessments of the family and within 10 days produce an intervention plan which is agreed with all parties, in order to test whether parents can overcome their drug and alcohol problems and meet their children's needs in the child's timeframe. Families are given the maximum possible support with overcoming their problems. Parents are expected to abstain from street drugs and alcohol, begin to address the difficulties driving their substance misuse, strengthen their relationship with their child/ren and create a child-centred lifestyle.
- 4.4 The FDAC team in London consists of a service manager, a deputy manager, social worker specialists, a clinical nurse specialist, drug and alcohol specialists, a domestic violence specialist, an administrator and part time child and adult psychiatrists. Parent Mentors are a key part of the FDAC approach. They are ex-service users who have gone through similar experiences to the parent they are supporting, which while not necessarily the same are close enough for them to offer meaningful support.
- 4.5 **Progress to date and current position**
- 4.6 The evaluation showed that FDAC delivers demonstrably better outcomes for children and families, as well as for the public purse and taxpayers. The independent evaluation conducted by Brunel University between 2008 and 2013 compared 3 London boroughs using FDAC with 3 without FDAC. The results were impressive.

Twice as many FDAC mothers were reunited with their children, having stopped misusing substances (35 v 19%). The rate of misuse cessation and reunification was higher if the case was referred earlier to FDAC (55% v 16%

FDAC fathers were 5 times more likely to stop misusing substances (25 v 5%).

Where children were returned home, fewer FDAC children were abused and neglected a year after proceedings (25 v 56%).

FDAC reduced the local authority spend on alternative care during proceedings by approximately £4K per family.

The savings from the FDAC model go well beyond proceedings. Our modeling suggests that the return on the investment would be £2.57 for every £1 spent.

5. Clinical Services and Activity Data

5.1 FDAC London are contracted to work with 46 families this year divided in the following manner ;

Camden	12
Islington	7
Southwark	10
Lambeth	9
Tri-borough	8
Total	46

The service is currently on track to deliver on this target.

5.2 Ethnicity ; data collected shows clients referred to FDAC London consisted of the following ethnic breakdown over the previous calendar year ;

- White British ; 42%
- White European ; 18%
- Mixed ; 11%
- Black or Black British ; 19.5%
- Asian/Asian British ; 5
- Other Ethnic Group ; 4.5%

6. Financial Situation

6.1 The service is run on a block contract with the commissioning local authorities for £559,084. Our last quarterly monitoring meeting on 26th January 2015 showed that we are within budget and on target with our forecast. The consortium is led by the London Borough of Southwark.

6.2 Currently the FDAC service is running with a small underspend.

6.3 The DfE has a small contract with the Trust (of £150,000 per year for 2 years ending on 31st March 2015) for the wider programme development of FDAC. This contract has specific service work streams which the DfE wanted the FDAC service to focus on ;

- Work Stream 1: Meeting the twenty six week time limit for care proceedings.
- Work Stream 2: Support to FDAC projects outside of London (and possibly new London boroughs joining)
- Work Stream 3: Identification of the wider use of the FDAC model (Domestic Violence and Mental Health)
- Work Stream 4: Exploration of the use of multi-disciplinary team assessments (pre and post proceedings)

We have been able to deliver on all of these work streams including the setting up of new FDAC sites in Milton Keynes and Buckinghamshire in July 2014 and East Sussex in April 2015. The Trust will not be providing the team for the East Sussex FDAC but will be providing training, mentoring, consultation and assisting with programme fidelity. The Milton Keynes and Buckinghamshire FDAC has a clinical team recruited locally in that area and seconded to the Tavistock. This contract has a value of £93,386 to the Trust and a full contract value of £327,348 including the secondments and local authority costs.

At the last quarterly monitoring meeting for the Milton Keynes and Buckinghamshire FDAC on 18.12.14 the commissioners reported back that the service was progressing well and that the local authorities were “very impressed” by the service.

6.4 More recently the Trust has made a bid for funding from the DfE within the Innovation Programme for funding for a National FDAC Unit run by the Trust.

6.5 This National Unit (if it receives funding from the DfE) would seek to roll out FDAC nationally with the DfE's and Ministry of Justice and HMCS support, via a scale-up plan, bringing together the information and the people that can scale-up and embed FDAC nationally and at the same time extract and act on lessons that will emerge. The Trust requested £2,500,000 to help design and deliver 4 new FDAC consortiums in Coventry; Kent & Medway; Plymouth, Torbay & Exeter; and West Yorkshire (Kirklees, Leeds, Calderdale, Bradford and Wakefield).

7. Clinical Quality and Outcome Data

7.1 The independent evaluation by Brunel University contained both quantitative and qualitative data. In the qualitative data collection, this involved interviewing 42 families about their experience of the service between 2008 and 2013. It reported that ;

“The parents were overwhelmingly positive in their comments about the team. They used terms such as ‘helpful’, ‘supportive’, ‘life-changing’ and ‘fantastic’. Parents liked ‘being talked to as normal’ and ‘not being judged straight away’. FDAC ‘listened’ and ‘were always explaining things’. The few exceptions were comments that the team was ‘over-worked’ or ‘stressed’. This was generally about meetings with workers sometimes feeling rushed, or meetings starting later than planned. ‘Honest’, ‘strict’, ‘supportive’ and ‘kind’ were the words used most often to describe team members.

The criticisms of the team made by a few of the parents included a comment that the intervention plan was insufficiently structured or strict, a comment that other treatment services involved were more helpful than FDAC, and a comment that the parents themselves had organised the support that they had found most helpful.”

- The evaluation found that FDAC is a service that parents would recommend to others. Those with previous experience of care proceedings found FDAC to be a more helpful court process that gave them a fair chance to change their lifestyle and parent their child well.
- Parents valued the practical and emotional support and treatment intervention from the FDAC team. They felt motivated by workers who knew how to help them regain responsibility whilst supporting them through difficulties. They would like more help to be available, from FDAC and other services, after care proceedings end.

- There is consensus amongst professionals of the value of the FDAC approach, notwithstanding some concerns about its fit with some aspects of the PLO reforms. Professionals were positive about the multi-disciplinary composition of the team, their specialism, and the fact that they carry out interventions as well as assessments. They were also positive about the multi-agency working facilitated by the team while cases are in FDAC. [link to How FDAC Works, section on team]

The benefits of the FDAC model are **the role of the judge** (having the same FDAC judge throughout a case, and through the non-lawyer reviews, both of which promote a problem-solving approach to the resolution of care proceedings), **an independent, multi-disciplinary team** (that works closely with the court and other parties, and does intervention as well as assessment work with parents) and, as a result, **proceedings that are less adversarial** than ordinary care proceedings (providing a more collaborative court atmosphere, whilst retaining due formality).

8. Feedback

The ESQ's collected from the clients by the team are not a required part of the outcome and service performance monitoring by the commissioners but we have been collecting this data and including it in our quarterly monitoring reports. The ESQs show that the clients expressed an overall satisfaction with the service in most areas. The questions in the ESQ are answerable by the client in a continuum ranging from 1) Certainly True, (2) Partly True, (3) Not True and (4) Don't Know. See Appendix 1 for a sample copy of an ESQ provided by an FDAC client.

- 8.1 Of the responses, 77% answered the questions in the ESQ as "certainly true", 19% answered the questions as "partly true" and 4% as "not true. We are collating the data at present in order that we can learn from the feedback.
- 8.2 We are collecting a great deal of data to include performance in relation to satisfaction with clinical services, environment, performance and outcome information and there is a full list of the data being collected in Appendix 2 which will form part of our national database information collection programme.

9. Serious Untoward Incidents and Safety Issues

9.1 Information Incident on 20.10.14; an FDAC assessment report including confidential and client identifiable and sensitive data, was found by a professional in the waiting room outside a different (non-FDAC) court and handed to FDAC staff. This was *not* left there by an FDAC staff member. Incident form completed and sent to Jonathan McKee. After review it was concluded that this was not a Tavistock incident.

9.2 In July 2014 a previous client of FDAC, a 38 year old woman with a long history of drug and alcohol abuse, died of a suspected drug overdose. The case was closed to FDAC at that time. The woman had been referred to FDAC from Southwark Children's Services for a pre-birth assessment on 11.11.13. FDAC worked with the woman and her partner and recommended the child was cared for by extended family members, and this plan was agreed by the parents.

9.3 An audit of files and a root cause analysis incident report was drafted by Dr Jessica Yakeley and sent to me on 23.01.15. An action plan is being drawn up currently to address the recommendations;

- To explore ways in which FDAC can continue to be funded for work with some high risk patients post final court dates, when the work done pre court has proven to be of benefit to the family
- The review team to meet with myself and the FDAC clinical lead and CAMHS Director to feedback findings and develop an action plan.

10. Staff Education and Training

10.1 We are currently training our domestic violence specialist to be an accredited DV expert as recognised by Respect.

We are training our group facilitators in Mentalisation-Based Family work.

We have invested in one of our substance misuse specialists to train in Systemic Psychotherapy.

Main Report; Westminster Family Services

11. Overview of the Service

The Westminster Family Services were commissioned in 2011 by the Westminster City Council and subsequently the Tri-Borough. This included the TUPE transfer of 19 members of staff who were previously employed by Action for Children and the original contract value was £995,050. The WCC asked for savings in the region of £170,000 on the contract over the last two years due to savings within the Council and an overestimate on their part of contact supervision and intervention work required from the service.

11.1 The service specification is for parenting assessments (the majority of them in court proceedings), an undefined range of ‘parenting interventions’ and contact supervision. The Trust introduced a multi-disciplinary team into the service, and a shorter timescale for the assessments for court, which met with the changing legislation at that time. This met with commissioner approval and the London Borough of Hammersmith and Fulham began buying into the service in 2014.

12 Progress to date and current position (November 2013 to November 2014); Clinical Services and Activity Data

Service	2014 target	2014 referred to service	No. variance
Assessments	60	54	6
Parenting Interventions	40	15	25
Pre & Post Court Contact Supervisions	80	34	46

Appointments DNA		39	
Hours Cancelled by Client		64	
Hours cancelled by Trust		2	

12.2 The service was commissioned to deliver 60 parenting assessments each year and 40 interventions for families each year. In addition 80 referrals for supervised contact (split evenly between post-final order and pre-final order contacts) were commissioned. While the service has accepted all of the referrals that have been made to it, the referrals have never met target levels in the interventions and contacts.

The commissioners acknowledge that they overestimated the target numbers and report that they are very pleased with the service.

13.1 Ethnicity

Clients referred to WFS consisted of the following ethnic breakdown over the previous calendar year;

- Asian or Asian British ; 4%
- Black or Black British ; 29%
- Mixed ; 21%
- Arab ; 3%
- Kurdish ; 3%
- White British ; 17%
- White European ; 13%
- Not known/stated ; 10%

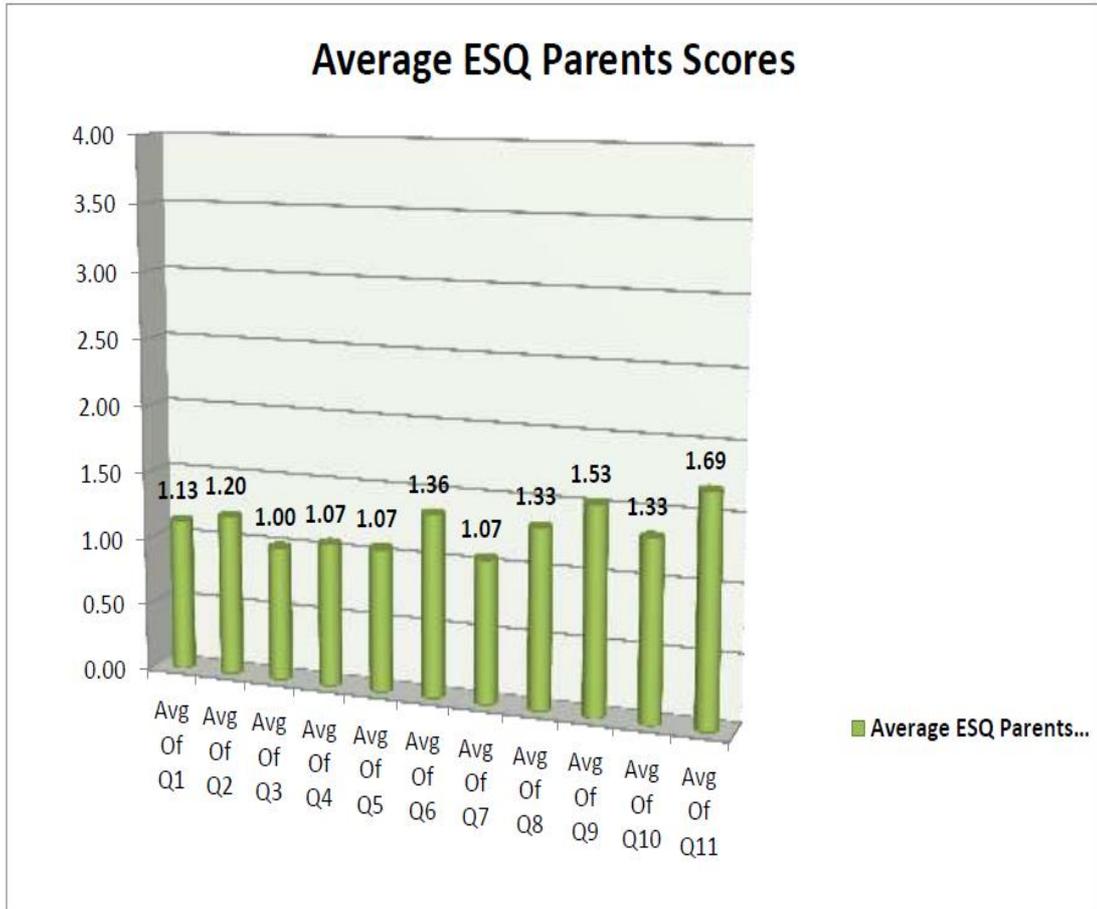
14 Financial Situation

14.1 We have just negotiated the budget for the final year of the contract, which included a small underspend (£6,000) on the previous year's budget. The final year budget is **£826,525.**

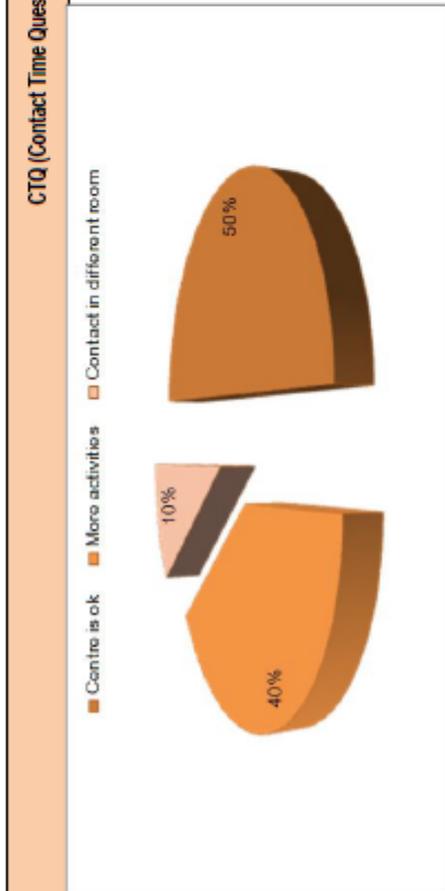
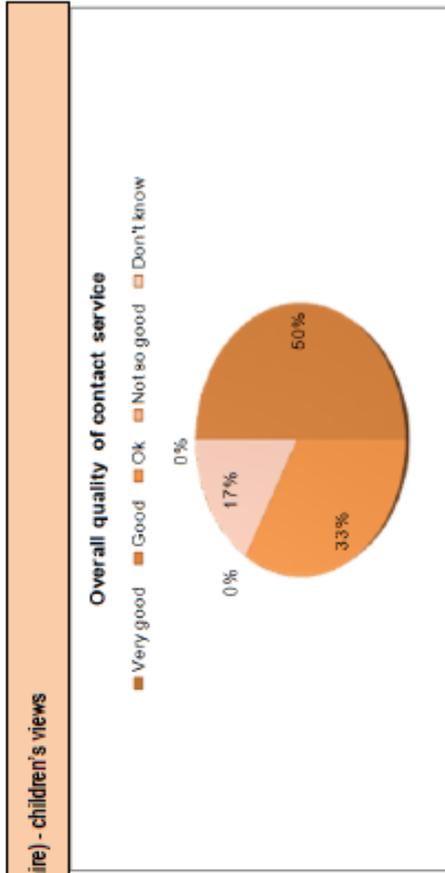
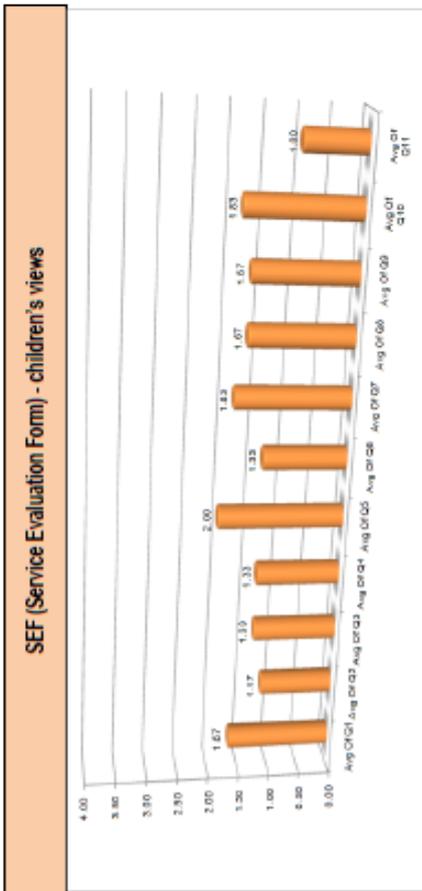
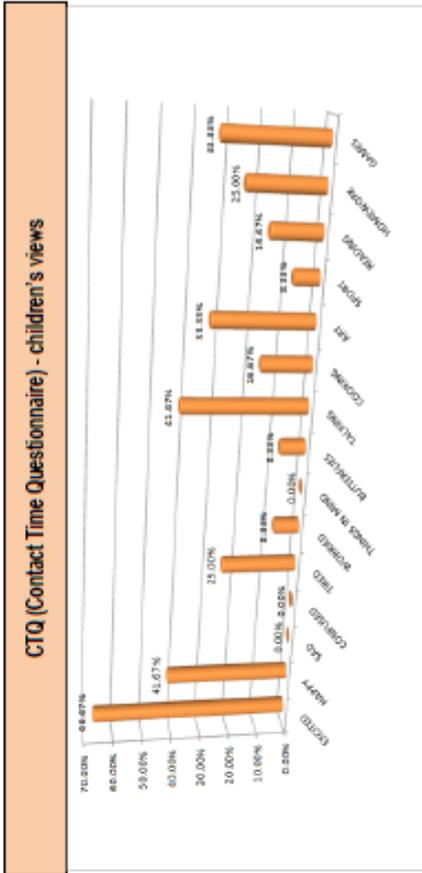
15 Clinical Quality and Outcome Data

- 15.1 The commissioners (Tri-Borough led by WCC) do not require the service to collect outcome data on anything other than throughput of cases against target numbers, incidents, source of referral and timescales for the individual pieces of work.
- 15.2 In October 2012, Westminster Family Service began independently implementing a set of outcome measures with the purpose of evaluating the quality of the services offered and their impact on the children's and families' functioning and wellbeing. This study includes the systematic gathering, analysis and dissemination of a series of quantitative data for all families referred to WFS. We presented a report to the commissioners in November 2014 covering a full year of data (see Appendix 3). It provides a clinically informed basis on which a critical thinking can be developed about the nature of current practices.
- 15.3 The data collected was from PIR-GAS, CGAS, SDQ's, ESQ's, Goal-based-Measure, SEF and CTQ's. The full report can be sent on request. The summary and learning points from the experience of the clients were contained in the ESQ's and Contact Time Questionnaires (for children).
- 15.3.1 **ESQ** ; the clients expressed an overall satisfaction with the service in most areas. The questions in the ESQ are answerable by the client in a continuum ranging from 1) Certainly True, (2) Partly True, (3) Not True and (4) Don't Know.

The lowest scores and therefore the most positive, were recorded in answer to Q3 "I was treated well by the people who saw my child" (average score 1). The highest scores and therefore the most negative about the service were recorded in Q11 ("If a friend or family member needed that sort of help, I would suggest them to come here" – which received an average score of 1.69).



15.5 The CTQ's and SEF's for children are shown in the tables below.



Parents' goals - Thinking Space group (Goals Based Measure)

- Knowledge and understanding of the way I act and behave towards my children and others
- I am here to hear what other parents' views is and my view of our problem and children and feelings...I want to do everything I can because I want to bring my son home, I am good mother but people judge as special social services
- I am happy to come to this class again, is been very helpful and great experience. I feel much better than 6-7 weeks ago
 - How we think about others
 - How we understand the others

Parents' views of quality of service

Areas of satisfaction

- Positive and friendly staff
- Staff talked about help available
- Staff listened and supported relationship with child
- Playing with child / seeing child
 - Easy to discuss issues
 - Good facilities (globe, toys, garden)

Areas of dissatisfaction

- Appointment times
 - Room size
- Saturday / weekend contacts non available
 - Post-case programmes non available
 - Nothing is good

15.6 We are continuing with the data collection.

In response to the outcome measures we began a Service User forum, opened the centre for contacts later into the evening and Saturdays and had the building decorated and re-named.

Also, to improve the quality of experience of our clients' we gained funding from the Waitrose Community Fund to develop our garden to make it more child-friendly and interactive.

We run a mindfulness group for parents to improve their parenting and ability to reflect upon their children's needs.

We have trained staff in specific evidence based tools to not only test the parents' capacity to change but also to instigate change through a trail of therapeutic intervention in the majority of cases, where this is clinically indicated.

16 Serious Untoward Incidents and Safety Issues

16.1 There have been several incidents (all reported) in the last year, involving threats made to staff by clients with a known violent history, aggression towards staff by children. and one incident of a client with serious health concerns suffering illness at the WFS centre.

16.2 These have all resulted in reporting to the statutory social worker and where appropriate suspension of contact until the issue can be resolved satisfactorily.

17 Clinical Governance and Audit

17.1 Internal file audits by senior team members are carried out on a regular basis.

17.2 In July 2014 the service undertook an audit of files using the Multi-agency audit tool as designed by the London Safeguarding Board.

18 Education and Training

18.1 We are currently training several staff in clinical areas of practice in order to broaden the multi-disciplinary skill-set. This includes training one of our Child & Family Practitioners to be a substance misuse specialist. This will include the service's ability to conduct substance misuse testing as part of our assessments of parenting.

18.2 Other team member is being trained in specific evidence based assessment tools such as PDIs, AAls, PEM's, PI's and therapeutic interventions such as Video Interactive Guidance and group work.

18.3 We have a partnership in place with Dr Chris Newman from PAI who consults to us on domestic violence assessments and he contributes to and can check the clinical validity of risk and vulnerability assessments of clients where there is a risk or known domestic violence.

19 Research

19.1 We have a current programme of research into the use of psychoanalytic theory in relation to testing parental capacity to change.

Steve Bambrough
Associate Clinical Director (CAMHS Directorate)
08.02.15

Appendix 1

FDAC Database

Report list

A. Timeframe

1. Per quarter - financial year April to March
2. Per year – April to March
3. All cases from start of FDAC

B. Basics

1. Number of referrals overall
2. Number of pre-proceedings referrals
3. Number of in proceedings referrals
4. Number of children overall and per case

C. Child and parent details

1. Number of carer 1 and gender
2. Number of carer 2 and gender
3. Number of carer 3 and gender
4. Number of cases where carers 1 and 2 living together
5. Age of children
6. Gender of children
7. With whom child living at start of proceedings/ or referral to FDAC if pre-proceedings
8. Ethnicity of carers
9. Ethnicity of children
10. Number of asylum seekers
11. Number of parents needing interpreter
12. Where the referrals have come from (issuing LA)

D. Problems –adults:

1. All first carers number with drug problem only
2. All first carers number with alcohol problem only
3. All first carers number with drugs and alcohol
4. All first carers - Length of SM histories
All first carers number with current DV
All first carers number with DV at any time

5. All first carers number with current MH problem
All first carers – length of contact with children’s services
6. All first carers – number with previous children removed
7. All first carers – level of insight into trigger for problems
8. All second carers (as above)

E. Problems - children:

1. All children – quality of relationship with parents
2. All children - number with health problem
3. All children – number with emotional/MH/behavioural problem
4. Numbers at different levels of severity
5. All children - numbers at different levels of confidence

F. Outcomes adults:

1. All first carers who have stopped misusing – and per use eg drugs, alcohol or both
2. All first carers still misusing
3. All first carers reduced severity of misuse
(and same for second and third carers)
4. All first carers reduced risk of DV
5. All first carers reduced MH problems
6. **(and same for second and third carers)**
7. All first carers improved insight

G. Outcomes children:

1. All children improved relationship with parents
2. All children health problem ?
3. All children improved emotional and MH health
4. All children improved confidence

H. Timing

1. Pre proceedings - Time from start of case (first FDAC pre proceedings meeting) to completion of first assessment **(would that be first IPM?)**
2. Pre proceedings – time from start of case to completion (case closed or first hearing in proceedings)
3. Pre proceedings – number of IPMs

4. Time from first hearing in FDAC to final order
5. Time from first hearing (if not in FDAC) to final order
6. Time from first hearing in FDAC to completion of first assessment
7. Time from first hearing in FDAC to FDAC recommendation re case progression

8. Time from first hearing in FDAC to final hearing in FDAC
 9. Time from FDAC recommendation re case progression to final order
- I. End of case process results**
1. Pre- proceedings – results – number CIN, closed, proceedings started
 2. Pre-proceedings – results – number of cases in proceedings going into FDAC (as opposed to ordinary court)
 3. Contests – number of **cases** where there were contested hearings
 4. Contests – length of contested hearings
 5. Proceedings – order made at end of cases:
 6. (supervision order, care order, care order with placement order, SGO, SGO with supervision, Child arrangements order (covers residence and contact), child arrangements order with supervision order, no order)
 7. Children living with –first carer, other relative, other permanent carer, short term carer (foster placement)

Study background

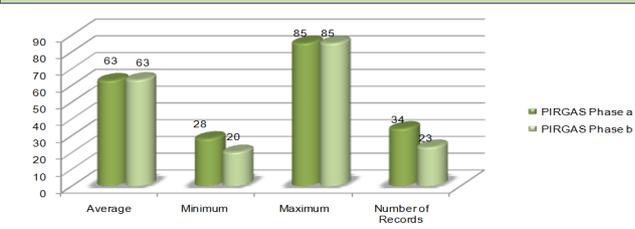
In October 2012, Westminster Family Service began implementing a set of outcomes measures with the purpose of evaluating the quality of the services offered and their impact on the children's and families' functioning and wellbeing. This study includes the systematic gathering, analysis and dissemination of a series of quantitative data for all families referred to WFS, the present report covering the period from October 2012 till August 2014. It opts to provide a clinically informed basis on which a critical thinking will be developed about the nature of current practices, including both validation of current approaches in the delivery of our services as well as new ideas and directions.

Methodology

Please refer to previous reports

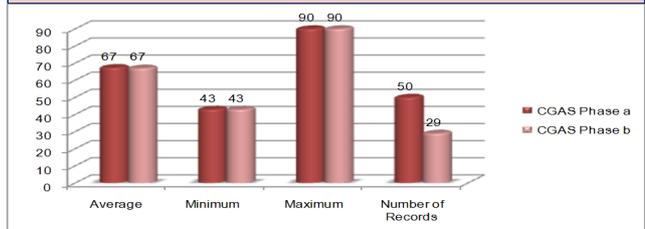
Results

PIRGAS (Parent-Infant Relationship Global Assessment Scale)



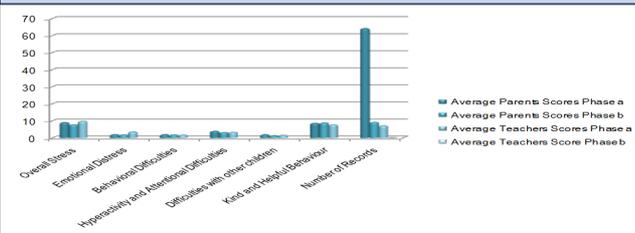
A child-parent relationship in the range of functioning 80-71 (Adapted) "evidences no significant psychopathology"
 A child-parent relationship in the range of functioning 70-61 (Perturbed) is considered "functioning, less than optimally in some way"
 A child-parent relationship in the range of functioning 60-51 (Significantly Perturbed) is considered "strained in some way but still largely adequate and satisfying to the partners"
 A child-parent relationship in the range of functioning 50-41 (Distressed) is considered "more than transiently affected but still maintain some flexibility and adaptive qualities"

CGAS (Child Global Assessment Scale)

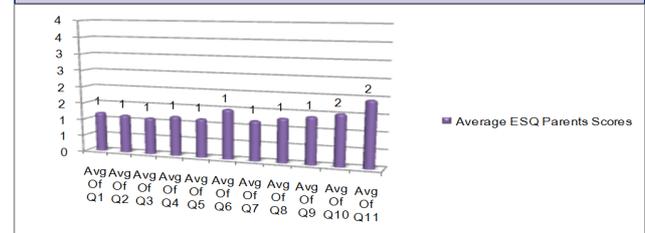


A child's functioning in the range of 50-41 indicates a "moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area"
 A child's functioning in the range of 60-51 indicates "variable functioning with sporadic difficulties or symptoms in several but not all social areas"
 A child's functioning in the range of 70-61 indicates "some difficulty in a single area but generally functioning pretty well"
 A child's functioning in the range of 80-71 indicates "no more than slight impairments in functioning"
 A child's functioning in the range of 90-81 indicates "good functioning in all areas"

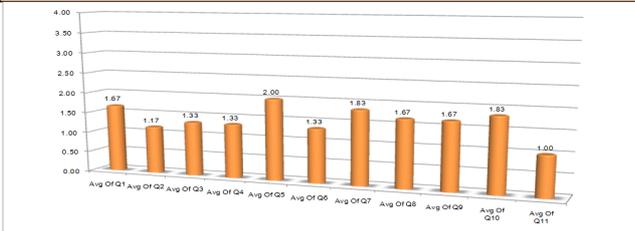
SDQ (Strengths and Difficulties Questionnaire)



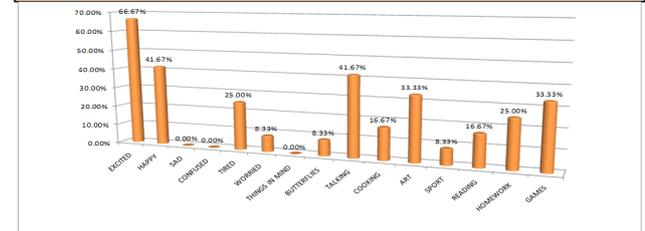
ESQ (Experience of Service Questionnaire)- parents' views



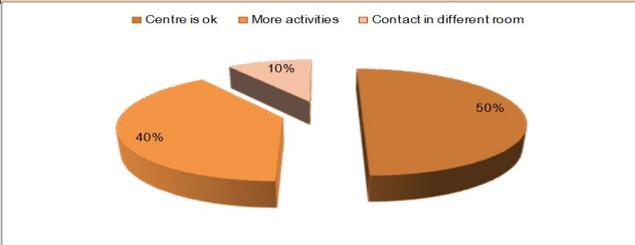
SEF (Service Evaluation Form) - children's views



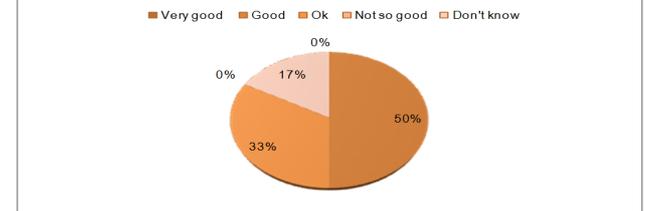
CTQ (Contact Time Questionnaire) - children's views



CTQ (Contact Time Questionnaire) - children's views



Overall quality of contact service



Parents' views of quality of service

- | Areas of satisfaction | Areas of dissatisfaction |
|--|--|
| <ul style="list-style-type: none"> Positive and friendly staff Staff talked about help available Staff listened and supported relationship with child Playing with child / seeing child Easy to discuss issues Good facilities (place, toys, garden) | <ul style="list-style-type: none"> Appointment times Room size Saturday / weekend contacts not available Post-case programmes not available Nothing is good |

Parents' goals-Thinking Space group (Goals Based Measure)

- "Knowledge and understanding of the way I act and behave towards my children and others"
- "I am here to hear what other parents' views is and my view of our problem and children and feelings...I want to do everything I can because I want to bring my son home, I am good mother but people judge as special social services"
- "I am happy to come to this class again, is been very helpful and great experience, I feel much better than 6-7 weeks ago"
 - "How we think about others"
 - "How we understand the others"

CAMHS Service Line Report - Westminster & FDAC

Board of Directors : February 2015

Item : 10

Title : CQSG Committee Report, Q3, 2014/15

Purpose:

This report gives an overview of performance of clinical quality, safety, and governance matters according to the opinion of the CQSG Committee. 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 Team

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

The notes from the Q3 meeting have been reviewed and approved by the Management Team but not by the CQSGC and therefore constitute a draft record.

This report focuses on the following areas:

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

For : Discussion

From : Rob Senior, CQSGC Chair

Clinical Quality, Safety, and Governance Committee

Notes from a meeting held at 11:00, Tuesday 3rd February 2015, Boardroom

2

Members	Present?
Rob Senior, CQSG Chair	Y
Angela Greatley, Trust Chair	Y
Dinesh Bhugra, Non-Executive Director	Y
Mary Burd, Public Governor	Y
Anthony Levy, Public Governor	Apologies
Paul Jenkins, Chief Executive	Y
Louise Lyon, Adult and Quality Director	Y
Rita Harris, CAMHS Director	Y
In attendance	
Pat Key, Director of Corporate Governance and Facilities	Y
Justine McCarthy Woods, Quality Reports Lead	Y
Sally Hodges, PPI Lead	Apologies
Caroline McKenna, CO & CA Lead	Y
Jessica Yakeley, PSCR Lead	Y
Simon Young, SIRO	From item 6e
Jonathan McKee, Governance Manager (& CQSG Secretary)	Y
Observing	
Gervase Campbell, Trust Secretary	To item 6

AP	Item	Action to be taken	By	Date
1	4	Explore solutions to the Portman's confidentiality concerns regarding the Outcome Monitoring tracking system	LL, JY	May 2015
2	5	Proposal to MT for any additional resources needed to meet revised TOR	JM	March 2015
3	6 (b)	Continue to pursue staff who have not completed OM requirements	RH, LL	Ongoing
4	6 (b)	Plan to address the issue of adult staff engagement with Outcome Monitoring to MT	JY	March 2015
5	6 (c)	Prepare proposal for Governance and Risk Adviser's post	RS, LL	March 2015
6	6 (c)	Extend root cause analysis training to key staff in the Adult department	LL	May 2015
7	6 (f)	Develop delivery plan for new data management group	LL	May 2015
8	6(h)	Request Associate Dean for Academic Governance and Quality Assurance to attend the CQSGC to report and develop links with DET and wider-governance	RS	May 2015

	Preliminaries	
		Action
1	Chair's opening remarks	

	Everyone was welcomed.	
3	<p>Notes from the last meeting</p> <p>A typing error was corrected; “reporting” was added to make clear the reference to targets in ‘Quality Reports’ was about quality reporting; these were then accepted as a true record.</p> <p>A reference to 10% should have read 100% [previously mooted target for interview panels to include a user, now to be an aspiration]</p>	
4	<p>Matters arising</p> <p>Matters not covered in work stream reports were addressed:-</p> <p>Portman staff and outcome-monitoring JY, as clinical governance lead for the Portman, was pleased to report staff had engaged with OM, but added that their results had not been uploaded onto the Trust’s tracking system due to worries by Portman staff about confidentiality. The committee felt that these worries were probably unfounded and that solutions should be explored.</p> <p>Temporary CQC work stream RS reported that the Board had approved the work stream [see item 6h].</p>	1LL, JY
5	<p>Revised CQSG TOR proposed to the Board</p> <p>Rob Senior circulated a paper setting out the rationale for change. The committee:-</p> <ul style="list-style-type: none"> • appreciated the clarity in the paper and agreed in principle • agreed that PPI activity needed to be embedded into practice at team level and must not be seen as a separate exercise undertaken centrally • looked to develop, with the Council of Governors, public engagement in particular • was keen to avoid conflating public engagement and service user engagement • looked to the development of public health related activity • wished to see more evidence of engagement with national bodies to influence national policy • agreed that the new work stream was, on balance, a better way to manage the various demands for assurance, and that it would be for senior staff to develop management arrangements to support activity and that a strategy and annual plan were indicated 	

	<ul style="list-style-type: none"> • 'SLMs' was changes to 'Directors' • Some small amendments were made to improve clarity • Management resources to make the structure work would need to be made available; a proposal to bring about the changes would be put to the MT <p>Members of the Committee expressed concern that further work needed to be done to ensure that the different elements contained within PPI were adequately addressed given the importance of engaging those who use our services and the wider public in the Trust's activities.</p> <p>The changes would come into effect from Q1 2015/16. The committee accepted the proposal.</p>	2JM
Reports from work stream leads		
6	<p>a) Corporate Governance and Risk</p> <p>Pat Key presented her previously circulated report and highlighted that:</p> <ul style="list-style-type: none"> • Safer recruitment training had been added to those areas being monitored; the Trust had made a good start despite problems with the externally mandated web site training tool • Several moves will follow the construction of a modular building and refurbishment of the previously vacated Monroe Centre due to the termination of the Centre Heights lease • The increase in the number of incidents at the Day Unit reflected the higher pupil numbers <p>The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place; the proposed green rating was confirmed.</p>	
	<p>b) Clinical Outcomes</p> <p>Caroline McKenna presented her previously circulated report and highlighted:</p> <ul style="list-style-type: none"> • CAMHS clinicians had reached 33% towards a 75% CQUIN target; the committee was concerned about the financial and reputation effect that this could have. Administrative staff were praised for chasing individuals; until returns are made. It was hoped that data capture improvements and pursuit of those who have not complied would enable the Trust to make progress • Portman staff had achieved 100% data collection (though see above) but there was some resistance and it took the resources of a psychology assistant to achieve this –not a cost-effective approach, and certainly not one that could be used elsewhere in the Trust. A plan to address the 	<p>3RH, LL</p> <p>4LL</p>

	<p>issue, especially in Adult services, will be put to the MT</p> <p>The committee:-</p> <ul style="list-style-type: none"> ❖ Was concerned that the CQC might take a dim view if collection rates do not improve ❖ Noted that that despite disappointed CO figures, patient experience questionnaire findings were very good ❖ Some teams had already established a can-do/will-do culture and that their returns were excellent <p>The committee accepted that action plans were in place and that an amber rating was appropriate</p>	
	<p>c) Patient Safety and Clinical Risk</p> <p>Jessica Yakeley presented her previously circulated report and highlighted:</p> <ul style="list-style-type: none"> • The level of reporting is holding up and this indicated that all incidents large and small were being identified and addressed • SUIs were being handled with due care and timeliness • the development of a self-harm reduction strategy is to be undertaken following a request from the Clinical Quality Review Group <p>The committee:-</p> <ul style="list-style-type: none"> ❖ Was concerned about a the gap in management resource as a replacement for the Governance and Risk Adviser’s post had not been developed; a proposal to be put to the MT as soon as possible ❖ Noted that the STEIS threshold was the trigger for reporting SUIs to the Board ❖ Was pleased that root cause analysis training had been undertaken in CAMHS and looked for this to be extended to Adult <p>The committee then accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place, and that a green rating was appropriate.</p>	<p>5RS, LL</p> <p>6LL</p>

<p>d) Quality Reports</p> <p>Justine McCarthy Woods presented her previously circulated report and highlighted:</p> <ul style="list-style-type: none"> • The CQRG is influencing management as their expectations evolve and emerge <p>The committee:-</p> <ul style="list-style-type: none"> ❖ Noted that physical health related CQUINS will be increasingly important and more of them will be applicable to the Trust <p>The committee then accepted the report as assurance on performance and accepted the rating as green.</p>	
<p>e) Patient and Public Involvement</p> <p>Rob Senior presented Sally Hodges' previously circulated report. The committee:-</p> <ul style="list-style-type: none"> ❖ Was pleased to note good progress to date <p>The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place. The proposed green rating was confirmed.</p>	
<p>f) Information Governance</p> <p>Simon Young presented his previously circulated report and highlighted:</p> <ul style="list-style-type: none"> • progress on training was being made and that efforts to meet the target had been stepped-up • progress had been made in several areas since the quarter end but that there was much to be done <p>The committee</p> <ul style="list-style-type: none"> ❖ was disappointed that several governors had not completed their IG training ❖ was pleased to note the formation of a new data management group, but wished to see a clear improvement delivery plan <p>The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place. The proposed amber rating was confirmed.</p>	7LL

<p>g) Clinical Audit</p> <p>Caroline McKenna presented her previously circulated report and highlighted:</p> <ul style="list-style-type: none"> • Plans were being developed to train staff in audit methodology • NICE guidelines were being reviewed and incorporated into Trust procedures <p>The committee</p> <ul style="list-style-type: none"> ❖ Noted that that Adult services were not as engaged as CAMHS ❖ Wished to see development between audit (drawing on NICE guidelines) and clinical outcomes ❖ Links with research could also be enhanced to good effect ❖ Engagement with influential external stakeholders would only be effective if the Trust could prove care was of the quality asserted <p>The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place. The proposed green rating was confirmed.</p>	
<p>h) CQC</p> <p>(i) Terms of reference</p> <p>These were noted.</p> <p>(ii) Report</p> <p>Louise Lyon presented her previously circulated report and highlighted:</p> <ul style="list-style-type: none"> • though the work had started as a project, a Project Board was in place and its final task would be to embed its work as business-as-usual • managing visiting lecturers was an area where arrangements were not always clear; there is a proposal to appoint one of the Associate Deans to lead on developing arrangements <p>The committee</p> <ul style="list-style-type: none"> ❖ directed the Associate Dean for Academic Governance and Quality Assurance should be requested to attend the CQSGC to report and develop links with DET and wider-governance ❖ was concerned that no permanent manager had been appointed to a role that would support the regulatory burden ❖ was concerned that two teams had not engaged with CQC preparation until prompted by the executive director leading on this work ❖ was pleased to note that the preparation process had prompted teams to engage with stakeholders and management to good effect 	8RS

	The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place. The proposed amber rating was confirmed.	
	Conclusion	
7	Any other business	
	None	
8	Notice of future meetings	
	11am, 5 th May 2015 11am, 1 st September 2015 11am, 3 rd November 2015	

Board of Directors : February 2015

Item : 11

Title : Review of the CQSG's terms of reference

Summary :

- This review is presented as requested in 2011.
- The committee has worked well and provides good assurance
- A streamlining of work streams is indicated and recommendations are made
- The Board is invited to commission the next review in 2019.

This report was reviewed by:

- The Management Team, 12th Feb 2015

For : Approval

From : Dr Rob Senior, CQSG Chair

Review of the CQSG's terms of reference

Introduction

In 2011, the Board established this committee and directed that a review of the TOR take place by March 2015. The work streams, and the CQSG as a whole, have undertaken an annual review of their work each year and this has not led to any significant changes. The Board accepted the reports as evidence that the committee was functioning as required. Since this time, much of what was deemed important in 2011 no longer seems to need the attention it once did, principally because of the good work undertaken in the meantime. In addition, external factors, such as new CQC rules, have also led to a need to evolve to maintain relevance.

Background

It is worth reiterating the basis upon which the Board understands governance:

The Board's committees are connected to the Board only; their function is to provide assurance directly to the Board, not to line manage the work of the Trust.

Individuals, not committees, are accountable for the delivery of work. Terms of reference need to reflect this fact in the language used in the duties section.

No part of the management structure is connected to board committees, though individuals and groups within the trust may be expected or commissioned by board committees to prepare reports. Board committees (such as the CQSG) can also function to support the work of the executive through providing leadership and direction and coordination. In addition, board committees are a forum to scrutinise outcomes, advise senior staff how standards might be improved, and provide assurance to the Board on these matters.

NEDs make an enormously valuable contribution to the work of the Trust, including within operational domains. This carries with it a risk, however, that they may be pulled out of role in a manner that makes the provision of assurance by NEDs of NEDs' work potentially very difficult.

On the CQSG, membership is enhanced by the inclusion of public governors. The role of these governors is to bring a patient perspective to the work of the committee, as well as providing the BG with an insight into the Trust's work and the performance of NEDs.

Annual reviews of each work stream are not repeated here, but it is useful to reflect on some of the findings. For example, on some occasions work streams have got into too much detail and presented very lengthy and repetitive reports on process and activity in which the link between strategic aims and evidence of operational delivery was confused. On other

occasions, work streams became embroiled in management of tasks in the absence of dedicated groups to address the issues. It has also been noted that having created the committee and its work stream leads, it is only relatively recently that middle management resources have been put in place to support the actual delivery. The group reviewing the TOR tried to hold these earlier findings in mind when undertaking the review.

FINDINGS

These are presented as a review of the work streams, then the implications of this review on the committee as a whole is set out. The implications for management of the work are outside the scope of this review but some suggestions are made.

PART A: DUTIES SET OUT IN THE TOR OF WORK STREAMS

There is no atypical work stream, each one is tailored to its function and is led by a senior member of staff.

1 : LEAVE ALONE!

The duties listed here were reviewed and it was felt that they were exactly what were required.

CGR functions at high-level to provide the assurance to the Board, whilst providing a forum to facilitate good management support. Its work is distinct having a corporate focus.

IG covers a very wide range of activity; it used to be part of CGR but the volume of activity was too great to contain it there. The Trust’s IG performance is specified in the national contract. Recently the format of reporting was changed to make it strategic.

PSCR is an area of critical risk for the Trust. Though a relatively small work stream, keeping it separate provides a useful focus.

The review group felt that subject to any proposed minor amendments, no changes were indicated.

A comprehensive IG training has been delivered by the Governance Manager	IG
Prospective submissions to the HSCIC (or successor body) are fit for purpose, and where there are shortfalls in the performance that action plans are drawn up and then monitored.	IG
That the Trust maintains an effective IG strategy and associated procedures that are fit for purpose	IG
That information assets are managed in accordance with the respective procedures and that external information governance submissions are accurate	IG
That reports on responding to the recommendation made by the external bodies following reviews and inspections are made on time and that the risk	IG

register is updated where appropriate	
That IG incidents are being managed effectively and in line with the Trust's procedures, and that all 9+ incidents are appropriately investigated, with outcomes documented in a quarterly report	IG
Prospective submission to the NHSLA are fit for purpose, and where there are shortfalls in compliance that action plans are drawn up and then monitored	CGR
That the Trust's maintains effective risk strategy and associated procedures that are fit for purpose	CGR
That non-clinical risk are effectively identified, assessed and managed and that the risk register is kept up to date with information about the management of these risks	CGR
That non-clinical incidents are being managed effectively and in line with the Trust's procedures, and that all 9+ incidents are appropriately investigated, through receipt of a quarterly report	CGR
That estate and facilities provide the optimal environment for therapeutic, learning, and related support activity [new]	CGR
There are reliable and robust systems and processes in place to ensure there is a workforce with the right skills, knowledge and experience to deliver effective care and treatment [revised]	CGR
That reports on responding to the recommendation made by external bodies following reviews and inspections are made on time and that the risk register is updated where appropriate	CGR
The Trust follows its processed on managing clinical incidents, complaints and claims	PSCR
The Trust learns lessons arising from clinical incidents, complaints and claims	PSCR
In the event of an SUI, the Trust follows its investigation procedure in relation to investigation – whilst being open with patients and relatives – and supports staff directly involved	PSCR
The Trust follows any agreed action plan arising from the investigation of an SUI	PSCR
Safeguarding arrangements for children and adults are effective and in line with the Trust procedure and pan-London procedures	PSCR
Clinical risks that the Trust's mission and annual strategic plan will not be delivered are adequately assessed and reviewed and the post-mitigation risk is captured on the assurance framework where indicated. [revised to make strategic link clear]	PSCR
The Trust responds in an appropriate and timely fashion to all relevant clinical safety alerts.	PSCR

2 : REMOVE FROM TOR AND REFER TO MANAGEMENT TO BE ADDRESSED AS BUSINESS-AS-USUAL

These items are important but are not the business of the Board, rather the business of the executive. It may well have been useful to have addressed them at a higher level some years ago whilst they became established as business-as-usual. Some suggestions have been added in square brackets.

That information security matters are effectively managed as confirmed by receipt of notes from the IT Manager	IG
That IG risks are effectively identified, assessed and managed and that the risk register is kept up to date with information about the management of these risks.	IG
That all request for information made under the Freedom of Information Act are responded to by the statutory deadline and that any trends are explored	IG
Arrangement for payment for results are fit for purpose	QR
Ensuring outcome data is utilised to shape service delivery [new]	CO
Arrangement to deliver CQUIN are fit for purpose	QR
The data quality is improving [refer to DARC]	QR
That non-financial SLM reports are fit for purpose	QR
Review patient information material to ensure the patient perspective is considered	PPI
Support PPI work of the Patient Advice and Liaison service	PPI
Provide support to membership activity, particularly the recruitment and retention of members	PPI
That Health and Safety matters affecting the staff are effectively managed as confirmed by receipt of notes from the Health and Safety Committee	CGR
That there is local monitoring in place on the levels of outcomes monitoring and that action is taken at Directorate Specialty level when levels of monitoring do not reach agreed target levels	CO
That there are improvements in outcome monitoring over the long term	CO
The Trust effectively supervises all clinical practitioners	PSCR
Reviews comply with the [Health Act 2006] {update ref} on reducing HCAs when undertaken and any recommendations are considered and implemented where appropriate	PSCR
The Trust follows robust record keeping practises (the audit lead will monitor progress of annual records audit plans)	PSCR
Clinicians' revalidation records are accurate	PSCR
That the Trust follows its procedures for responding to, and following guidance relevant to, practice; including NICE, and other external guidance.	CA
Compliance with the procedure for clinical audit	CA
Compliance with annual audit programme (including follow up of lessons learned)	CA
That clinical staff are engaged in audit of their practice	CA
That audit and reviews are commissioned as required	CA`

3 : [NEW] CLINICAL QUALITY EFFECTIVENESS AND PATIENT EXPERIENCE REPORTS

The wording of these requirements will be edited so that they link with the Board's strategic aims, and they have been brought together with a view to provide a single patient-focused forum for consideration.

That the implementation of recommendations made as a consequence of audit exercises lead to improvements in patient's care	CA
That SLMs lead on quality matters effectively [revised]	QR
That data to be collected has been agreed with commissioners and the adequacy of outcome measures reflect corporate planning and the needs of external assessors and commissioners [revised]	QR
Liaise with groups and stakeholders to ensure that consistent good quality information is made available to members, patients, stakeholders and relevant public groups about treatment options available at the Trust, to support patients making informed decisions about their treatment.	PPI
Receive feedback from the <i>Experience of Service Questionnaire</i> on a quarterly basis. The Committee will monitor action plans arising from PPI aspects of the feedback received via the annual PPI report.	PPI
Provide details on how public members' views influence strategic planning	PPI
Develop and raise profile of patient and public involvement in the work of the Trust and ensure that activity is co-ordinated and undertaken at service level [revised]	PPI
Receive assurance that the use of clinical outcome data has improved patient outcomes	new
That outcome monitoring methods in use in the Trust reflect best practice for our patient population	QR
Ensure action plans based on the findings reports on patient feedback and other PPI work result in improved patient care, the patient environment and the patient experience	PPI
That the annual programme is aligned with organisational objectives as set out in the annual strategic plan [revised]	CA

See appendix for final version.

4 : TASKS TO BE REMOVED

It was felt that these items provided work stream leads with no useful steer to their work and that they should be removed.

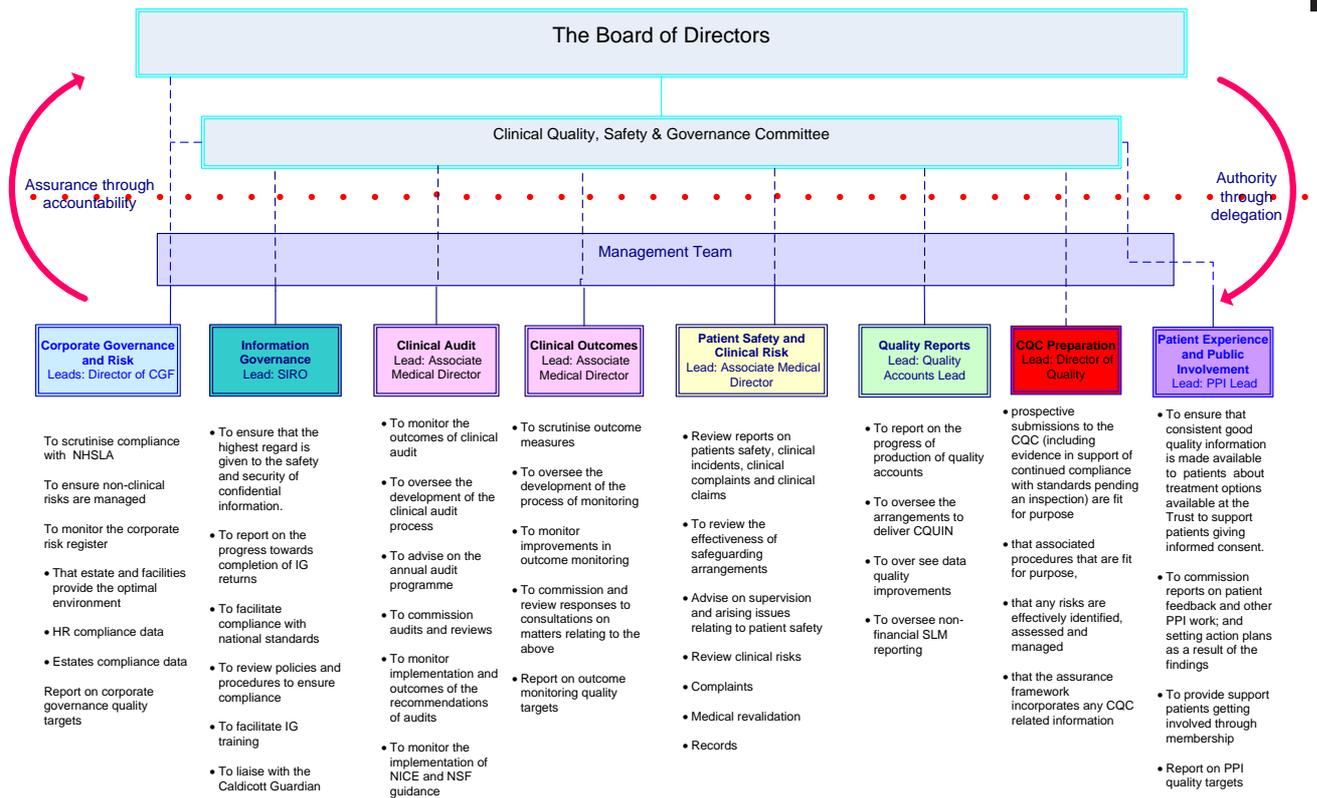
Quality accounts are produced to a high standard	QR
That guidelines on the nature of data are satisfactory	QR

PART B : IMPLICATIONS FOR THE CQSG TOR AND STRUCTURE

This section looks at what the CQSG did and how it fitted into the Board's structure, what is trying to achieve, and, having completed the review in part A, what the implications are for the structure. This is well expressed pictorially:

The CQSG now:-

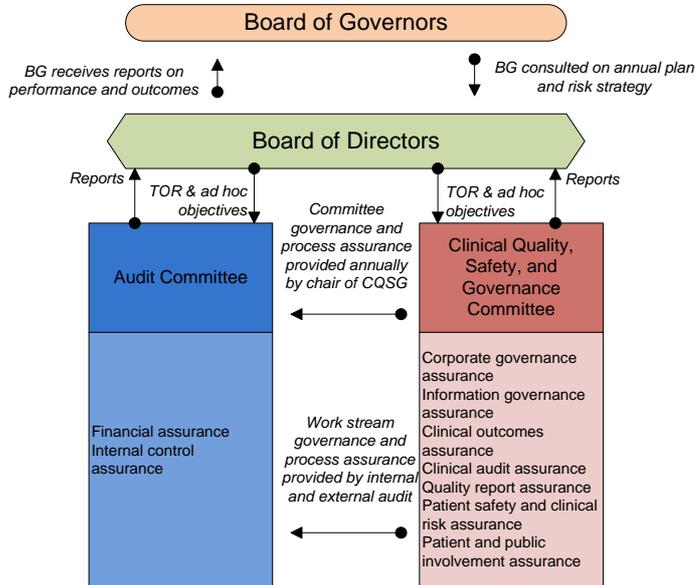
Reporting Quality, Safety, and Risk to Board of Directors



The impression of the working group was that much here was process orientated, and that whilst there may have been a time at which the Board wanted detailed assurance that these matters were being addressed, things had developed as a result of the work undertaken and that such detail was no longer required. It is also apparent that the practicality of presenting eight reports and giving each sufficient time and attention is a challenge in itself.

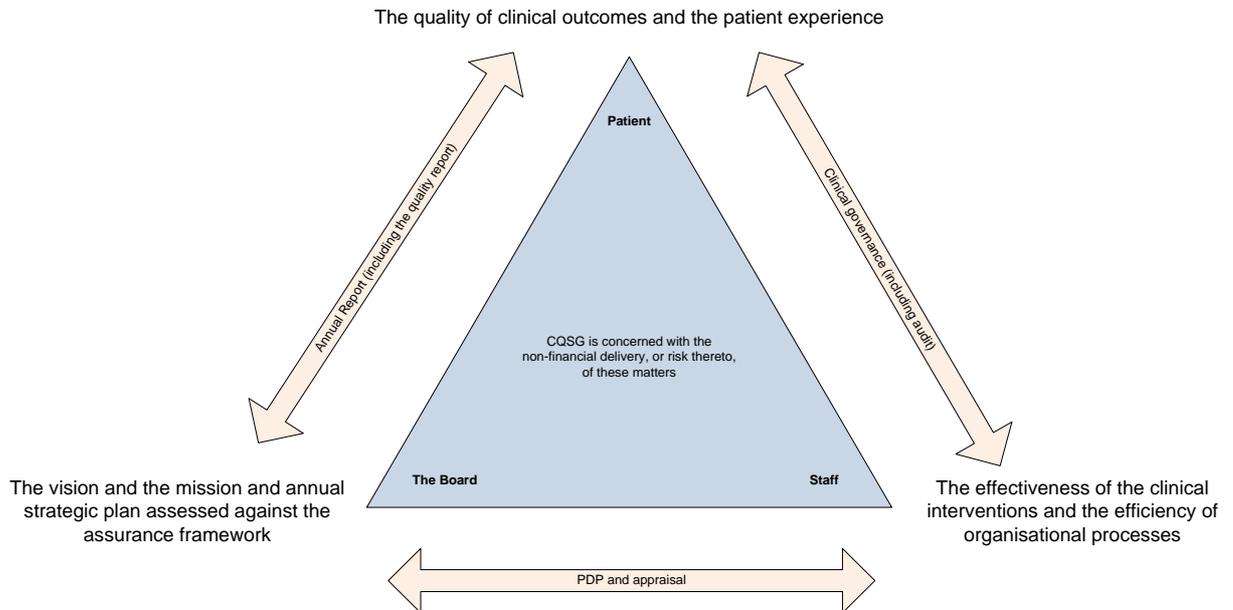
The CQSG within the Board structure:-

Provision of assurance to the BD -the role of the respective
BD committees and their interrelationship



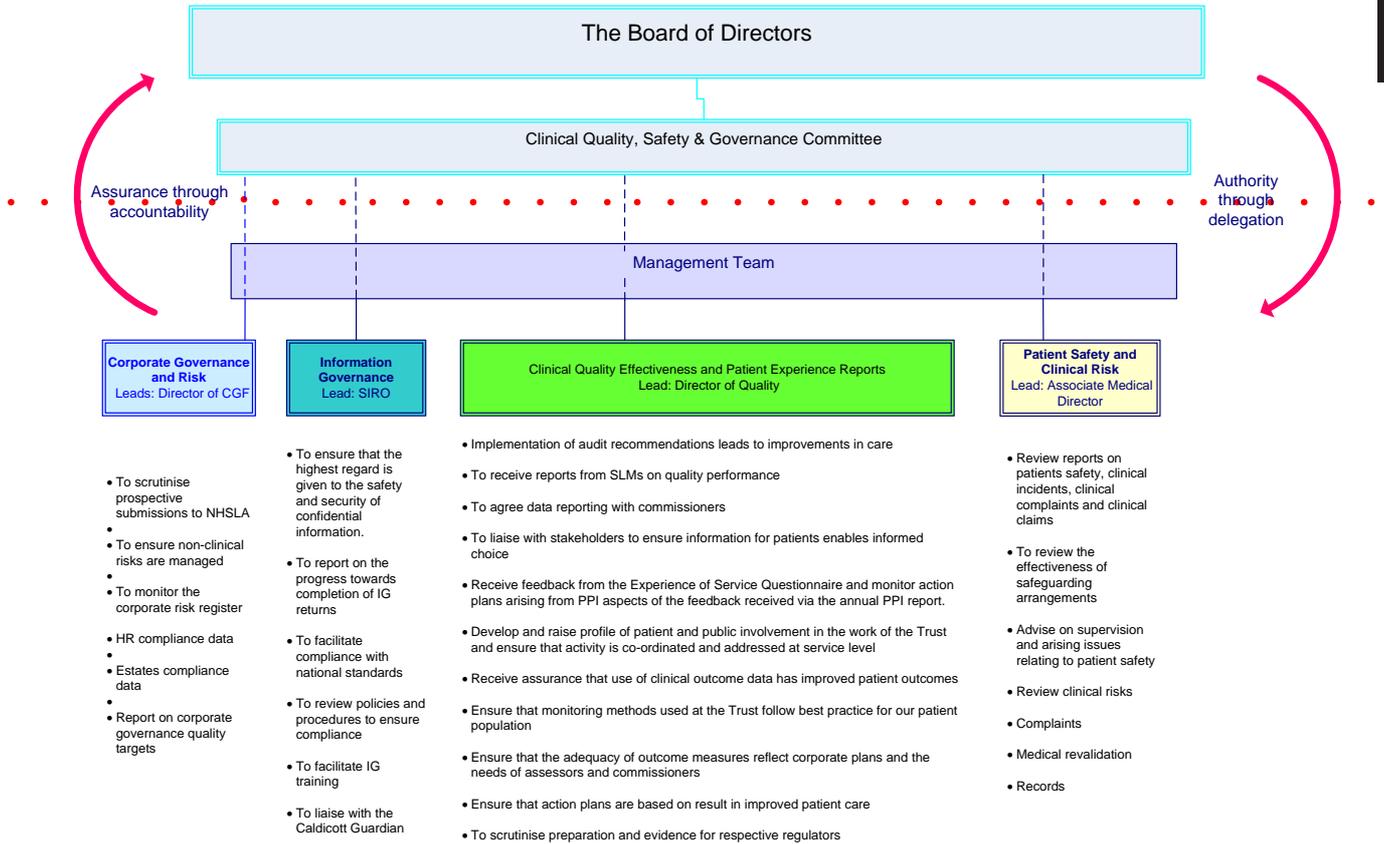
The review group was generally satisfied that this relationship was right and did not explore this further.

What the CQSG is trying to achieve:-



The CQSG as it could look as form is adapted to follow function:-

Reporting Quality, Safety, and Risk to Board of Directors



Checking back against the benefits anticipated in 2011 when the CQSG was established, indicates that the new structure will continue to meet those expectations:

- The system is clinically focussed and clinically led
- The approach should generate quality assurance that will stand up to robust challenge from external assessors
- The executive has a clear mandate and can focus its efforts on the development and delivery of high quality services
- The executive's performance is not scrutinised in public but at committee level, whilst the resulting assurance is scrutinised in the public domain
- The Board of Directors should have increased capacity to consider strategy
- The structure will allow Trust leaders to work in partnership with senior managers to deliver a whole systems product

- The Trust will be able to retain its excellent quality rating and work towards higher standards as set by the regulators
- NEDs will not be pulled out of role nor their contribution diluted
- Outcome results will inform the annual business planning process at the optimum point in the year so planning can be more effective
- Other areas, such as the NHS constitution, information governance can be included without any change to the system

It is envisaged that the new work stream report would be presented by the lead executive and that all existing work stream leads would continue to attend the CQSG meetings. It is likely that individual work stream leads will continue to meet in their own forums during the quarter. Work to follow-through the implication as a consequence of developments and changes in the Trust's staffing establishment needs to be considered in parallel.

Conclusion

The important work of each of the work streams should continue, and the opportunity should be taken to thank each lead for the hard work and perseverance involved in writing and presenting reports on areas for which they were not always responsible.

The reporting to the Board on assurance needs to change to provide assurance that the Trust's vision is being realised through the delivery of its mission as detailed in the annual strategic plan. At present no work stream does this explicitly and it is left for the board to fathom it out; not only is this a leaden approach, it does not provide staff with the inspiration to understand their own work in its strategic context.

Tasks that properly belong in the realm of management should be referred there. Some terms were updated to reflect the Board's strategic aspirations, whilst bringing focus on the patient in reporting structures. This focus complements the approach taken by the CQC.

Recommendations

1. That the proposed changes to work stream TOR are agreed
2. That the proposed changes to the CQSG TOR are agreed
3. That management put into place staff and systems to support this structure

Appendix : new TOR for the Clinical Quality, Safety and Governance Committee

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Committee to advise and support the Executive Directors who lead on clinical and corporate governance, clinical quality and safety and to provide assurance to the Board of Directors that clinical quality, safety, and governance are being managed to high standards. The Committee shall be known as the Clinical Quality, Safety and Governance Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

2. Membership

2.1 Membership of the Committee shall be as follows:

2.1.1 Medical Director (and Committee Chair)

2.1.2 Two Non-Executive Directors (one to be Deputy Committee Chair)

2.1.3 Up to two Governors

2.1.4 Chief Executive

2.1.5 Director of Quality, Patient Experience, and Adult Services

2.1.6 CAMHS Director

3. Attendance

3.1 The following staff shall be in attendance:

3.1.1 Director of Corporate Governance and Facilities

3.1.2 Clinical Governance Manager

3.1.3 Associate Medical Director (Safety, Revalidation)

3.1.4 Association Medical Director (Clinical Outcomes, Audit)

3.1.5 Quality Reports Lead

3.1.6 Patient and Public Involvement Lead [title may change]

3.1.7 Senior Information Risk Owner (for information governance, as required)

3.1.8 Governance Manager

3.1.9 Associate Dean for Governance

3.1.10 Acting Governance and Risk Adviser [to change to new role when appointed]

4. Quorum

4.1 This shall be at least one third of members, to include at least one Non-Executive Director.

4.2 Each member will be expected to attend at least 75% of meetings in any year.

5. Frequency of meetings

5.1 The Committee will meet four times per year.

6. Agenda & Papers

6.1 Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.

6.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

7. Minutes of the Meeting

7.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

7.2 Approved minutes will be forwarded to the Audit Committee for noting and the Board of Directors for discussion as required.

8. Authority

8.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

9. Duties

9.1 The Committee's primary duty is monitoring implementation of the Trust's strategic plan, providing assurance of compliance with regulatory requirements, and providing assurance that the Trust is providing best patient safety, governance and quality improvement practice. Where assurance of quality is not sufficient, or where unmitigated risks are identified, the Committee shall seek assurance that plans are in place to effect improvements. The Committee shall seek assurance for the following:

9.2 Corporate Governance and Risk

To receive assurance that

9.2.1.1 prospective submissions to the NHSLA are fit for purpose and that the submissions of information to Monitor on governance matters are well managed

9.2.1.2 the Trust maintains an effective risk strategy and associated procedures that are fit for purpose

9.2.1.3 non-clinical risks are effectively identified, assessed and managed and that the risk register is kept up to date with information about the management of these risks

9.2.1.4 non-clinical incidents are being managed effectively and in line with the Trust's procedures, and that all 9+ incidents are appropriately investigated

9.2.1.5 there are robust systems and processes in place to ensure that there is a workforce with the right skills, knowledge, and experience to deliver cost effective care and treatment

9.2.1.6 the estate and facilities provide the optimal environment for therapeutic, learning, and related support activity

9.2.1.7 reports on responding to the recommendations made by external bodies following reviews and inspections are made on time and that the risk register is updated where appropriate

9.3 Clinical quality, effectiveness, and patient experience

To receive assurance that

9.3.1 directors of clinical services have plans in place to improve the culture and practice of data collection, management, and quality

9.3.2 reports provide assurance that outcome data has improved outcomes at individual and patient group levels and that the results, where they can be benchmarked, compare favourably against those of other providers

9.3.3 outcome monitoring methodology and practice best suits the Trust's patient population

9.3.4 data to be collected have been agreed the commissioners and other appropriate external parties

9.3.5 the annual audit programme is aligned with organisational priorities as set out in the annual operational plan

9.3.6 the implementation of outcomes of the recommendations of clinical audits leads to improvements in patient care

9.3.7 information on outcomes facilitates patient choice and that any published information is of consistent good quality and is accessible and available to prospective patients and referrers

9.3.8 the feedback from Experience of Service Questionnaires is dealt with effectively, both individually, and by analysing trends and common issues

9.3.9 members contribute to strategic discussions to aid planning based on data from all available sources

9.3.10 the Trust has prepared for inspections from the regulator of clinical services

9.4 Patient safety and clinical risk

To receive assurance that

9.4.1 the trust follows its processes on managing clinical incidents, complaints and claims

9.4.2 the trust learns lessons arising from clinical incidents, complaints, claims, and other feedback

9.4.3 in the event of and SUI the trust follows its investigation procedure in relation to investigation, whilst being open with patients and relatives, and supports staff directory involved

9.4.4 the trust follows any agreed action plan arising from the investigation of an SUI

9.4.5 safeguarding arrangements for children and adults are effective and in line with the trust procedure and pan-London procedures

9.4.6 clinical risks are adequately assessed and reviewed

9.4.7 the Trust responds in an appropriate and timely fashion to all relevant clinical safety alerts

9.4.8 the Trust ensures confidential enquiries are handled efficiently and effectively

9.5 Information Governance

To receive assurance that

9.5.1 prospective submissions to the HSCIC (or successor body) are fit for purpose, and where there are short falls in performance that action plans are drawn up and then monitored

9.5.2 the Trust maintains an effective IG strategy and associated procedures that are fit for purpose

9.5.3 IG risks are effectively identified, assessed and managed and that the risk register is kept up to date with information about the management of these risks

9.5.4 IG incidents are being managed effectively and in line with the Trust's procedures, and that all 9+ incidents are appropriately investigated, out outcomes documented in a quarterly report

9.5.5 information security matters are effectively managed

9.5.6 information assets are managed in accordance with the respective procedures

9.5.7 that all requests for information made under the Freedom of Information Act were responded to by the statutory deadline and that any trends are explored

9.5.8 a comprehensive IG training programme has been delivered by the Governance Manager.

10. Liaison

10.1 The Committee will work with the Audit Committee to provide assurance that the process for managing risk is sufficient to meet the requirements of the regulatory bodies, and the needs of the Trust.

11. Other Matters

11.1 The committee may make minor changes to the terms of reference of reporting work streams

11.2 At least once a year the Committee will review its own performance, constitution and terms of reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

12. Sources of Information

12.1 The Committee will receive reports from the following:

12.1.1 Corporate Governance and Risk Lead

12.1.2 Director of Clinical Quality and Patient Experience

12.1.3 Information Governance Lead

12.1.4 Patient Safety and Risk Lead

12.2 The Committee may also commission *ad hoc* reports as required.

13. Reporting

13.1 The minutes of the Committee, once approved by the Committee, will be submitted to the Audit Committee for noting and the Board of Directors for discussion. The Committee Chair shall draw the attention of the Audit Committee or the Board of Directors to any issues in the minutes that require disclosure or executive action.

13.2 A quarterly Clinical Quality, Safety and Governance Report will be presented to the Board of Directors.

13.2 The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

14. Support

14.1 The Committee will be supported by a Secretary from the Director of Corporate Governance and Facilities' team.

Board of Directors : February 2015

Item : 13

Title : The Duty of Candour and the Fit and Proper Person Test:
Update and Action Plan

Summary:

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into force in November 2014. From that date the fit and proper person test and the duty of candour applied, whilst all other fundamental standards of care come into force from April 2015.

This paper provides an update on how the Trust is meeting the required standards. It includes a list of proposed actions, and it is suggested that an update on the progress of these actions should return to the Board in three months' time.

This paper was reviewed by:

- Management Team on the 12th February 2015.

This report focuses on the following areas:

- Governance
- Patient / User Experience
- Quality

For : Approval

From : Gervase Campbell, Trust Secretary

The Duty of Candour and the Fit and Proper Person Test for Directors

1. Introduction

- 1.1 The Department of Health has published the draft Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Regulations came into force in mid-November 2014.
- 1.2 The Regulations will introduce:
 - 1.2.1 A “fit and proper person” test for directors of health service bodies.
 - 1.2.2 Fundamental standards of care, including the duty of candour.
 - 1.2.3 A series of criminal offences where care standards do not meet new requirements.
- 1.3 The fit and proper person test and the duty of candour applied as soon as the regulations come into force, whilst all other fundamental standards of care come into force from April 2015.
- 1.4 The CQC and Monitor have published guidance on how Trusts should abide by the standards.

2. The Duty of Candour

- 2.1 The general statutory duty is to:

Regulation 20.1

“Act in an open and transparent way with service users (or, in certain circumstances, a person lawfully acting on their behalf) in relation to service user care and treatment”

Regulation 20.2

“As soon as reasonably practicable after becoming aware that a *notifiable safety incident* has occurred a health body must –

- (a) notify the relevant person that the incident has occurred in accordance with paragraph (3)
- (b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

- 2.2 In interpreting the regulations the CQC uses the definitions used by Robert Francis in his report:

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

2.4 In its inspections the CQC will consider the duty of candour under two of the KLOEs:

S2: Are lessons learned and improvements made when things go wrong?

○ Prompt: Are people who use services told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result?

W3: How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote good quality care?

○ Prompt: Does the culture encourage candour, openness and honesty?

2.5 In its detailed guidance on the Duty of Candour the CQC states that in meeting this component of the regulation, providers must consider the following:

2.5.1 There should be a board level commitment to being open and transparent in relation to care and treatment.

2.5.1.1 Whistleblowing was discussed at the board in March 2014, leading to inclusion of a whistleblowing clause in Trust contracts, and an updated Whistleblowing policy.

2.5.1.2 The Board received a report on the Duty of Candour in October 2014, and now this update.

2.5.1.3 The board receives a report on complaints annually, and in addition we have one NED, Ms Edna Murphy, who is the link for whistleblowing and complaints. In future an update on all whistleblowing cases will be presented by the Trust Secretary at the same time.

2.5.2 The culture of the organisation should encourage candour, openness and honesty at all levels, as an integral part of a culture of safety that supports organisational and personal learning.

2.5.2.1 Incident reporting training is given at each INSET day and in the Trust Inductions. This will now include explicit explanation of the Duty of Candour and the importance the Trust places on openness.

- 2.5.2.2 The Complaints team have worked with Communications to design a new poster advertising the complaints procedure, which will be displayed around the Trust.
 - 2.5.2.3 We will begin publishing a summary of number of complaints received and length of time to respond on the website on a quarterly basis. The House of Commons Health Committee recommended also publishing a summary of cases and actions taken, but it was thought that our low number of complaints would make maintaining confidentiality difficult if we gave this level of detail. The full details do go to the CQRG quarterly.
 - 2.5.2.5 Through the work of Rhona Hobday in visiting teams we now have a list of frontline staff's 'worries and concerns'. Work is being done in the Management Team on how this can inform the risk register, how the work being done on the issues can be fed back to staff, and how to maintain this valuable source of information in the future.
 - 2.5.2.6 Action plans resulting from Serious Untoward Incidents are followed up within various bodies within the Trust, for example the Child Safeguarding Board, but the Medical Director will discuss with the Patient Safety Lead, Dr Jessica Yakeley, whether there would be benefit in having a single group, reporting to the Patient Safety Work stream of the CQSG, to look at all the action plans resulting from SUI, serious complaints, etc, to track centrally whether the action plans are being followed, and lessons learnt more widely.
 - 2.5.2.7 We already share clinical lessons learnt through team meetings and cascades through the clinical directorates, but the Trust is looking at additional methods for sharing learning, including inclusion of key points within the new 'Quality News' newsletter.
 - 2.5.2.8 There is a Scientific Meeting in the Trust on the 11th May on the topic, "Is Anyone Listening: comments on the North Staffs Enquiry".
- 2.5.3 *The provider should have policies and procedures in place to support a culture of openness and transparency, and ensure these are followed by all staff.*
- 2.5.3.1 The Being Open and Duty of Candour policy has been updated to reflect the regulations and

- summarises the Trust's position on supporting staff and encouraging openness.
- 2.5.3.2 The Raising Concerns and Whistleblowing policy was updated in Jan 2015 to include details of keeping a central register and reporting incidents to the board annually.
- 2.5.3.3 The SUI and Incident Reporting have been updated to reflect the regulations and detail our process for identifying notifiable safety incidents and dealing with them appropriately
- 2.5.3.4 The Bullying and Harassment policy now includes a responsibility for HR to assess whether B&H incidents involve any aspects where attempts at whistleblowing or raising concerns have been constrained or blocked by managers, and to both encourage staff to raise these issues via the whistleblowing procedure, and also to report them to the Trust Secretary for inclusion on the Whistleblowing Register.
- 2.5.4 *The provider should take action to tackle bullying, harassment and undermining in relation to duty of candour, and must investigate any instances where a member of staff may have obstructed another in exercising their duty of candour.*
- 2.5.4.1 Human Resources investigate every bullying and harassment case that comes to their attention to check whether there are any openness or whistleblowing issues involved, and if there are, then to refer them to be dealt with under Trusts Whistleblowing procedures.
- 2.5.4.2 Human Resources, in partnership with our unions, offer training to staff and managers on managing bullying and harassment properly, which includes consideration of the duty of candour.
- 2.5.4.3 The Trust is introducing an external helpline to support staff in relation to bullying and harassment, and those staffing have been briefed on the importance of encouraging openness and candour within the Trust, and our policies on this, and will encourage staff to consider the openness and whistleblowing provisions if they are relevant.
- 2.5.5 *The provider should have a system in place to identify and deal with possible breaches of the professional duty of candour by staff who are professionally registered, including the obstruction of another in their professional duty of candour. This is likely to include an investigation and*

escalation process that may lead to referral to their professional regulator or other relevant body.

2.5.5.1 The Capability Procedure and Disciplinary Procedure include the requirement to maintain professional standards, including the duty of candour.

2.5.6 *The provider should make all reasonable efforts to ensure that staff operating at all levels within the organisation operate within a culture of openness and transparency, understand their individual responsibilities in relation to the duty of candour, and are supported to be open and honest with patients and apologise when things go wrong.*

2.5.6.1 The importance of a culture of openness is stressed in Trust wide inductions, clinical inductions, and the INSET day trainings. The training given on reporting incidents has been updated to explain the importance of the Duty of Candour.

2.5.6.2 Specific training is offered to staff on whistleblowing and openness.

2.5.7 *Staff should receive appropriate training, and there should be arrangements in place to support staff who are involved in a notifiable safety incident.*

2.5.7.1 Training is given in Trust wide inductions, Clinical inductions, and the INSET day trainings.

2.5.7.2 Staff involved in incidents are given full support by their supervisor, manager, and the wider directorate.

2.5.8 *In cases where a relevant person informs the provider that something untoward has happened, the provider should treat the allegation seriously, immediately consider whether this is a notifiable safety incident and take appropriate action.*

2.5.8.1 Our systems for analysing and responding to incidents have been updated to include the identification of 'notifiable safety incidents', a category defined in the new legislation, so that we can ensure we respond to these correctly and keep appropriate records to demonstrate this.

2.6 The 'Freedom to Speak Up' review was published on the 11th February. This is the review that Sir Robert Francis undertook over the previous 7 months looking at whistleblowing and creating a culture of openness in the NHS.

2.6.1 David Bennett, Chief Executive of Monitor, sent a letter to our CEO regarding the review and giving suggestions of how

managers could discuss it with their staff. This was circulated to our leadership group with details of our Being Open policy, and whistleblowing policy, and a request for it to be cascaded through teams to all staff.

2.6.2 The review makes a number of recommendations for specific actions boards should take forward. The key recommendations are:

2.6.2.1 Assess progress in creating and maintaining a culture of safety and learning, ensuring the culture is free from bullying.

2.6.2.2 Encourage reflective practice, individually and in teams, as part of everyday practice.

2.6.2.3 Have a policy and procedure built on good practice.

2.6.2.4 Talk about and publicly celebrate the raising of concerns.

2.6.2.5 Ensure staff have formal and informal access to senior leaders, including:

2.6.2.5.1 A 'Freedom to Speak Up Guardian', to be appointed by the chief executive.

2.6.2.5.2 An executive director and non-executive director be nominated to receive concerns.

2.6.2.5.3 A manager within in each department be nominated to receive concerns.

2.6.2.5.4 Staff have access to advice and support from an external organisation, eg a whistleblowing helpline.

2.6.3 As this review is so new the Management Team have not yet had time to consider the recommendations in detail, and it is proposed that an update on these recommendations come to a future board meeting with the progress report on the actions plan, below.

2.7 Action plan for Duty of Candour

• Whistleblowing clause included in contracts	Completed 2014	ST
• Updated whistleblowing policy	Completed 2014	ST
• Board to be updated on progress on DoC	May 2015	GC
• Annual complaints report at the Board to be accompanied by whistleblowing report	April 2015	GC
• DoC to be included in Trust wide Inductions	Feb	NN
• DoC to be included in INSET training	May	NN
• DoC to be included in Clinical Inductions	Sept	IH
• Complaints information posters to be displayed in Trust	March	PK
• Publishing summary of complaints quarterly	April	PK
• 'Worries and Concerns' list to inform risk register	April	LL
• Central 'Action Plan' review committee to be considered	March	RS
• Lessons learnt to be shared via the 'Quality News'	March	LL

- 'Being Open' policy has been updated Completed PK
- SUI and Incident Reporting policies have been updated Completed PK
- Bullying and Harassment policy has been updated Feb ST
- HR to routinely consider bullying and harassment cases for openness considerations. Completed ST
- External helpline to consider openness considerations End Feb ST
- Training available on managing bullying and harassment to include openness and duty of candour Completed ST
- Capability and Disciplinary procedures covers professional standards and the duty of candour Completed ST

2.8 The Board is asked to approve the steps detailed in this report and action plan for ensuring we meet the requirements of the regulations with regard to the duty of candour.

2.9 It is recommended that an update on progress with these actions, and the recommendations of the 'Freedom to Speak Up' review, should return to the Board in 3 months.

3. Fit and Proper Person Test for Directors

3.5 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 introduce a set of requirements individuals must satisfy in order to be appointed. The relevant paragraphs from the Regulation can be found in Appendix 1.

3.6 The Regulations are an extension of existing CQC regulations, and Condition G4 of the Monitor Licence.

3.7 The regulations cover Executive and Non-Executive Directors on the Board, but also, "an individual...performing the functions of, or functions equivalent or similar to the functions of, such a director".

3.7.1 For our organisation this would mean the test should apply to anyone who acts up to the board as an interim director.

3.7.2 In addition, we have decided to also apply the test to those directors who sit on the Management Team.

3.7.3 The tests have been applied to the new appointees to the Board, and Human Resources will begin to apply the test retrospectively to all existing members over the coming months.

3.7.4 The tests are supposed to be an ongoing process as well, so Human Resources will conduct annual checks of the

insolvency list and list of barred directors, along with DBS checks every three years in line with Trust policy. In addition the appraisal process for the relevant directors will be amended to ensure they meet the remainder of the requirements, including asking about health and fitness for the role. Records will be retained as evidence of ongoing compliance for CQC inspections.

3.7.5 In addition Directors will be asked to sign a declaration of their current good standing, and a commitment to inform the Trust if anything material should change in their circumstances.

~~3.8~~ The guidance states that where a director no longer meets the fit and proper persons requirement the Trust must take action to ensure the post is held by a person who does meet the requirements. To this end the contracts of directors on the board and management team will be amended to include a clause stating that if the director is no longer a fit and proper person their employment will end following due process as per Trusts Disciplinary Policy.

3.8.1 The most important area for meeting the regulations is to conduct adequate pre-employment checks, and keep good records of these. For Directors the pre-employment checks now include:

3.8.1.1 Take up references

3.8.1.2 Check qualifications

3.8.1.3 Conduct Occupation Health clearance, to ensure that the individual is able by reason of health, after suitable adjustments, of properly performing the tasks of the position.

3.8.1.4 Conduct DBS/CRB checks

3.8.1.5 Explicit checking of CVs for gaps, to be addressed at interview

3.8.1.6 An online check of previous employers to look for occurrences of mismanagement at those organisations contiguous with the candidates employment, to follow up at interview.

3.8.1.7 A declaration from candidates detailing the areas of good character, to be completed before interview.

3.8.1.8 Checks of the insolvency and Companies House list of disqualified company directors.

3.8.1.9 Keeping detailed records of these checks, and giving the Chair a summary of them once they have been completed.

3.8.2 Human Resources are confident that these checks meet the requirements of the regulations. They have updated their recruitment policy to detail the checks and the processes.

3.9 Action plan for compliance with the Fit and Proper Person Test:

- Pre-employment checks for new directors and members of MT strengthened to meet needs of FPPT Completed ST
- FPPT of current Directors and MT to be done Sept 15 ST
- Appraisals of Directors and MT to cover FPPT 2015 ST
- Directors & MT to sign declaration of good standing 2015 GC
- FPPT clause to be included in Dir.'s and MT contracts 2015 ST

3.10 The Board is asked to approve these steps for ensuring we meet the requirements of the regulations with regard to employing fit and proper people as Directors of the Trust

3.11 It is recommended that an update on progress with these actions, should return to the Board in 3 months.

Gervase Campbell
Trust Secretary
Jan 2015

Appendix 1

Paragraphs of the Regulations covering the Fit and Proper Persons Employed

Regulation 5 (2)

Unless the individual satisfies all the requirements set out in paragraph (3), the service provider must not appoint or have in place an individual –

- (a) As a director of the service provider, or
- (b) Performing the functions of, or functions similar to the functions of, such a director.

Regulation 5(3)

The requirements referred to in paragraph (2) are that-

- (a) The individual is of good character,
- (b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,
- (c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,
- (d) The individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and
- (e) None of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

Regulation 5(4)

In assessing an individual's character for the purposes of paragraph (3)(a), the matters considered must include those listed in Part 2 of Schedule 4.

Schedule 4, Part 1 – Unfit Person Test

1. The person is an undischarged bankrupt of a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
2. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(b).
4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and has not been discharged in respect of it.

5. The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
6. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

Schedule 4, Part 2 – Good Character

7. Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.
8. Whether the person has been erased, removed, or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Board of Directors : February 2015

Item : 14

Title : Patient Stories – summary and reflection

Summary:

The Board agreed last year to hear four patient stories, and then to take time to reflect on all of them together. This paper provides a summary of the four stories and suggests some initial conclusions from the cases for the Board to consider.

This report has been reviewed by the following Committees:

- Management Team, 12th Feb 2015

This report focuses on the following areas:

- Quality
- Patient / User Experience

For : Discussion

From : Paul Jenkins Chief Executive
Claire Shaw, Patient Stories Lead for PPI
Gervase Campbell, Trust Secretary

Patient Stories – summary and reflection

1. Introduction

- 1.1 At its July 2014 meeting the Board of Directors heard its first patient story. Since then a further 3 stories have been considered. At the outset of this initiative, the Board decided to create the space to reflect on the first couple of stories to consider how the initiative had been going and to think through the general lessons which had emerged from the stories listened to so far.
- 1.2 **Annex A** sets out a summary of the 4 stories and the issues raised in discussion with the Board. This paper attempts to highlight some of the key issues highlighted by the process and by the details of the stories considered.

2. How have the patient stories worked?

- 2.1 The inclusion of the patient stories in Board meetings has in general been an excellent initiative. The presentations have been very powerful and the discussions have been open and constructive. In two case stories have been delivered directly by patients themselves, in a third case the presentation was made by a family member and in a final case a written presentation was considered.
- 2.2 The individuals involved have been offered excellent support from both their own clinical teams and the Patient and Public Involvement team. The importance of such support is not to be underestimated and while all the stories have gone well we should not underestimate the potentially challenging nature of the experience for patients and family members.
- 2.3 The format of the stories has generally worked well and a period of around half an hour for the item seems to be about right. Some flexibility about timing is important so that we can fit in with the commitments of presenters. However, on the whole, the format of starting the meeting with the patient story where it can help set the tone for our discussions appears to work best.
- 2.4 The routine inclusion of a patient story does have an impact on the timings of the meeting as a whole. We may as a result need to consider extending the timings of the main meeting so that we can accommodate patient stories as a routine item.
- 2.5 All the format used so far have worked well but it would be possible to consider others such as video presentations.

3. What have we learnt from the stories so far?

3.1 A number of important themes have emerged from the stories so far. While there should be follow up of significant individual concerns or issues, in general, it is important to focus on the general messages emerging from the stories and, in particular, those which emerge consistently on a number of occasions.

3.2 Key messages have included:

- The impact, even for very experienced clinicians, of hearing the stories is significant. In particular there is a value from completed stories told from the patient's perspective which offer different insights from those gathered in normal clinical interactions. This reinforces the importance of including this as a mainstream activity in the Trust and of ensuring wider dissemination of the stories which do come to the Board.
- In general the stories have been positive and we should take much satisfaction at the evidently positive impact which the services we offer have had on individuals and their families. Without, however, any implication that stories have been "cherry picked" it is important that as part of the programme, in the future, we deliberately seek stories from some individuals where we know their experience of our care has been less positive. In addition, while positive views have predominated, there have been some important issues raised by patients about areas of our care and processes which have been less positive.
- A number of patients have highlighted the importance of identifying and responding to their wider needs beyond what can be addressed through therapy. This has included the value of peer and social support. These issues are not totally in the Trust's gift but could be enhanced by building stronger partnerships with voluntary sector and service user organisations as we are beginning to do.
- A number of issues were raised about how difficult it was on occasions to reach the Trust's services through gatekeeping arrangements operated by other agencies. There were also issues in some cases about our own appointments system making it more difficult for patients to access support. The stories stress the importance of prompt access to help at times of greatest anxiety for individuals and their families.

- The issue of the length of treatment and the ways in which the process of ending treatment is negotiated and managed was raised in a number of cases. The key message was around flexibility. The value of longer term treatment was recognised but in some cases treatment might have, appropriately, been finished earlier. The value of some follow up support was also highlighted.
- One story in particular (Mr D) highlighted the value of patients being able to raise issues about the impact of the way clinicians spoke about them and their issues. The ability of clinicians to respond to feedback constructively enhanced the effectiveness of the intervention.
- Issues were raised in some cases about a failure to communicate in sufficiently accessible language about the understanding of an individual's problem and the purpose of treatment interventions being offered.

4. Conclusion

- 4.1 The Board are asked to consider their paper and offer their own reflections on the process of Patient Stories and the lessons learnt from the 4 stories considered so far.

Paul Jenkins
February 2015

Annex A

Summary of the First Patient Stories Heard at the Board

Introduction

'Patient stories' enable people who have used our services to talk directly to those who develop and monitor the clinical services that the trust provides and can be a helpful reminder of the impact of these services on individuals. Patients may be motivated to talk to the board by a variety of factors, we hope that by talking to the board they are able to communicate a real sense of their experience of receiving treatment within the trust. As part of this process they will also share their thoughts on what they felt went well, as well as areas that could be improved upon. The sharing of a real story rather than a hypothetical scenario can have a strong emotional impact on listeners, who may be able to relate to the patient's experience or to the experience of those providing treatment. During times of organisational upheaval or change, stories, particularly those that show the trust in a more negative light, may be more difficult to consider. Patient stories may be shared in a variety of ways such as someone attending the meeting in person, a written account or through video link or film.

July 2014 – Mr A

Mr A had first attended the Trust with his wife in 1991, then returned alone in 2002 and joining a therapy group. He gave a candid explanation of the difficulties he had suffered, and was grateful for the help the group, and the Trust, had provided, but also had some comments about areas that could be improved.

Mr A commented on three main areas where improvements could be made:

- At the end of his therapy there was no follow up or further support – he suggested that even a single session 3 to 6 months after the end of therapy would be welcome, or some other way for the Trust to check up on an ex-patients progress.
- For those suffering panic attacks, which often occur late at night, a 24 hour help line staffed by those who had been through similar events would be enormously helpful, as it was the immediacy of assistance which was important, and the Samaritans weren't always familiar with the specific difficulties being faced. He commented that he had offered to be available to others by

phone, but the Trust hadn't taken him up on this because he wasn't a clinician.

- His main source of support over the years had been his wife, but there had been no support available for her in her role as a carer.

Ms Lyon commented that the Trust was better at managing the end of therapy than it had been. Ms Shaw noted that PPI had started a small reference group which looked at how the Trust might better support carers. Dr Senior noted that he had seen how important out of hours support could be for other groups, for example the frail elderly. Dr Harris commented that peer support was a way to address continuing support, and noted that FDAC had a strong system of mentors, albeit in a different context. Ms Jones commented that peer support was more common in the wider mental health environment, and the Trust should look into it.

September 2014 – Mr B

Mr B explained that his son, who was now 13, had been happy when younger but started having problems in school from Year 1, getting left behind by the system, with little independent play and depending on classroom assistants. In Year 4 he started pulling his hair out, and was originally diagnosed with alopecia, then trichotillomania, which led to a referral from his GP to the Trust four years ago.

At the Tavistock they had seen three people: CE, SH, and then HM. They had come to the Trust looking for a way to help their son cope with school, and had 'drifted' into the mental health field as the problems got worse. Worried about secondary school they had accepted an assessment for autism. The assessment had been thorough, and involved a number of sessions, some with family members, one involving observation from behind a two way mirror. Getting the diagnosis had proved very helpful to the family in managing the situation and in reassuring the parents that the problems weren't their fault.

Mr B had four main comments he wanted to share:

1. CE had been excellent, kind and sympathetic, but her final report was very technical and hard for lay people to understand – including a covering summary in simpler language for parents would be very helpful.
2. The appointments he had been offered had always been very considerate, but the process of confirming them by phoning an administrator was cumbersome and he would have preferred email confirmations and text message reminders.

3. Sharing information and reports with the SENCO at the schools was very important, and had been slow in practice. Mr B suggested that in the future it might be better to put the onus onto the parent, to give them the report to pass to the school.
4. Mental health issues never really end, they change as the child grows, but there needs to be a point where treatment stops. Commenting on his own personal history he noted that knowing you were able to go back to clinicians allows you to stop treatment if you think you don't need it at a particular juncture in life.

Mr Jenkins thanked Mr CJ by summarising the discussion by noting that the Trust needed to be aware of how the package offered was perceived by the patient, and that the appointment system may protect busy clinicians but be difficult for parents, with email preferred but not offered.

October 2014 – Ms C

Ms C was not able to attend in person, but sent a very helpful written story, summarised below, followed by the minutes of the Board's discussion.

Story in brief:

We are a family of four. We have two children, one is J is 6 and the other B is 10. We were referred by B's school - as I requested a referral because he was acting very strangely in the playground, in a paranoid way, and his development clearly wasn't right. My kids had been through the stress of their Dad leaving home; multiple subsequent house moves and we had been trying to navigate how access would work since he had been diagnosed with Bipolar type 2. This had all caused me a lot of stress and that again was impacting on my own mental and emotional health - and that of the children.

Services received:

As soon as we arrived at the Tavistock, they understood the complexity and long standing nature of the issues we were facing. It was a genuine relief to talk to someone who could see the problem, or that there was a problem. We had family sessions with a therapist; I had individual therapy for 6 months to resolve lifelong issues and build my own resilience to stress; and then my son, B joined the children's group for a year; and I came to the concurrent adult sessions for the whole year.

Great Things

* The main great thing for us has been the outcome - my son really is so much better - the teachers say - 'oh B is normal now'; another mother said her son said to her 'B is like a different child'; B now has friends at school, he goes to play sport and circus skills out of school. As a family we are much more together and organised. The kids understand that their dad is ill, and they can talk about it and discuss it with others outside of the family. They can cope now when he lets them down, and can process the reasons.

* The impact has also been on our family - the therapy which was for B has had a massive impact on everyone around me as far as I can see. The grandparents on both sides now have

good relationships with myself and my ex - and with the children; we feel like a family. My own health is back. The group work was incredible, and I learnt so much and worked through so much; I just am a better parent and person all round.

- * All of the therapists have been amazing and really known what they were doing and I have observed the changes that their work has brought about week by week, and how that has built up to a larger impact through incremental changes.
- * The length of the support is really amazing, and it does take time for therapy to work so it is great that this is available.
- * The centre is a really lovely place to come, it feels like a respectful place, it makes you feel human - rather than like a patient.
- * The range of therapies is fantastic. The mindfulness course was a brilliant thing to do and really well run
- * The quality of the individual therapists - and the sense of the organisation being research backed - gives you the confidence you need to be able to trust in a process which is quite frightening to engage with at a time when you are vulnerable.
- * One of the things I found really useful was that my personal one to one therapist was from a minority ethnic British background- it made a big difference to me to have someone who could really understand the huge issues that come with cross cultural upbringing and to whom I didn't have to try to bridge a gap in understanding those things - I think that was a big factor in helping the therapy to work for me. Implicit, lived understanding of multi-cultural heritage.

Tricky things

Gatekeepers

I think that the main issue that you might want to think about is not directly in the control of the Tavistock, and that is gatekeeping. I asked at my son's school for help two full years before arriving at the Tavistock. The school CAHMS representative and the school decided that we did not need help, when in fact I believe that things were very critical at that point. Things had got really bad by the time I got settled at the second school; and managed to persuade them to refer me to your services.

Attendance

I think that we really struggled with getting my ex-husband to come to sessions. Partly perhaps because I was more in control - as always - and that it is difficult to get buy in from the other person in that situation. But also partly because of his illness meaning that even setting appointments well in advance could not guarantee that he would be well enough to come in. I am not sure what the way around that is? It must be very difficult to schedule for patients who are often not well enough to come in.

Fears

It was a massive leap of faith for me to let B go to the kids group. Firstly the wider family were very fearful of it. Secondly, it was counter intuitive for me to send my child who was fragile and vulnerable in nature to a group with a mix of aggressive and quiet children. The group was always managed well, and I trusted the process. I do feel that it worked in building B's resilience and he has shown pretty much full recovery at school. I have however requested a rest from his having therapy because it is in school time and being taken out of school was quite disruptive for B.

After the Board had read the story together, Ms Lyon began the discussion and various board members contributed their insights. Some of the key points taken were:

- The importance to the patient of the ethnic origin of the therapist, of having a therapist from a minority background. Whilst this may not be the case for everyone, it highlights the importance of attempting to have our clinical workforce reflect the population we serve, in all aspects of diversity.
- The length of the treatment, and the variety of treatments we offered. This is a very positive aspect of the way we help people, and we should highlight the way we put together a range of different support services for families, and the flexibility we exhibit in listening to feedback and adjusting what we do.
- How long it took for the child to reach our services. This isn't something under our control, but it is distressing that the child could have received help earlier, and perhaps there is more we could do with consultations for teachers as well as educating them on our services and referrals, or indeed in getting involved in training teachers to help them manage the emotional wellbeing of their pupils.

January 2015 – Mr D

Dr Jessica Yakeley, Consultant Psychiatrist at the Portman Clinic, introduced 'Mr D', who had been her patient for 18 months in individual and group sessions, and was now discharged and staying in touch with intermittent follow up visits.

Mr D explained that he had been convicted for possession of offensive weapons and sentenced to two and a half years custodial and two and a half years probation. On probation he was informed that because of his risk level he was not allowed to work or return to education until he had a psychological assessment. The first assessment did not go well, but the second assessment was with Dr Yakeley and led to him starting at the Portman.

Mr D noted that he had suffered various traumas and abuse in childhood and grew up to feel that forcing people to do things was an acceptable way to behave, and didn't realise that he was violent and aggressive. Life was filled with constant frustration, and he did not know why.

Joining the group allowed him to talk to people he wouldn't have done otherwise, and he came to realise that he could use his brain instead of violence to relate to other people, and was better able to read situations and gain control through knowledge. He stressed that the abused never feel control or power over their lives and so this got distorted.

Dr Bhugra asked what he would have liked more of from the service. Mr D replied that the service is as good as the user, and what is important is how the user engages with it.

Mr Holt asked whether 18 months had felt like the right length of time for the sessions. Mr D commented that he felt he had achieved his goal in a year, but kept with the sessions as he continue to learn and could contribute by interpreting and helping express problems other members were sharing.

Dr Harris asked what his friends and family might say about how he had changed. Mr D said they would notice he was a lot calmer, that he hoped they would see a change.

Mr Jenkins asked whether looking back he thought something could have been done earlier, or was it going to jail that made the therapy possible. Mr D commented that he first sought counselling in prison, but it wasn't prison that was necessary, he had started having flashbacks and felt it was a fault to be addressed, and when the opportunity came up he took it.

Gervase Campbell
Trust Secretary
February 2015

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 24th February 2015, 14.00 – 16.20
 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.10
4.	Matters arising Ms Angela Greatley, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	Trust Chair's and NED's Report Non-Executive Directors as appropriate	To note	Verbal	-
6.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To note	Enc.	p.11
7.	Finance & Performance Report Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.14
8.	Training and Education Programme Board Report Mr Brian Rock, Director of Education & Training, Dean	To note	Enc.	p.24
9.	CAMHS Service Line Report – Westminster & FDAC Dr Rita Harris, CAMHS Director	To discuss	Enc.	p.30
10.	Clinical Quality, Safety and Governance Report – Quarter 3 Dr Rob Senior, Medical Director	To approve	Enc.	p.51

11.	Clinical Quality, Safety and Governance Report – Terms of Reference Dr Rob Senior, Medical Director	To approve	Enc.	p.59
12.	Draft Operational Plan Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	late	-
13.	Duty of Candour/Fit and Proper Person Test Mr Gervase Campbell, Trust Secretary	To discuss	Enc.	p.76
PATIENT STORY				
14.	Patient Story – Review and Discussion Ms Clare Shaw, Patient Stories Lead for PPI	To discuss	Verbal	p.88
CONCLUSION				
15.	Any Other Business		Verbal	-
16.	Notice of Future Meetings <ul style="list-style-type: none"> • Wednesday 4th March 2015: Joint Board Meeting, 2.00pm – 4.30pm, Lecture Theatre, Tavistock Centre • Tuesday 10th March 2015: Leadership Group Conference, 9.00am – 1.00pm, Lecture Theatre, Tavistock Centre • Tuesday 31st March 2015: Board of Directors Meeting, 2.00pm – 5.00pm, Board Room, Tavistock Centre • Tuesday 28th April 2015: Board of Directors Meeting, 2.00pm – 5.00pm, Board Room, Tavistock Centre 		Verbal	-