

## Board of Directors Part One

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

2.00pm–4.00pm  
Tuesday 26<sup>th</sup> May 2015

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



## BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 26<sup>th</sup> May 2015, 14.00 – 16.00  
Board Room, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

### AGENDA

PRELIMINARIES				
1.	<b>Chair's Opening Remarks</b> Ms Angela Greatley, Trust Chair		Verbal	-
2.	<b>Apologies for absence and declarations of interest</b> Ms Angela Greatley, Trust Chair	To note	Verbal	-
3.	<b>Minutes of the previous meeting</b> Ms Angela Greatley, Trust Chair	To approve	Enc.	p.1
3a.	<b>Outstanding Actions</b> Ms Angela Greatley, Trust Chair	To note	Enc.	p.9
4.	<b>Matters arising</b> Ms Angela Greatley, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	<b>Trust Chair's and NEDs' Report</b> Non-Executive Directors as appropriate	To note	Verbal	-
6.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To note	Enc.	p.10
7.	<b>Finance &amp; Performance Report</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	late	-
8.	<b>Training and Education Report</b> Mr Brian Rock, Director of Education & Training; Dean	To note	Enc.	p.12
9.	<b>CQSG Report, Quarter 4, 2014/2015</b> Dr Rob Senior, Medical Director	To approve	Enc.	p.16
10.	<b>Service Line Report – Camden CAMHS</b> Mr Andy Wiener, Associate Clinical Director CAMHS	To note	Enc.	p.23
11.	<b>Annual report and Accounts</b> a. Annual Report b. Annual Accounts c. Letters of Representation Mr Simon Young, Deputy Chief Executive & Director of Finance & Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.56 p.166
12.	<b>Annual Quality Report</b> Dr Justine McCarthy Woods, Quality Lead	To approve	Enc.	p.175
13.	<b>Developing a 2 year Strategic Plan Consultation</b> Mr Paul Jenkins, Chief Executive	To discuss	late	-

14.	<b>Documentary Films Proposal</b> Ms Laure Thomas, Director of Marketing and Communications	To note	late	-
15.	<b>HR Action Plan from 2013 Staff Survey update</b> Ms Susan Thomas, Director of Human Resources	To note	Enc.	p.250
16.	<b>Duty of Candour &amp; FPPT: Action Plan update</b> Mr Gervase Campbell, Trust Secretary	To note	Enc.	p.253
17.	<b>'Freedom to Speak Up' Report</b> Mr Gervase Campbell, Trust Secretary	To note	Enc.	p.257
18.	<b>Jimmy Savile Recommendations Report</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.267
19.	<b>Annual Governance Statement (part 1)</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.273
20.	<b>Use of Trust Seal</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.275
21.	<b>Patient Story – video of patient</b> Anthony Newell, Patient Experience Manager	To note	-	-
<b>CONCLUSION</b>				
22.	<b>Any Other Business</b>		Verbal	-
23.	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"> <li>Tuesday 9<sup>th</sup> June 2015: Directors' Conference 12.00pm – 5.00pm, Lecture Theatre</li> <li>Tuesday 23<sup>rd</sup> June 2015: Board of Directors Meeting 2.00pm – 5.00pm, Board Room</li> <li>Thursday 25<sup>th</sup> June 2015: Council of Governors Meeting 2.00pm – 5.00pm, Board Room</li> <li>Tuesday 14<sup>th</sup> July 2015: Leadership Group 12.00pm – 5.00pm, Lecture Theatre (tbc)</li> </ul>		Verbal	-

## Board of Directors

### Meeting Minutes (Part One) Tuesday 28<sup>th</sup> April 2015, 2.00 – 4.00pm

Present:			
Ms Angela Greatley Trust Chair	Ms Jane Gizbert NED	Dr Rita Harris CYAF Director	Mr David Holt NED
Mr Paul Jenkins Chief Executive	Ms Lis Jones Nurse Director	Ms Louise Lyon Director of Quality, Patient Experience and A&FS	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)	Mr Mark Pearce Governor	Ms Laure Thomas Communications and Marketing Director (item 12)	
Apologies:			
Dr Ian McPherson Non-Executive Director & Vice Chair of Trust	Prof. Dinesh Bhugra NED		

#### Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor changes to be made to the minutes	GC	Immd.
2	6	Address addition of NEDs to 'everyone' email list	GC	May
3	10	Circulate more details of waiting time data, including average wait.	JMW	May
4	11	Produce summary sheets for every service	LL	July

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

Ms Greatley opened the meeting.

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

Apologies as above.

There were no declarations of interest specific to this meeting.

Mr Campbell noted that Mr Holt had declared a new interest for the register – with effect from 20<sup>th</sup> April he is deputy chairman and chair of the audit committee for the Ebbsfleet Development Corporation.

#### AP1 3. Minutes of the Previous Meeting

The minutes were approved subject to minor amendments

#### 4. Matters Arising

Action points from previous meetings:

AP1 – (minor changes to minutes) – completed.

AP2 – (communicate year-end financial situation to staff) – this had been completed, but it was noted that a further message would be appropriate when the year end results were signed off.

AP3 – (arrange a broad equalities event) – it was noted that this might be better held in the autumn.

AP4 – (proposal for 360 to be taken to leadership group) – this was on schedule.

Outstanding action points:

OAP6 – (NED invited to link to KLOE) – invitations had been sent, completed.

OAP4 – (Coordination of NED Visits) – list of sites to visit agreed and circulated to NEDs, complete.

No further matters arising.

## **5. Trust Chair and NEDs' Report**

Mr Holt noted he had attended the HFMA audit conference.

Ms Murphy noted that the research work and links with universities were progressing.

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

Mr Jenkins noted that the Essex CAMHS bid had been submitted on the 10<sup>th</sup> April, and whether we were successful or not valuable lessons had been learnt both on the Thrive model, and on tackling challenges of this size. Mr Young commented that the bid had been submitted after it was circulated for approval, supported by members, and approved by the CEO and Chair on that basis.

GIDS had again been in the media, and Mr Jenkins commented that this sort of unthinking attention was natural given the work they did, and Ms Laure Thomas and Ms Emma Heath had done a lot of work on proactively getting more deliberate stories reported as well. Ms Gizbert commented that the improved agility, and the bank of spokespeople, were positive steps, and that giving spokespeople the training and support they would need was important. Mr Jenkins commented that as well as doing this in house they would be able to use some of the infrastructure that the Cavendish Group had for this purpose.

Mr Jenkins talked about developing the 2/3 year strategy, which would incorporate the work on mission and values, and about which he hoped to consult Governors and staff after May, with the aim of agreeing it at the July board.

**AP2** Mr Holt noted that the NEDs did not always receive the media updates, or

board summaries as they were not on the 'everyone' email list, and it was agreed the Trust Secretary would address this.

The Board **noted** the report.

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

Mr Young explained that the 2014/15 accounts had been submitted to Monitor as required, but there was a small difference from those agreed by the Board, with the restructuring costs now £935k as £55k had been incorrectly classified.

The financial situation for the month was as expected and a good outcome for the year, although that did not help with the budget for the coming year. There were some minor changes to some contracts and costs since last month, and these related to what would be reported to Monitor, as they requested that figures in the plan should be those agreed by commissioners. Mr Holt clarified that although the contingency had moved the bottom line was unchanged.

Mr Young noted that the accounts would go to the auditors now, and would return to the board next month for approval with the auditors' opinion.

The Board **noted** the report.

## **8. Training and Education Report**

Mr Rock introduced his report, noting that the new project board for ICT had done substantial work engaging with suppliers over the student management system. They had held their first validation event with the University of Essex, which had gone very well and the feedback on the course was generally very positive. A programme of validation events is underway over the next couple of months to ensure that all courses have secured full or interim validation in time for the 2015/6 academic year.

Ms Greatley asked about the timetable for the ICT process, and Mr Jenkins noted that it would be a shame to have to wait until the end of September, and so an approval process similar to that used for the Essex bid might be appropriate, with the board having sight of material before and either agreeing by email or delegating this to a smaller group.

Ms Greatley questioned whether the issue of subsequent registration for students might be a problem, paragraph 4.5. Mr Rock commented that it could have implications both for students and the Trust's resources, and

they would be discussing it further with the University of Essex.

Mr Holt noted that the IT assessment referred to in para. 6.5 had been debated at the audit committee as well. After discussion it was clarified that this was a specific assessment to be conducted by internal staff to address known issues and would operate in addition to the auditor's wider review.

The Board **noted** the report.

## **9. Q4 Governance Statement**

Mr Young noted that the risk assessment framework was changing for the coming year, with additional indicators that were currently being considered by the Management Team, but that did not affect the format of this statement.

Mr Young noted that the governance indicators on page 32 were as in previous quarters, with the data completeness well clear of the 92% target. He went through the financial indicators in detail, explaining how the capital service cover rating and liquidity rating were calculated, and how they combined into the Continuity of Service rating, which was projected to be 3 over the coming year, which was satisfactory.

The Board **approved** the statements.

## **10 Q4 Quality Report**

Dr McCarthy Woods took the Board through the quality indicators of the report in depth, noting that most targets had been met and exceeded, including waiting times, DNA rates and patient satisfaction, which was at 93% for the quarter. Overall it was reassuringly positive, with some points on which they had been worried seeing recovery, and that better systems of monthly review were now in place and working well.

Ms Murphy asked if the average or median wait was available, rather than the number that breach waiting time targets, because that could be a useful indicator of trends. Mr Holt added that it would also be a useful way to get assurance on the accuracy of the figures. It was agreed that further details of waiting times including the average wait would be circulated to the board.

Dr McCarthy Woods noted that attendance at safeguarding training was between 94% and 100%, depending on the level. She gave full details of the reasons for each person who had not been trained, as requested last quarter, noting that there were no repeat offenders, and all were booked

**AP3**



into the next available course.

She noted that the CORE score (indicator 4b, improvement from pre-assessment to post-assessment) was only 57% and target had been missed. She was not yet sure why this was, as in previous quarters it had been around 62%, but suspected it was in part due to a low return rate this quarter, and they would be looking at it in more detail. Dr Senior noted that this indicator was useful for benchmarking, but was not so helpful as a way to pick up change, and goal based measures were a better way to think about outcomes. Ms Lyon commented that there might only have been one session between pre- and post- assessment surveys, which was too soon to see progress, and noted that the CORE indicator 4a (improvement from pre-assessment to end of treatment), was a better tool and there the target had been met.

The Board **noted** the report.

## **11 Draft Annual Quality Report**

Dr McCarthy Woods presented the draft of the Annual Quality Report for comments, noting that the final version would come to the May Board for approval.

Mr Holt asked whether it would be possible to move away from the technical language used in the opening statement to something more accessible. Ms Greatley commented that a lot of the format was set, and they needed to consider the main audience which was commissioners, but if possible, perhaps by annotation, it should be made more readable.

The Board made a number of comments about details of the content, and agreed to forward anything further outside the meeting.

Mr Jenkins commented that one of the most accessible elements of the report was the summary sheets for individual services, and suggested it would be helpful if every service could produce something similar. Ms Lyon agreed to take this forward.

**AP4**

The Board **noted** the report.

## **12 Century Films Tavistock Documentary Update**

Ms Laure Thomas reported that the research phase was over, and they were looking to move to production, subject to an access agreement. This was being worked on now and would come to the May board. The production company had a shortlist of services that might be included in the

documentary, but this had not been finalised yet.

Ms Thomas noted that a separate documentary was in production that would feature patients of Leeds GIDS, which the Trust had not been involved with as the patients were approached via a different organisation, but to which Dr Carmichael, the GIDS Director, had given some background to help represent our views.

Mr Holt commented that it was important to be clear on what we wanted out of the project, and how it would benefit patients, and asked that this be included in the board paper. Dr Senior commented that although focussed on the Trust it was also about getting the message concerning C&A mental health out to the public, and whilst it might do us some good it was primarily about helping young people and families and exposing the work being done with them.

Mr Jenkins commented that after the May board there would be a clear communication to staff about what we are doing, why, and what we hope to achieve.

The Board **noted** the report.

### **13 Annual Complaints Report**

Mr Jenkins introduced the report, noting that it was important to reflect on complaints at the Board. He saw the cases and final letters before they went out, which provided an important window into quality in the Trust. He was confident that the systems for investigating and following up were robust. He explained that the Trust did not receive many, and there hadn't been a significant increase in numbers this year. There were no overall themes that could be drawn from them and no implications of serious issues about our work.

Mr Jenkins explained that he had been working on ways to deal with long term complaints, where finding a way to draw a limit would be helpful to the patient. He noted that the current complaints manager was retiring, and that his PA would take on that role, which would align with his role to have oversight of the process.

Mr Holt noted the small numbers and asked if this reflected the reality. Dr Harris commented that we lacked many of the sources of complaint that acute Trusts hold, such as A&E, surgery, or overcrowded inpatient services. Dr Senior suggested that overall our patients were treated well even when in difficult circumstances, and were generous with their appreciation. Ms Lyon commented that they were doing work on promoting lower-level, non-formal concerns and criticisms, and ways to show how we respond to them. Dr Harris confirmed that she often dealt with lower level complaints at an informal level and it played a valuable role for some patients. Ms

Murphy commented that the low numbers of formal complaints implied they were being dealt with well at an informal level, which was best for the patients, and reassuring.

Ms Murphy noted that no formal complaints were upheld in full, and asked if they were being handled as objectively as possible. Mr Jenkins commented that it was a matter of judgement, and they started from the legitimacy of the right to complain and to be taken seriously, and there genuinely had not been issues this year that should have been upheld. Complaints could be right in part, as it was possible to do the right thing but still communicate it poorly. Mr Jenkins invited NEDs to review cases in depth with a clinician, to understand the issues and the complexities, for assurance. He commented that as responses were a matter of judgement, it would also be helpful to get another view to calibrate that judgement, and it would also enable NEDs to better explain our work externally.

The Board **noted** the report.

#### **14 Annual Whistleblowing Report**

Mr Campbell noted that this was the first time the whistleblowing report had been brought to the board, but it would now be done annually. There had been no cases of whistleblowing this year, as there had not in the previous year either.

He noted that work was being done to improve the way less formal worries and concerns of staff could be gathered, addressed, and then the responses and learning shared within the Trust. Mr Jenkins commented that this would be a way to communicate with staff across the spectrum. Ms Greatley noted that there had been a recent communication to all staff on how to raise concerns, and Mr Young commented that all policies, including 'Raising Concerns' were now on the website and so available to staff on all sites.

The Board **noted** the report.

#### **15 Corporate Governance – External Contacts List, Elections, and use of Trust Seal**

Mr Campbell noted that the Trust had sealed a contract for the modular building, which had been previously agreed by the board.

Mr Campbell introduced the timetable for the Governor elections, and Ms Greatley added that they had met with the Comms team to discuss all the possible ways of communicating and raising awareness with members.

Mr Campbell explained that the Trust reviewed its links with external organisations annually, and the attached list represented the summary of those links and staff internally responsible.

The Board **approved** the use of the seal, **noted** the elections, and **approved** the review of the external links.

#### **16 AOB and Notice of Future Meetings**

Ms Greatley reminded the board of the possible extra meeting of the Council of Governors on the 20<sup>th</sup> May.

Part one of the meeting closed at 4.00pm

# Outstanding Action Part 1

Action Point No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
3	Nov-14	11. Follow up to staff survey -action plan	Further update to the 2013 staff survey action plan to return to the board	Susan Thomas	May-15	On May agenda.
6	Jan-15	13.CQC Upddate	NEDs to be invited to link with a KLOE lead for CQC	Louise Lyon	Feb-15	Completed -Invitation had been sent, April 2015
2	Feb-15	5. Trust Chair Report	Action plan on 'Freedom to Speak Up' to come to board with update on Duty of Candour	Gervase Campbell	May-15	On May agenda.
4	Feb-15	5. Trust Chair Report	Coordination of NED visits with PPI and CQC work	Louise Lyon	Apr-15	Completed. Suggested sites had been agreed, and visits would now be arranged.
6	Feb-15	14. Patient Story Review	Paper on PPI development to come to the board	Paul Jenkins	Jun-15	
3	Mar-15	10. Annual Equalities Report	Arrange a broad equalities/ Time to Change event	Louise Lyon	Sep-15	
4	Mar-15	11. HR Proposal on 360 Feedback	Proposal for 360 to be taken to leadership group	Susan Thomas	Jul-15	



## Board of Directors : May 2015

**Item :** 6

**Title :** Chief Executive's Report (Part1)

**Summary:**

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

**For :** Discussion

**From :** Chief Executive

## Chief Executive's Report

### 1. Two year strategy

- 1.1 The Board is due to consider a proposed consultation paper for the development of a 2 year strategy for the Trust. A range of consultation meetings with staff and the Council of Governors are planned for June and early July with the aim of bringing a final strategy document for approval to the Board of Directors in July.

### 2. Business Development

- 2.1 As Directors are aware we received the disappointing news that we had not been successful in our bid to run Essex, Southend and Thurrock CAMHS. The tender was won by North East London Foundation Trust.
- 2.2 The Trust came second and our bid scored well. I have asked the Commercial and Strategic Programme Board to oversee a review of our performance with the aim of identifying lessons which can inform our strategy for future CAMHS tenders.
- 2.3 I would again like to register my appreciation of the enormous effort which Rita Harris, Julia Smith and many colleagues from across the Trust put in producing a high quality bid of which we could be proud.
- 2.4 We are progressing with the implementation of the "Camden Team around the Practice" service which we were successful in winning at the end of March.

### 3. Modular Building

- 3.1 The Modular Building, which the Trust has purchased as part of moves to accommodate staff who would be displaced by the ending of the lease at Century Heights, is the course of being erected in the back car park. This is due to be completed by the beginning of June. I would like to offer my thanks to Pat Key and her team for the work they have undertaken to manage these moves.

### 4. Century Films

- 4.1 We have been working with Century Films to reach agreement on an Access Agreement which provides an appropriate level of safeguards for patients or staff involved in the filming. A paper on this is on the agenda.

Paul Jenkins, Chief Executive  
18<sup>th</sup> May 2015



## Board of Directors : May 2015

**Item : 8**

**Title:** Training & Education Board Report

**Purpose:**

To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 11 May 2015.

**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 Board report May 2015

### 1. Introduction

- 1.1 The Training & Education Programme Management Board (TEPMB) held its eighth meeting on 11 May 2015.
- 1.2 Due to the shorter than usual period between meetings on this occasion and current pressure on a number of issues, the CEO and Dean decided to use this meeting in a different way than usual by, firstly, taking stock on how far we have come since the establishment of the Programme Board last September and take a shared view of the strengths and weaknesses of current performance. Secondly, the meeting engaged in discussion about the objectives we should set going forward and which should be part of the 2 Year strategy we are developing across the Trust.
- 1.3 This was preceded by a brief verbal update on current issues by the Dean.

### 2. Dean's update

- 2.1 **National Training Contract:** We recently submitted an outline workplan for 15/16 to show how the contract would be allocated. This was positively received by HENCEL. They have requested further specification of the number and the makeup of our learners who engage with our regional national activity outside of the provision by Associate Centres. This reflects an anticipated scrutiny on where learners are coming from (regional v London activity) and where they are working and where they are ending up after their training with us.
- 2.2 **Peri-natal MH training:** Lis Jones, Director of Nursing, has secured further funding from HENCEL to develop the training initiative that had been piloted. It is a modest amount of funding that will allow us to continue to develop the good work in this area, which provides a significant opportunity.
- 2.3 **Education & Training Restructure:** Portfolio Manager interviews took place in mid-April. We were able to make appointments to four of the six portfolios. The overall calibre of the successful candidates was extremely high and their experience as trainer/clinicians in and outside the organisation as well as their commitment to developing our training offer was immensely encouraging. The Associate Deans are now working closely with the appointees to effect a transition into their new roles over the next few months. This includes ensuring that individual courses do not suffer without the needed staff to deliver in this academic year.

External adverts for the two remaining portfolios will be placed in the next week.

- 2.4 **ICT Procurement:** The Project Board has been working closely with the Project Team to engage with prospective suppliers, which involved a successful supplier engagement event on 24 April 2015. It was well attended and attracted positive feedback from the suppliers in attendance. The tender itself closes in late May and it is expected to attract more interest this time.
- 2.5 **VLs – Employment claim:** The meeting with the claimants has been set back to mid-June and will be reported on more fully at the next Board meeting.
- 2.6 **Essex transition:** There have been two successful validation events held in late April. The respective courses teams received positive feedback. The outcome has certainly increased confidence in both organisations about the working together, increasing optimism too. Associate Centres are also positively engaged. The constructive and collaborative approach by Essex colleagues should be noted. There is an imminent three way meeting with Essex, UEL and the T&P on 15 May 2015 to chart a way forward for the transition and teach-out period.

### 3. Strategic Discussion

- 3.1 The rest of the meeting was used to hold a strategic discussion to think about how far the Programme Board has come since it was convened last year and to set future objectives.
- 3.2 The Programme Board discussed the cultural difficulties of change and the need to ensure that these changes were clear across the Trust.
- 3.3 The Programme Board discussed the importance of the Trust's national reach and the factors that impact upon our ability to achieve this including different commissioning requirements and a need to understand what training employers want.
- 3.4 Laure Thomas informed the group that the marketing department was undertaking research to better understand why students choose the Tavistock.
- 3.5 Paul Jenkins asked the group to consider areas for potential course development in the future. A number of suggestions were made with particular emphasis on; training for health and social care staff, (particularly those in lower pay bands), training for teachers, training related to dementia and an ageing population and supporting primary care.

- 3.6 Paul suggested that a mini options appraisal was carried out to ascertain which of these suggestions should be taken further.
- 3.7 The Programme Board discussed this and the importance of ensuring that any new courses were accessible and did not meet needs already provided for by existing courses.

**Brian Rock**  
**Director of Education & Training / Dean of Postgraduate Studies**

## Board of Directors : May 2015

**Item : 9**

**Title : CQSGC Report, Q4, 2014/15**

### **Purpose:**

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

- Management Team, 14<sup>th</sup> May 2015

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

The notes from the Q4 meeting have been reviewed by the Management Team but not by the CQSGC so, 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 5<sup>th</sup> May 2015, Boardroom

2

Members	Present?
Rob Senior, Medical Director, CQSGC Chair	Y
Angela Greatley, Trust Chair	Y
Dinesh Bhugra, Non-Executive Director	Y
Mary Burd, Public Governor	Y
Anthony Levy, Public Governor	Y
Paul Jenkins, Chief Executive	To item 5 (c)
Louise Lyon, Quality, Patient Experience and Adult Services Director	Y
Rita Harris, Children, Young Adults and Families Director	From item 5 (c)
<b>In attendance</b>	
Pat Key, Director of Corporate Governance and Facilities	Y
Justine McCarthy Woods, Quality Reports Lead	Y
Sally Hodges, PPI Lead	Y
Caroline McKenna, CO & CA Lead	Y
Jessica Yakeley, PSCR Lead	Y
Elisa Reyes Simpson, Associate Dean for Academic Governance and Quality Assurance	Y
Jonathan McKee, Governance Manager (& CQSGC Secretary)	Y

AP	Item	Action to be taken	By	Date
1	4	Work stream leads will take responsibility for picking up directions from the committee and will add them to their respective action tracker; existing items would be transferred with immediate effect.	JM	31.5.15
2	4	Delay in IDCR would be a risk to effective data management and patient administration, risk to be assessed	RS	31.5.15
3	5 (e)	HR should be responsible for ensuring that users were on all interview panels; HR to be asked to report on this	RS	31.5.15
4	7	a clear improvement delivery plan set by the new data management group had been approved by the MT	LL	30.6.15

	<b>Preliminaries</b>	
		<b>Action</b>
1	<b>Chair's opening remarks</b>	
	Everyone was welcomed, especially Elisa Reyes Simpson attending for the first time in her new role.	

CQSG Report - Quarter 4

	<p><b>b) Clinical Outcomes</b></p> <p>Caroline McKenna presented her previously circulated report and highlighted:</p> <ul style="list-style-type: none"> <li>• an evolving approach which will enable clinicians to answer the question “do you know if what you do is effective?”. The Trust is working with stakeholders to develop formats of presenting data visually that will be meaningful to readers</li> <li>• frustration that some CQUIN targets were being set (externally) with no obvious advantage to the patient population as a whole</li> <li>• the Trust exceeded the national average of 75% ESQ scores by attaining 92%</li> </ul> <p>The committee wished to see:-</p> <ul style="list-style-type: none"> <li>❖ more benchmarking against other providers</li> <li>❖ evidence of the incorporation of the OM process into the mechanics of clinical work</li> <li>❖ evidence that <i>all</i> senior staff were engaged in promoting OM, and that this should be a requirement in person specifications for prospective staff appointments.</li> </ul> <p>The committee accepted that action plans were in place and that an amber rating was appropriate subject to the directions given to be addressed on the work stream action tracker.</p>	
	<p><b>c) Patient Safety and Clinical Risk</b></p> <p>Jessica Yakeley presented her previously circulated report and highlighted:</p> <ul style="list-style-type: none"> <li>• There had only been 16 clinical incidents, all relatively minor</li> <li>• SUIs action plans were being followed through</li> </ul> <p>The committee:-</p> <ul style="list-style-type: none"> <li>❖ Wished to see evidence that lessons were being learned: in future, any indications for action will be put to the respective directors who will feedback their follow-up to the lead who will note it in the work stream report</li> <li>❖ Noted that any safeguarding related data requests not met by a local authority would be followed-up at director level</li> </ul> <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 an amber rating was appropriate subject to the directions given to be addressed on the work stream action tracker.</p>	



	<p><b>d) Quality Reports</b></p> <p>Justine McCarthy Woods presented her previously circulated report and highlighted:</p> <ul style="list-style-type: none"> <li>• The draft Quality Report has been submitted to stakeholders for comments, and will be put to the external auditors in due course.</li> </ul> <p>The committee:-</p> <ul style="list-style-type: none"> <li>❖ Noted that not all 2014/15 CQUIN targets had been achieved</li> <li>❖ That 2015/16 CQUIN targets had not yet been set (by the external CQRG)</li> </ul> <p>The committee then accepted the report as assurance on performance and accepted the rating as green.</p>	
	<p><b>e) Patient and Public Involvement</b></p> <p>Sally Hodges' presented her previously circulated report and highlighted</p> <ul style="list-style-type: none"> <li>❖ The PPI team would find a service user for job interview panels but only if asked.</li> <li>❖ The PPI committee is considering a range of data that will provide a richer source of material upon which patient service development plans can be based.</li> </ul> <p>The committee</p> <ul style="list-style-type: none"> <li>❖ Was pleased to note that a patient reference group would be supporting the new work stream</li> <li>❖ suggested that HR should be responsible for ensuring that users were on all interview panels</li> </ul> <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>	4RS
	<p><b>f) Information Governance</b></p> <p>Jonathan McKee presented the previously circulated report from the SIRO Simon Young and highlighted:</p> <ul style="list-style-type: none"> <li>• the Trust had exceeded the national target for training</li> <li>• the Trust was amongst the best in the country for IG, albeit that some assessments had been made on the basis of good action plans rather than outputs</li> </ul>	

	<p>The committee</p> <ul style="list-style-type: none"> <li>❖ was pleased to note good performance</li> <li>❖ was not aware that there were 6 websites but was reassured that these had been identified and confidential data related thereto was being managed appropriately</li> </ul> <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>g) Clinical Audit</b></p> <p>Caroline McKenna presented her previously circulated report and highlighted:</p> <ul style="list-style-type: none"> <li>• the volume of Clinical Audit activity was relatively low compared with other trusts</li> <li>• there will be more steer from the lead on areas to be audited rather than being reactive to others' suggestions; a risk-focus would be useful</li> <li>• quality improvement projects that incorporate audit components may be used as a proxy for specific audits where appropriate</li> </ul> <p>The committee</p> <ul style="list-style-type: none"> <li>❖ Noted that directors will be responsible for audit activity in their directorates and should report this to the lead for inclusion in the report</li> <li>❖ Wished to see a realistic resourced plan that would enable activity to grow and flourish</li> </ul> <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 subject to the directions given to be addressed on the work stream action tracker.</p>	
	<p><b>h) CQC</b></p> <p>Louise Lyon presented her previously circulated report and highlighted:</p> <ul style="list-style-type: none"> <li>• Gaps had been identified and a plan was in place to address them</li> <li>• Peer review trials had commenced</li> </ul> <p>The committee noted that this would be the last work stream report; though a supplementary report [to the CGR work stream which reports on CQC] would be useful in order to note progress; hereafter the CQC Project Board will manage this work and report to the Board.</p> <p>The committee accepted the report as assurance on performance or as</p>	

	satisfactory progress towards attaining assurance where action plans were in place. The proposed amber rating was revised to green as the governance matters were being addressed subject to the direction given being addressed.	
	<b>Conclusion</b>	
<b>7</b>	<b>Any other business</b>	
	<p>Louise Lyon outlined some ideas recently emerging from the first of a series of development meetings to finalise the working arrangements for the new Quality and Patient Experience Work Stream. The work stream will work in parallel with a proposed high level group to set data requirements. Links with CQC and other activity will need to be firmly embedded if the system is to work. Further planning meetings have been scheduled.</p> <p>The committee was pleased to note the proposal for a new data management group, but wished to know that a clear improvement delivery plan had been approved by the MT.</p>	5LL
<b>8</b>	<b>Notice of future meetings</b>	
	<p>11am, 1<sup>st</sup> September 2015</p> <p>11am, 3<sup>rd</sup> November 2015</p>	



## Board of Directors : May 2015

**Item :** 10

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

### **Summary:**

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

This report has been reviewed by the following Committees:

- Management Committee, 14<sup>th</sup> May 2015

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

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

- Quality
- Risk
- Finance

**For :** Discussion

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

## Service Line Report – Camden CAMHS

### Executive Summary

#### 1. Highlights and Achievements

- 1.1 We were successful in tendering for the Minding the Gap Transition Service in partnership with Catch 22, Camden and Islington Mental Health Foundation Trust, Anna Freud Centre, Brandon Centre, The Winch and MAC-UK Training Foundation. More details below.
- 1.2 The participation stream of the CYP IAPT programme ran a name change competition for Camden CAMHS. The new name was chosen and selected by young people and parents. The name chosen was "Open Minded" A design competition followed resulting in a new logo. See below. This has gone into email signatures and signs have been put outside South Camden Team premises.



emotional health & wellbeing in Camden,  
for children, young people and their families

- 1.3 The Young Parent Service went out to tender and the T&PFT bid was successful.

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

- 2.1 Demand for CAMHS is continuing to increase, with an increase in volume of work by the North and South Community Teams. This is linked to concerns about increasing complexity of cases with less prospect of bringing about significant change. Another change in the system which is causing stress to staff, is stricter threshold criteria being applied by social services, which means that more cases are now being seen in CAMHS without social services being part of the professional network.
- 2.2 CYP IAPT outcome monitoring reporting to NHS England has not reached expected levels. An action plan was put in place to address this issue. and the number of cases that were reported to NHS England went up from 24 in Q1 to 100 in Q4. The problem was due to patients not being asked for consent to share information with NHS England.

#### Main Report

3. Overview of the Service
  - 3.1 A description of the Service was given in the report to the Board in previous reports, but this information has been updated and repeated here, in Appendix 1.
  - 3.2 Update on issues raised in report from April 2014
  - 3.3 CYP IAPT programme continues. A further therapist and 2 supervisors have gone forward for training. The service change towards a culture where outcome monitoring is part of routine practice is still on-going, with 54% percentage of cases seen more than 3 times now having outcome monitoring using the goal based measure. The participation work has been making strong progress – see below.
  - 3.4 As planned the Associate Clinical Director and Camden CAMHS Commissioner provided a joint presentation to the CYP IAPT commissioning summit in May 14, which was well received. The message to other CCG commissioners and providers was to develop regular dialogue in order to understand each other's positions more clearly, and develop shared objectives.

- 3.5 Regarding the financial deficit of the service of 393K last year, this has reduced to 345K this year (see later in report).
4. Developments
- 4.1 There has been a lot of work in the last year improving services for young people age 17-24 who have mental health difficulties and are in the transition to adulthood. There are two groups of young people who require additional support, those in transition between CAMHS and AMHS, and those presenting to adult services for the first time. As a result of the bid to Camden CCG, jointly by the commissioners and the local providers, a transition service has been set up with "Transition Champions" appointed in AMHS teams to develop a more flexible, holistic and young person centred approach, and to develop culture change within adult mental health services. This work is supported by fortnightly meetings for AMHS managers and CAMHS managers, where young people in transition are discussed and transition plans are made, and another meeting to support the culture change agenda of the Transition Champions.
- 4.2 The agreed operational principles of the Transition Service are that it is recognised that young people will be ambivalent about engaging with AMHS, and that this has to be taken into account by offering assertive engagement at the assessment stage, and offering support to young people who have to wait for mental health services. It has also been agreed that there should be a holistic and less medical approach to improving the emotional wellbeing of young people, e.g. encouraging engagement in training and education opportunities.
- 4.3 The other part of the transition project is the setting up of a young person Hub. This had to go out to competitive tender due to the value of the contract. The Tavistock were part of a partnership led by Catch 22, and including Camden and Islington Mental Health Trust, The Anna Freud Centre, The Brandon Centre, The Winch, and MAC UK Training Foundation. The partnership was successful in the bid, and now staff are being recruited to the project. The programme manager (employed by Catch 22) has been successfully



appointed, and 2 Clinical Team Leads are being interviewed in May, one employed by Camden and Islington Foundation MHF Trust and the other by the Tavistock and Portman Foundation MHF Trust. 8 young person workers, who it is anticipated will themselves be young people, will be appointed in June. The Hub will be at the old post office building in Finchley Road and will be called "The Hive" (named by young people). The Hive will engage young people who are at risk of adult mental health disorder in activities, social enterprise, education training and work opportunities as well as mental health interventions if required.

- 4.4 Camden MALT were provided with 50K, fixed term for a year, to improve the CAMHS offer to the Camden LA Fostering and Adoption teams. The service is for children and young people in care or transitioning into adoption, as well as for foster carers and adopters. A clinical psychologist was appointed to provide this service. A report was presented to commissioners regarding the work done, resulting in the funding being made permanent.
- 4.5 After a period of dialogue and negotiation between commissioners and providers, Camden MOSAIC CAMHS, part of the integrated MOSAIC disability service, which included a Social Care team, and a Child Development Team, became part of a much wider Children with Developmental Concerns service, under the co-ordination of CNWL. The new service now includes all Speech and Language Therapists, Occupational Therapists and Physiotherapists who were previously outside of the MOSAIC structure, employed by Whittington Health and the Royal Free Hospital. There is now a partnership board where accountability for the service is shared. If KPIs are met then each partner (T&PFT, CNWL, Whittington Health and Royal Free Hospital) receive 100K on top of baseline costs. So far KPIs have been met and 50K has come to the T&PFT.

## 5. Clinical Quality and Outcome Monitoring

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

outcomes and the quality and impact of the service. Reports of compliance with targets in the service specifications and of DBS checks are also reported quarterly.

## **6. Activity Data**

6.1 Activity is reported quarterly for each service. Activity over the last year is shown in the tables below over the following 2 pages.

Camden Outputs 2014-15			
		Annual Target	Year to date Actual
CAMHS Social, Emotional and Behavioural Difficulties (SEBD) pathway - Robson House & Camden Centre for Learning (Behavioural Support Service) (3.2 WTE)	Number of pupils and/or carers in receipt of direct clinical involvement at any one time (across Robson House & CCfL)	45	63
	Cases seen per year (YTD, nos of cases i.e. any attendances under 1 referral)	45+	107
Early Intervention Service Camden CAMHS (2.6 WTE)			
	First attendances per year	8	10
	Open cases (measured at end of quarter all cases open who have been offered appointments in the previous 3 months)	24	19
	Cases seen per year (YTD, nos of cases i.e. any attendances under 1 referral)	24+	29
Fostering Adoption and Kinship Care Team (proportion of 5.7 WTE)			
	First attendances per year	19	23
	Subsequent appointments per year	640	766
	Open cases (measured at end of quarter all cases open who have been offered appointments in the previous 3 months)	35	32
	Cases seen per year (YTD, nos of cases i.e. any attendances under 1 referral)	49	51

		Annual Target	Year to date Actual
<b>Integrated Early Years Service (IEYS) (Children's Centre Services) (3.9 WTE)</b>	First attendances per year	140	166
	Subsequent appointments per year	600	508
	Open cases (measured at end of quarter all cases open who have been offered appointments in the previous 3 months)	60	71
	Cases seen per year (YTD, nos of cases i.e. any attendances under 1 referral)	200	208
<b>MOSAIC CAMHS (Children's Disability Service) (10.1 WTE)</b>	Number of first attends	135	101
	Attended appointments per year	3650	3167
	Open cases (measured at end of quarter all cases open who have been offered appointments in the previous 3 months)	190	228
	Cases seen per year (YTD, nos of cases i.e. any attendances under 1 referral)	270	258
<b>Multi Agency Liaison Team (MALT) (7.2 WTE)</b>	Number of planning meetings per year	200	tbc
	Number of first appointments per year	150	tbc
	Number of subsequent appointments per year offered (or attended) by practitioners	2150	tbc
	Open cases (measured at end of quarter all cases open who have been offered appointments in the previous 3 months)	100	tbc
	Cases seen per year (YTD, nos of new cases)	150	tbc
	Comprehensive Family Reports (PLO and CP)	40	tbc
	Addendum Reports (PLO and CP)	10	tbc

		Annual Target	Year to date Actual
<b>Refugee Team (approx 50% of 3.0 WTE)</b>	First attendances per year	18	21
	Subsequent appointments per year	350	363
	Open cases (measured at end of quarter all cases open who have been offered appointments in the previous 3 months)	32	27
	Cases seen per year (YTD, nos of cases i.e. any attendances under 1 referral)	54	43
	Community based group sessions	0	12
<b>Tavistock Specialist Adolescent Service (cases referred under 18) (small proportion of 11.7 WTE)</b>	First attendances per year	12	10
	Subsequent appointments per year	103	216
	Open cases (measured at end of quarter all cases open who have been offered appointments in the previous 3 months)	17	11
	Cases seen per year (YTD, nos of cases i.e. any attendances under 1 referral)	24	20
<b>Complex Needs Outreach Team (2.4 WTE)</b>			
	Open cases (measured at end of quarter all cases open who have been offered appointments in the previous 3 months)	30	21
	Cases seen per year (YTD, nos of cases i.e. any attendances under 1 referral)	50	40

		Annual Target	Year to date Actual
<b>Youth Offending Service (YOS) (0.8 WTE)</b>	Open cases (measured at end of quarter all cases open who have been offered appointments in the previous 3 months)	10	6
	Cases seen per year (YTD, nos of cases i.e. any attendances under 1 referral)	10+	22
	Hours/days service related activity (consultation, training, advice)	0	200
<b>North Camden CAMHS (10.3 WTE)</b>	First attendances per year	240	328
	Subsequent appointments per year	4300	6732
	Open cases (measured at end of quarter all cases open who have been offered appointments in the previous 3 months)	230	381
	Cases seen per year (YTD, nos of cases i.e. any attendances under 1 referral)	470	652
<b>South Camden CAMHS (11.00 WTE)</b>	First attendances per year	242	322
	Subsequent appointments per year	3190	4549
	Open cases (measured at end of quarter all cases open who have been offered appointments in the previous 3 months)	226	319
	Cases seen per year (YTD, nos of cases i.e. any attendances under 1 referral)	422	516

6.2 Camden operates as a block contract so the targets are not linked to finances. Also for North Camden Team 37% of activity is provided by trainees, and in South Camden Team 25% is provided by trainees. Nevertheless, regarding the increase in activity provided by staff, over the last year, North Camden first attends activity actually stabilised over the last quarter and ended slightly lower than last year (328 this year, vs 338 last year) but subsequent attends provided by staff (excluding trainees) increased by 11%. South Camden saw the bigger increase in demand this year, with an 20% increase in first attends from 256 first attends last year to 322 first attends this year, and a 23% increase in subsequent appointments offered by staff (excluding trainees). Staff activity levels are tracked on a quietly basis. In Q4 last year on average 1.5 appointments were offered per clinical session, but this year this has gone up to 1.8 appointments per clinical session. According to our service modelling this is still a manageable level of service delivery however a review is underway to look into this issue in more depth, and feedback has been obtained from all staff in these teams.

6.3 THRIVE: During the year the Anna Freud Centre and the Tavistock worked together on devising a new model for conceptualising the work of Child and Adolescent Mental Health Services. The model is called THRIVE. Broadly, in this model initial assessment takes a resilience based approach, considering that families can be helped to self manage. This domain of work is called COPING. CAMHS need to prioritise providing as many children young people and families with brief evidence based treatment as possible in a domain called GETTING HELP. If this is not sufficient to bring about change a review needs to take place to decide whether to offer MORE HELP (intensive treatment domain) or whether further change is unlikely, so that it would be more sensible to offer RISK / SUPPORT.

6.4 This latter domain of work has different outcomes to to the outcomes of treatment. Rather than aiming for improvement, the focus is on maintaining the best level of functioning possible in the circumstances.

6.5 In the Camden Service Line, and in fact across the new CYAF Directorate the plan going forward is to implement the THRIVE approach

in the service. It is hoped that the Camden Service Line clinicians based within the Local Authority can work in partnership with local authority support services to operationalize Risk Support.

6.6 Within the North and South Team the implementation of THRIVE would mean a bigger focus on the HELP domain, with a clear offer of short term work rather than open ended work. Then there would be a multi disciplinary review process as an entry point to MORE HELP if that was justifiable.

6.7 Finally if cases were explicitly placed in the RISK SUPPORT domain they should by rights not be seen in the North or South Team but transferred into Local Authority Support services with clinical guidance and support from CAMHS professionals.

6.8 Risk Support work, rather than more treatment would also be seriously considered for referrals where there have been previous episodes of care without effective change, where further episodes of care are unlikely to be effective.

6.9 A significant number of CAMHS cases have child protection concerns that do not meet social services thresholds for statutory intervention. Liaison is underway with the social services department about what can be realistically achieved by CAMHS in cases where there are child protection concerns or a high level of need, and also what support and advice social services can give when cases do not meet child protection thresholds, but where CAMHS are worried about safety.

6.10 DNA rates this year were 7.2%. This is exactly the same rate as last year.

6.11 Data was not available this year for Camden MALT due to technical difficulties with the local authority data collection system.

## 7. Financial Situation

7.1 Below is a table showing the financial situation with the Camden Service Line: There was an overall deficit of 345K. Part of this deficit was due to the fact that overheads were calculated at 21% but costs



are 16%. The actual gap between income and expenditure for salary costs alone is 105K this year (see next page)

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	Camden CAMHS		Camden CAMHS	
	Budget 13/14	Actual 13/14	Budget 14/15	Actual 14/15
Clinical Income	5,099	4,878	4,930	5,078
Training course fees and other acad income	0	0	0	0
National Training Contract	627	627	670	670
Total Training Income	627	627	670	670
Consultancy Income	0	0	0	0
Research and Other Income (incl Interest)	12	11	12	9
<b>Total Income</b>	<b>5,738</b>	<b>5,516</b>	<b>5,612</b>	<b>5,757</b>
Clinical Directorates and Consultancy	4,840	4,529	4,619	4,688
Other Training Costs	0	0	0	0
Research Costs	0	0	0	0
Accommodation	524	609	505	537
<b>Total Direct Costs</b>	<b>5,364</b>	<b>5,138</b>	<b>5,125</b>	<b>5,224</b>
Contribution	374	379	487	533
Central Overheads (excl Buildings)	1,029	1,018	1,002	1,077
Central Income	195	246	126	199
<b>Surplus/(deficit)</b>	<b>-460</b>	<b>-393</b>	<b>-389</b>	<b>-345</b>
Overhead rate		20%		21%
CAMHS costing				16%
Difference %				5%
Difference £				<b>261</b>

	Budget Q4 14 15 £'000		Actual Q4 14 15 £'000	
<b>Expenditure</b>				
Staff	3,749		3,721	
Savings	0		0	
HCAS			0	
		3,749		3,721
Non Pay		124		90
Accommodation		325		325
Overheads		657		666
<b>Total Expenditure</b>		<b>4,856</b>		<b>4,803</b>

<b>Camden SLA Funding</b>				
-				
Camden CAMHS Contract incl 100% CQUINS		4,681		
High Area Cost Supplement (HCAS)		191		
Camden CAMHS Contract excl HCAS		4,490		
Factor in 49% of HCAS (Camden CAMHS element)		94		
Additional income for MALT manager post		50		
Total income for Camden CAMHS		<b>4,633</b>		<b>4,698</b>
<b>Gap</b>		<b>223</b>		<b>105</b>

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

Date received	CCG	Dept	Core topics of complaint	Response <25 days?	Outcome/Lessons learned	Status at time of report
10.11.14 (7)	Camden	CAMHS	Parent claiming misdiagnosis of son resulting in inappropriate treatment and emotional and physical damage. Questioning son's current treatment, and reasons for referral to social services	Yes	Not upheld Found that mother had had concerns for her son over a long period of time, but that mother's view of diagnosis and appropriate treatment did not always accord with the clinical view Chief Executive replied, acknowledging mother's concerns; explaining the roles of the clinicians involved; acknowledging mother's view of the treatment, but explained that this was not how the clinicians had experienced their work with mother and son; stating that clinicians were prepared to continue to discuss with mother and son what could be offered by the Trust's services to a young person with particular needs, and that the Team Manager would be happy to meet with mother and son to review any plans that involved input from the Trust. Found that the young person was of an age where the Trust had to respect the young person's own wishes with regard to treatment and confidentiality (patient was over 16)	CLOSED Reply from CEO 20.11.2014
25.02.15 (13)	Camden	CAMHS	Parent complaining about incident in connection with son's arrest. Staff had been called as he had been unable to go home. Son (17/18). Mother considered this 'dereliction of duty'		Long-standing complex complaint involving a network of services. Matter investigated alongside Camden Social Services investigation. No evidence of dereliction of duty on the part of Trust staff. Long history of mother disagreeing with the help being offered to her son. Mother recently met with Trust's CAMHS Director and Chief Executive to discuss her concerns about her son's needs.	OPEN

**9. Patient Safety Incidents**

9.1 In 2014-15 there were 3 low level incidents one of a child patient running out of the Tavistock, another of a adolescent managing to get into a cupboard and locking herself in, and a child breaking a glass panel on a door. These have been investigated and steps taken to reduce the risks in future.

9.2 An adolescent patient developed a romantic fixation on her male community nurse. She was an inpatient during this period, and unfortunately when discharge was planned her care had to be transferred to another team.

9.3 A serious incident occurred in November 2014 in the Young Parent Service. An 8 week old baby suffered very serious brain damage while in the care of her parents. At the time Social Services were conducting an assessment regarding concerns about domestic violence. A Serious Case Review has been commissioned by the Camden Safeguarding Children Board, and the baby is subject to Care Proceedings.

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

10.1 The use of the CHI Experience of Service Questionnaire is now routine. The number of ESQs gathered in this year was 1001, compared to 444 in 13/14 and 150 in 12/13. The table on the next page summarises the data that has been collected this year.

Responses for Camden CAMHS	% True or Partly True	Certainly True	Partly True	Not True	Do not Know	Missing
Listened to	98%	898	79	7	8	9
Easy to talk	96%	734	217	30	11	9
Treated well	99%	921	58	5	5	12
Views and worries	98%	875	93	4	19	10
Know how to help	93%	665	261	13	53	9
Given enough explanation	74%	490	231	44	205	31
Working together	91%	767	124	14	69	27
Comfortable facilities	95%	745	194	22	23	17
Convenient appointments	94%	688	234	53	11	15
Convenient location	94%	746	184	47	9	15
Recommend to friend	94%	807	117	23	41	13
Options	92%	556	131	31	27	256
Involved	92%	573	115	28	32	253
Quickly Seen	89%	499	158	66	12	266
Good help	96%	832	103	11	24	31

10.2 Despite pressure on our services our satisfaction ratings remain very high. They have not fallen in any area. The commissioners have focused on our performance in the area of “good enough explanation of service” which has historically been the area with the lowest score. This has been addressed with more leaflets, improved website design, and explicitly including explanation as part of the first appointment. This rating has improved from 66% last year to 74% this year. Many other services have introduced the Friends and Family Test, but our survey includes “recommend to a friend” which is 94% this year. Last year the figure was 93%.

10.3 On the next page is a table with a sample of comments that were made in the ESQ. These are grouped under “what was really good about your care?” “what didn’t you like or anything that needs improving?”, and “is there anything else you want to tell us?”. There were very few negative comments in comparison to positive ones. The most common response to “didn’t like or needs improving” was “nothing”. Comments are monitored by the PPI and quality team and improvements made as appropriate



What was good?	Didn't like / needs improving?	Any other comments?
My daughter felt unconditionally cared for and accepted for what she was going through. [Clinician] was able to understand her condition in a way that has enabled her to move through a very dangerous time, and to do so without medication. The whole family was involved and I was also supported so that I was able to support my daughter and believe her.	The times are not flexible - not enough sessions. I wanted more sessions, in order to finish off what we were talking about that week.	The fact that my daughter continues to receive help even though she is no longer in a critical condition, is incredibly valuable to us all and now when she has a small lapse/wobble things come into balance much more quickly - she is able to do A levels and have a normal life where as this time last year I was just grateful she was still alive
I feel I have been taken seriously. I am cared for and I've been able to look at some things that I wouldn't usually because I feel safe here. The chairs are comfy.	It did take a long time to be referred	After the sessions were coming to an end was offered 121 meetings once a month for a catch up and if needed in the future.
Being able to talk to someone that I can trust about any overwhelming feelings that I may have had I think that its important to be able to vent out some emotions and [clinician] has helped me to do that without getting overly involved in different aspects of my personal life. I was able to talk freely knowing I wouldn't be judged.	We saw the clinician in various rooms in hampstead group practice, none of which is suitable for this kind of appointment with a child, I didn't really understand what services were available, or where the clinician fitted within the NHS care. I don't know whether any reports have been sent to GP. It wasn't always easy to contact the clinician - email would have been easier.	It was really good, I was a bit sceptical at first, but now will definitely recommend to anyone that may need your help.
The person allocated to us really did care. Tried to help us in the best way possible	Initially we felt it wasn't focused enough on our child but then maybe the therapist was waiting for us to realise that we were the root of the problem. In effect nothing needs improving.	I would definitely recommend to a friend or family member
I was given reminders by text.	It is frustrating that the CAMHS service at RFH and Tavistock do not work together more smoothly.	More people should come here because I learnt something here I didn't know before. People are always there for you when you need help.
Attentive, supportive staff, caring and very easy to communicate with i.e. to speak to and to contact when needed	I didn't know whether I could 100% trust the person who saw me	They were helpful and the right length of time (not too long/ not too short)
The understanding and flexibility. Always on the end of the telephone. The fact that Dr (clinician) was able to come to the boys school on 2 occasions	The waiting area is not very private or comfortable, but in the greater scheme of things this is a minor concern.	I feel it is really important that this service is retained and protected by the government cuts. I feel the mental health is key to helping children find their way in the world
Appointments were arranged at venue that was convenient to us eg arranged for afterschool with enough travelling time	The system of contacting the team (via text) could be improved. Some of the rooms are rather bare. Stella was being assessed for a long time before seeing her therapist initially. The car park supervisor is sometimes make us move the car which seems unnecessary and can make arrival a bit stressful.	Helped me very much, showed me how to bring up my own children in this Country. Please keep up the good work.
Good team. Taken seriously. Real effort to engage me. Was made to feel comfortable during recorded session by whole team	My improvement is about the curtain and mirror, because I didn't like that I could not see the other people.	Since having come here a lot of things have changed about me in good way which I am really happy about

- 10.4 Outcome data is collected across the service and presented in Appendix 2, is data from the North and South Camden Teams. MOSAIC and IEYS. Results are given from the goal based measure, CGAS and Strengths and Difficulties Questionnaires and other service specific measures. There is a lack of consistency in the way data is presented across teams. It is hoped that this will improve when an automated process is developed to produce charts from outcome data.
- 10.5 The Goal Based measure is most valued by our commissioners as it is user led, setting individual goals for outcomes of intervention. On a scale of 0 – 10 clients say how close they are to reaching their desired goals. Improvement is reported if the mean score across the goals has risen by at least one point between two time points.
- 10.6 The Child Global Assessment Scale is a clinician rated scale where the a general assessment of functioning is made. The scale is from 0 to 100 where a score above 70 indicates that there are no significant clinical problems. Any rise is currently considered a sign of improvement but the threshold for clinically significant improvement needs to be agreed
- 10.7 The Strengths and Difficulties Questionnaire (SDQ) is a behavioural screening questionnaire for 4 to 16 year olds. The questionnaire includes 25 items on positive and negative psychological attributes and screens for emotional symptoms, conduct problems, hyperactivity and inattention, peer relationship problems and pro-social behaviour. For each of these scales, the score can range from 0 to 10 which can be used as continuous variables although it is sometimes useful to classify scores as normal, borderline and abnormal. The Total Difficulty Score is the sum of scores from each scale except the pro-social scale. The measure also has an impact supplement which enquires further about chronicity, distress, social impairment, and burden to others. The Total Difficulties Score can be broken down as follows: 0-13 Normal Range, 14-16 Borderline Significant, and 17-40 Abnormal.



- 10.8 Some teams use measures that are specific to their populations, for example the HONOS in EIS (not reported here) the CORE in the Adolescent Service (not reported here) the PIR-GAS (a global measure for under 5's) (see Appendix 2), and the SLDOM (see appendix 2) which is a measure of parental capacity and resilience for parents who have disabled children.
- 10.9 Last year data was produced for the service as a whole, rather than team by team, so directly comparable data is not available from last year. However the amount of Time 1 (Assessment) to Time 2 (6 months) data has increased from last year, for example 395 paired Goals were recorded this year compared to 248 last year, and 570 GCAS this year compared to 304 last year.
- 10.10 One consistent finding across the teams is that less change is achieved between Time 2 (6 months) and Time 3 (end of treatment or 1 year), than between Time 1 and Time 2. This supports the view that the most change is brought about in the first 6 months of treatment and supports the THRIVE plan that there needs to be more robust review of cases, using outcome measures as part of the review, at 6 months to make decisions about cases moving from HELP into MORE HELP.
- 10.11 Looking at the figures in Appendix 2 for the Goal Based Measure, North Camden shows a smaller proportion of cases showing improvement and a smaller shift in scores, than the other teams. It is hard to understand this difference, particularly as changes on CGAS are almost identical across the North and South Team. It may be that attention needs to be paid to setting "SMART" goals that will respond to treatment. There is often a balance to be struck between accepting that some families want to set goals that may seem unrealistic to the clinician, but are client centred, against negotiating for more achievable goals which may feel less client centred.
- 10.12 The SLDOM used in the MOSAIC service shows improvement in about 50% of cases, but the lack of change, or even deterioration in the other 50%, underlines the difficulties of bringing about change in a disabled population.

10.13 SDQ data has not been presented for North and South Camden due to the fact that charts were not produced for monitoring meetings with commissioners, but data is presented for MOSAIC and IEYS. This shows an interesting difference between client groups. The average scores of the MOSAIC children are in the abnormal range and fall very slightly during treatment, whereas in IEYS the time 1 scores are just within the borderline abnormal range and fall at Time 2 into the normal range.

## Appendix I

### Description of Camden Open Minded (Previously Camden CAMHS)

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

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

The Refugee Team is a small specialist team based at the Tavistock Clinic which takes cases from Camden and further afield. This is a small team (3 WTE) with strong links with the Somali and Congolese communities in Camden.

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

Beyond this there is a Disability CAMHS Team called MOSAIC CAMHS which is managed CNWL.

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

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

This complex multi provider network is coordinated by a Single Point of Entry Service, called Camden Joint Intake. It is clinically led and receives referrals from General Practitioners and a wide constituency of other professions and also self-referrals. The referrals are passed on, as appropriate to the Camden CAMHS teams and also the Royal Free Hospital CAMHS, the Brandon Centre and the Anna Freud Centre.

The Young Adult Service is now part of the Child, Young Adult and Family Directorate but is not part of the Camden Service Line.

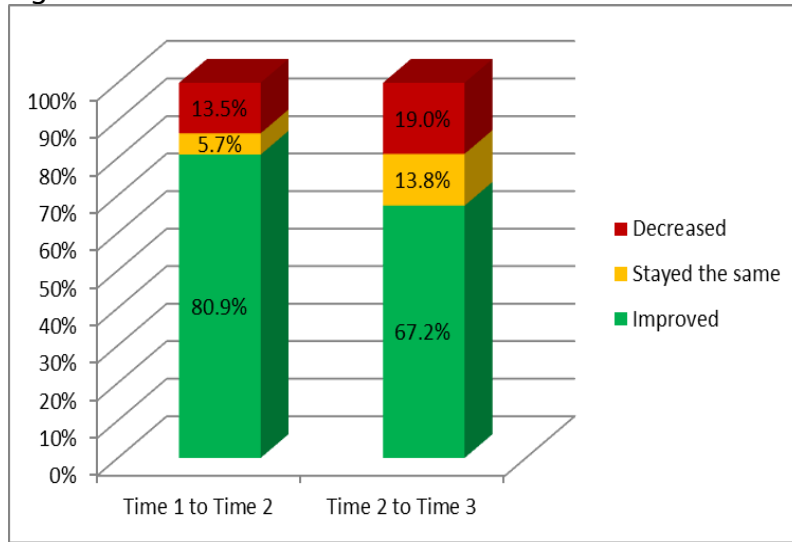
## Appendix 2. Outcome Measures

### Goal Based Measure: Stacked Bar Charts showing proportion of improved / not improved

#### North Camden CAMHS Quarters 1-4 2014-2015

Of the cases open from 371 set goals at Time 1 and 141 had reviewed these goals at Time 2. As shown in Figure 1, 114 scores increased 8 stayed the same and 19 decreased. 165 cases had set goals at Time 2. 58 cases reviewed these goals at Time 3. As shown in Figure 3, 39 scores increased, 8 scores stayed the same and 11 decreased.

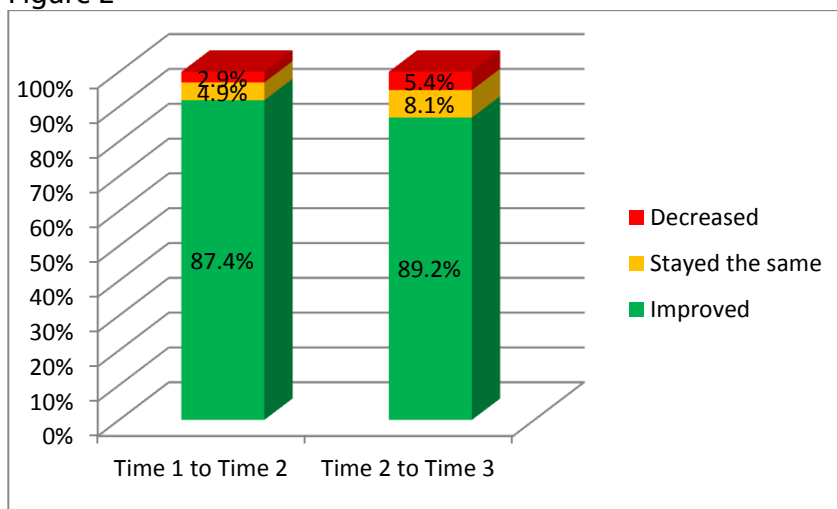
Figure 1



#### South Camden Community CAMHS Quarters 1-4 2014-2015

Of the cases open 282 set goals at Time 1. 98 had reviewed these goals at Time 2. As shown in Figure 2, 90 scores improved, 5 stayed the same and 3 deteriorated. 130 cases had set goals at Time 2. 40 cases reviewed these goals at Time 3. As shown in Figure 3, 33 scores increased, 3 stayed the same and 2 decreased.

Figure 2

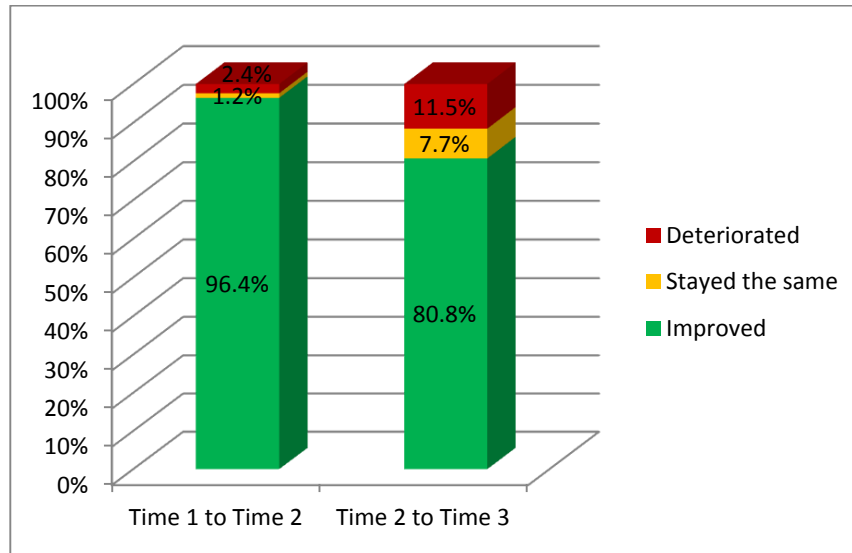


Mosaic CAMHS

Of the cases open 141 cases had set Time 9 goals and 84 cases had reviewed these goals at Time 2. As shown in Figure 3, 81 scores increased, 1 stayed the same and 2 decreased.

41 cases had set goals at Time 2 and 27 cases had reviewed these goals at Time 3. As shown in Figure 2, 21 scores increased, 2 score stayed the same and 3 decreased.

Figure 3



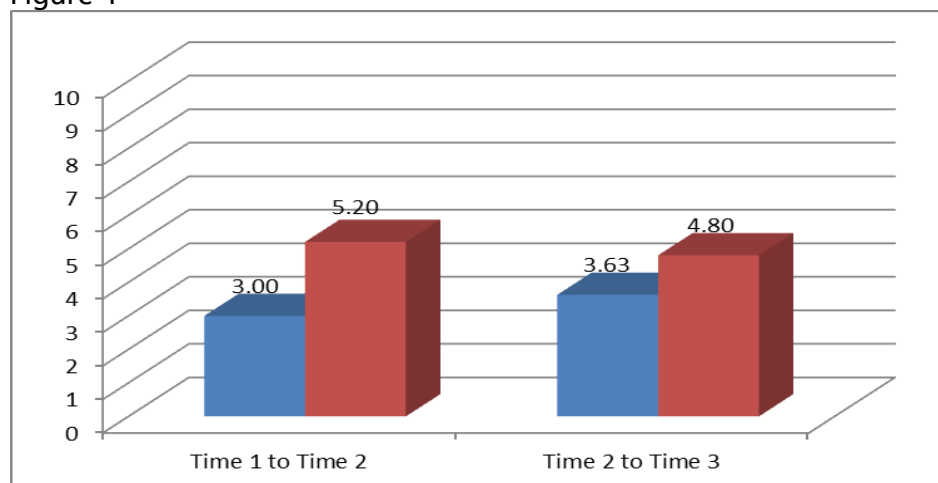
#### Goal Based Measure, Mean Change in Score

##### North Camden Team

As shown in Figure 4, the mean initial value at Time 1 was 3.00 (S.D= 1.70). The mean review value at Time 2 was 5.20 (SD= 2.08). The mean improvement in scores was therefore 2.20.

The mean initial value at Time 2 was 3.63 (SD= 2.81). The mean review value at Time 3 was 4.80 (SD= 2.94). The mean improvement in scores was therefore 1.17.

Figure 4

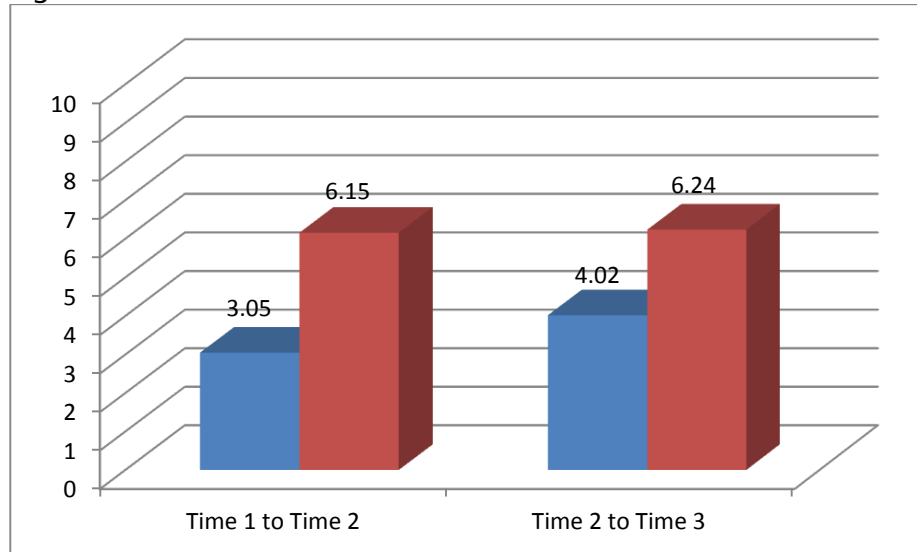


##### South Camden Team

As shown in Figure 5, the mean initial value at Time 1 was 3.05 (SD=1.70). The mean review value at Time 2 was 6.15 (SD=1.76). The mean improvement in scores was therefore 3.11.

The mean initial value at Time 2 was 4.02 (SD=2.07). The mean review value at Time 3 was 6.24 (SD=2.81). The mean improvement in scores was therefore 2.22.

Figure 5

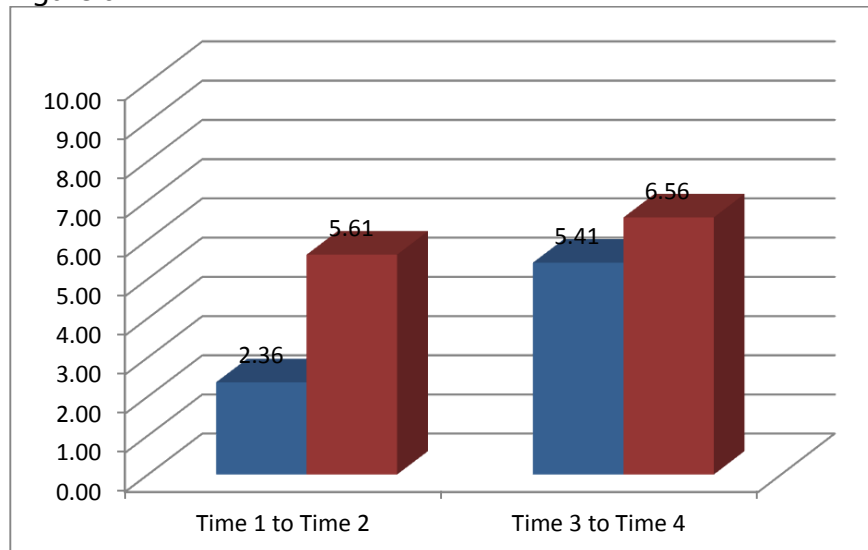


#### Mosaic

As shown in Figure 6, the mean initial value at Time 1 was 2.36 (S.D= 1.43). The mean review value at Time 2 was 5.61 (SD= 2.02). The mean improvement in scores was therefore 3.25.

The mean initial value at Time 2 was 5.41 (SD=2.03). The mean review value at Time 3 was 6.56 (SD=2.02). The mean improvement in scores was therefore 1.15.

Figure 6

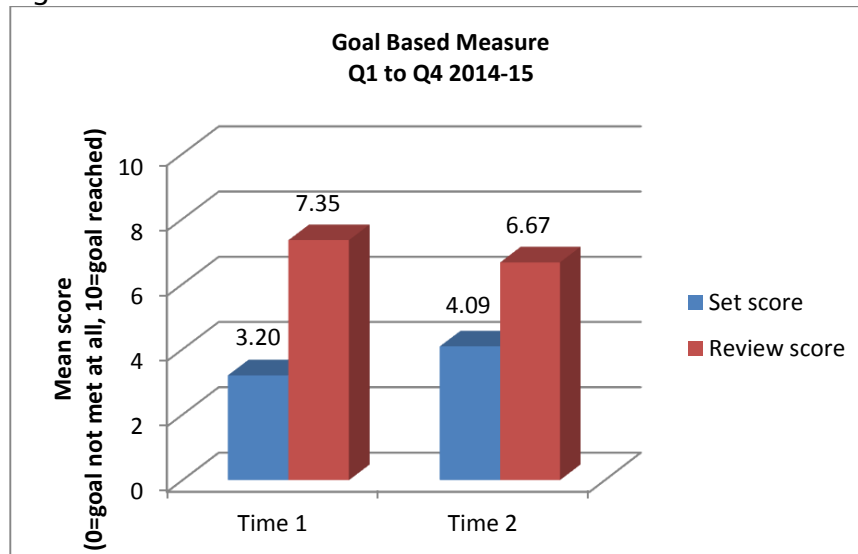


#### IEYS

During Q1-Q4, there were 142 Goal Based Measures set at Time 1 and 72 of these were then reviewed. 21 Goal Based Measures were set at Time 2 with 14 of these then being reviewed. 95.8%

of Time 1 Goal Based Measures improved between being set and being reviewed, with 4.2% staying the same. 100% of Time 2 goals improved between being set and being reviewed

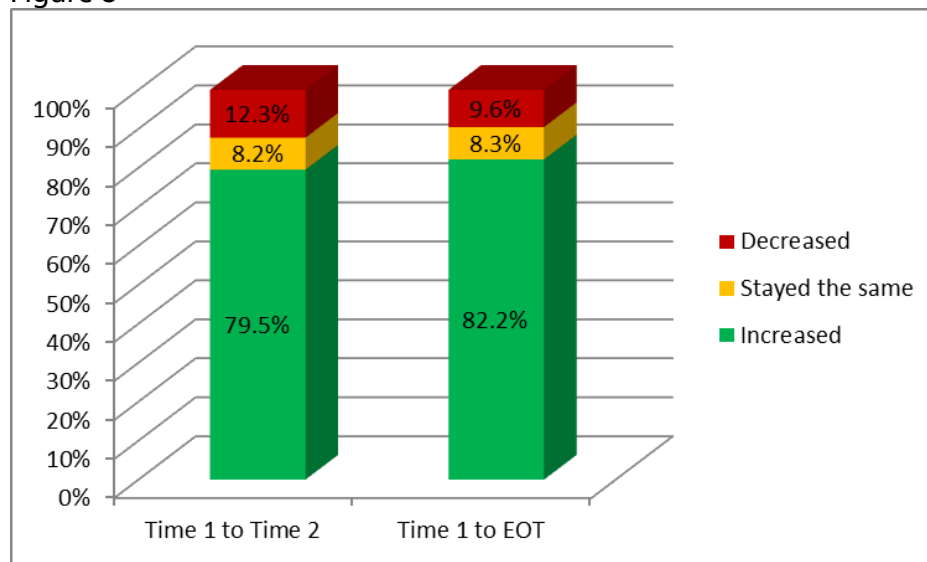
Figure 7



Child Global Assessment Scale: Stacked Bar Charts showing proportion of improved / not improved

North Camden Team: Of the cases 485 had a Time 1 CGAS. 293 had a Time 1 and 2 CGAS. 157 closed cases had a Time 1 and End of Treatment CGAS As shown in Figure 8, 233 scores increased from Time 1 to Time 2, 24 stayed the same and 36 decreased. 129 scores increased from Time 1 to End of Treatment, 13 stayed the same and 15 decreased

Figure 8



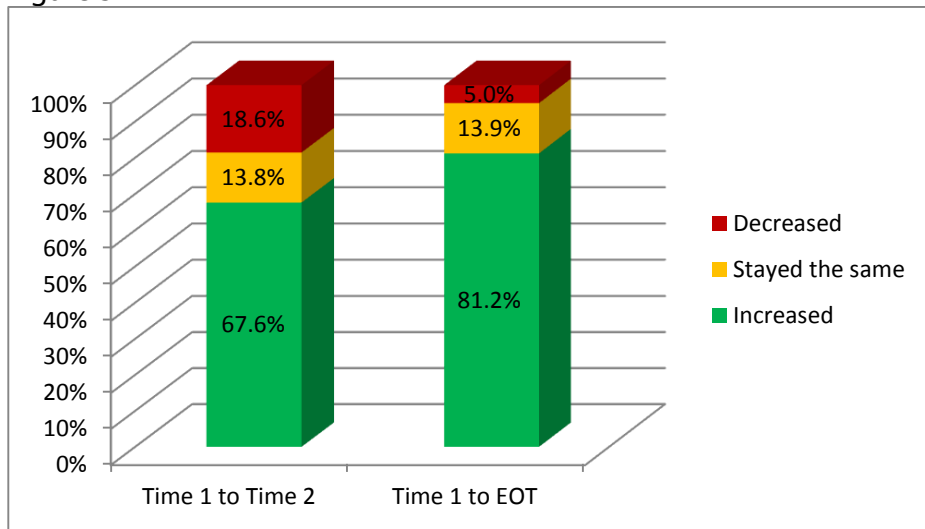
South Camden Team

Of the cases open from April 2014 – March 2015, 381 had a Time 1 CGAS. 210 cases had a Time 1 and Time 2 CGAS. 101 closed cases had a Time 1 and End of Treatment CGAS.

As shown in Figure 9, 142 cases improved from Time 1 to Time 2, 29 stayed the same and 39 deteriorated. 82 scores increased from Time 1 to End of Treatment, 14 stayed the same and 5 decreased.



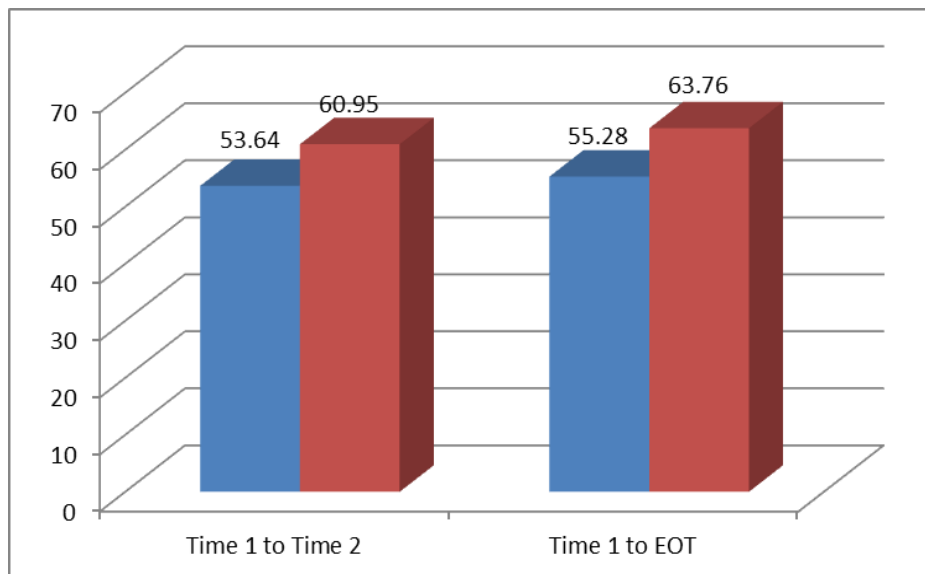
Figure 9



#### Child Global Assessment Scale – Mean Change in Score

North Camden Team: As shown in Figure 10, the mean score at Time 1 was 53.64 (SD=9.41) and the mean score at Time 2 was 60.95 (SD=10.70). For cases with a Time 1 and End of Treatment CGAS, the mean score at Time 1 was 55.28 (SD= 9.38) and the mean score at End of Treatment was 63.76 (SD= 11.13). The mean improvement in scores was therefore 8.48.

Figure 10

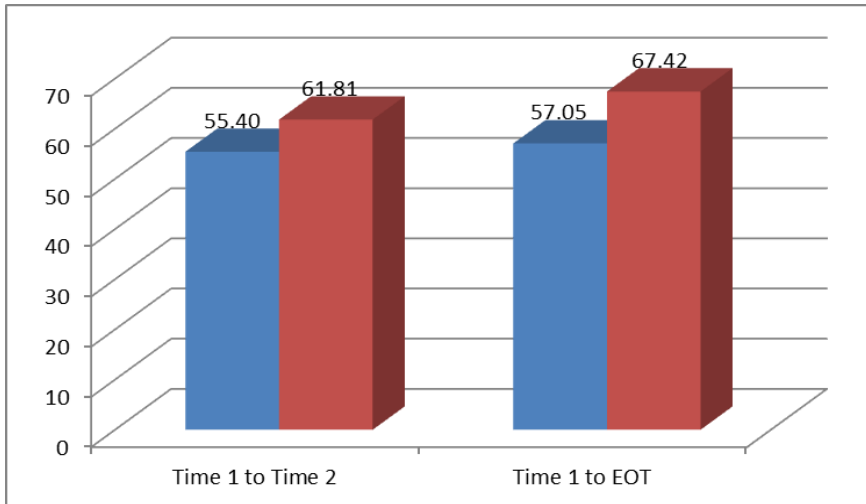


#### South Camden Team

As shown in Figure 11, the mean score at Time 1 was 55.40 (SD=11.79) and the mean score at Time 2 was 61.81 (SD=12.00). The mean improvement in scores was therefore 6.42.

For cases with a Time 1 and End of Treatment CGAS, the mean score at Time 1 was 57.05 (SD=10.26) and the mean score at End of Treatment was 67.42 (SD=10.92). The mean improvement in scores was therefore 10.37. This met the reliable change criterion of 10.11, thus indicating that change was due to the impact of the intervention.

Figure 11

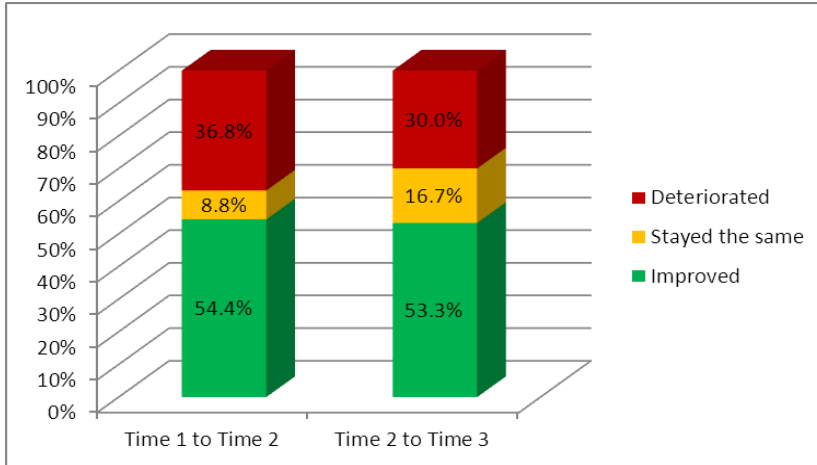


#### Other Measures:

##### SLDOM

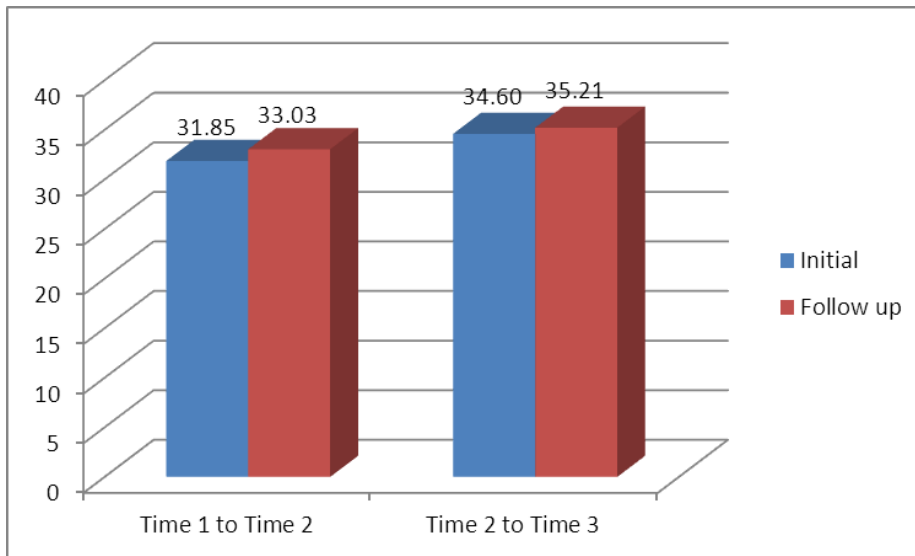
Mosaic: This is a measure of parental perception of capacity to cope with children's difficulties, particularly useful for children with disabilities. 123 cases had a Time 1 SLDOM and 68 cases had a Time 2 SLDOM. As shown in Figure 12, 37 scores increased from Time 1 to Time 2, 6 stayed the same and 25 decreased. 30 cases had a Time 2 and Time 3 SLDOM. As shown below, 16 scores increased, 5 score stayed the same and 9 decreased.

Figure 12



As shown in Figure 13, the mean value at Time 1 for the SLDOM was 31.85 (S.D= 4.68). The mean value at Time 2 was 33.03 (SD= 5.17). The mean improvement in scores was therefore 1.18. The mean value at Time 2 was 33.03 (SD= 5.17). The mean value at Time 3 was 34.60 (SD=4.85). The mean improvement in scores was therefore 1.57.

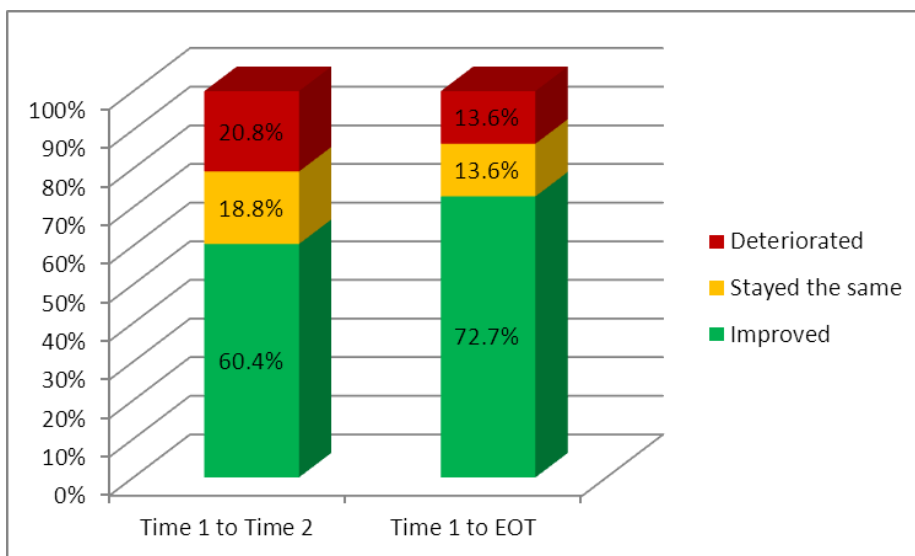
Figure 13



### Strengths and Difficulties Questionnaire

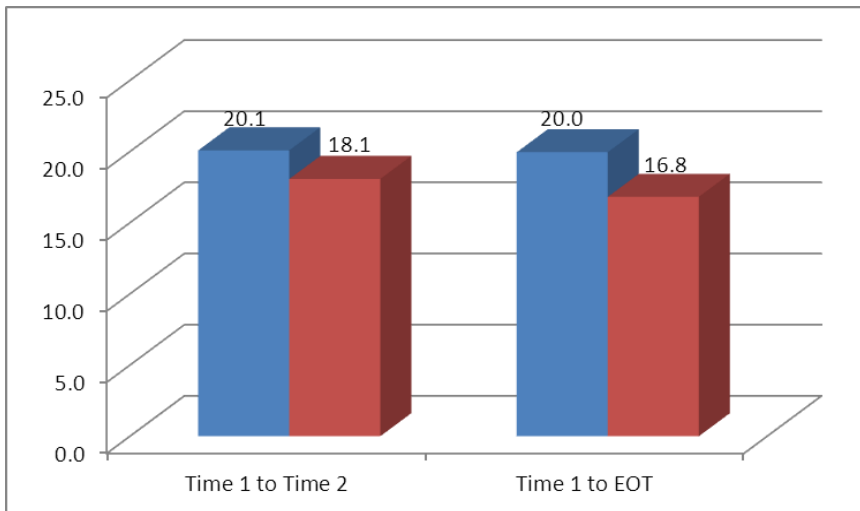
Mosaic: 106 cases had a Time 1 SDQ and 48 cases had a Time 2 SDQ. As shown in Figure 14, 29 scores decreased (improvement), 9 stayed the same and 10 increased (deterioration). 22 cases had a Time 1 SDQ and an End of Treatment SDQ. Of these cases, 16 scores decreased (improvement), 3 stayed the same and 3 increased (deterioration).

Figure 14



As shown in Figure 14 the mean score at Time 1 was 20.10 (SD= 5.06). The mean score at Time 2 was 18.10 (SD=5.59). The mean improvement in scores was therefore 2.00. For cases closed this period, the mean score at Time 1 was 20.0 (SD=4.60). The mean score at End of Treatment was 16.80. The mean improvement in scores was therefore 3.20.

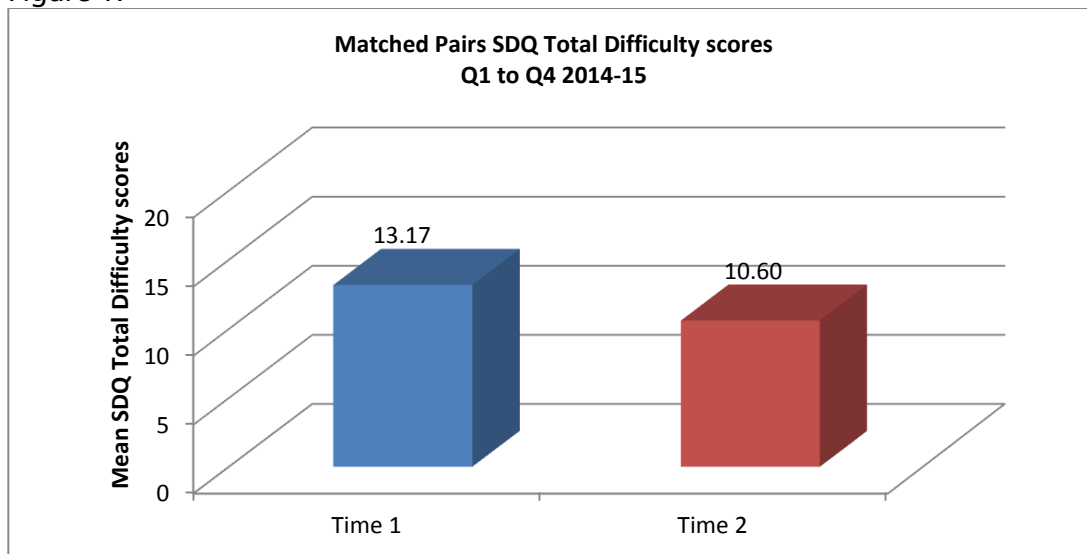
Figure 14



### Integrated Early Years Service

During Q1-Q4, there were n=65 T1 scores and there were n=20 T2 scores. The mean score at T1 was 13.17 and the mean score at T2 was 10.60. 66.7% (n=12) improved from T1 to T2, 11.1% (n=2) stayed the same, and 22.2% (n=4) reported an increase in their total difficulty score.

Figure 17

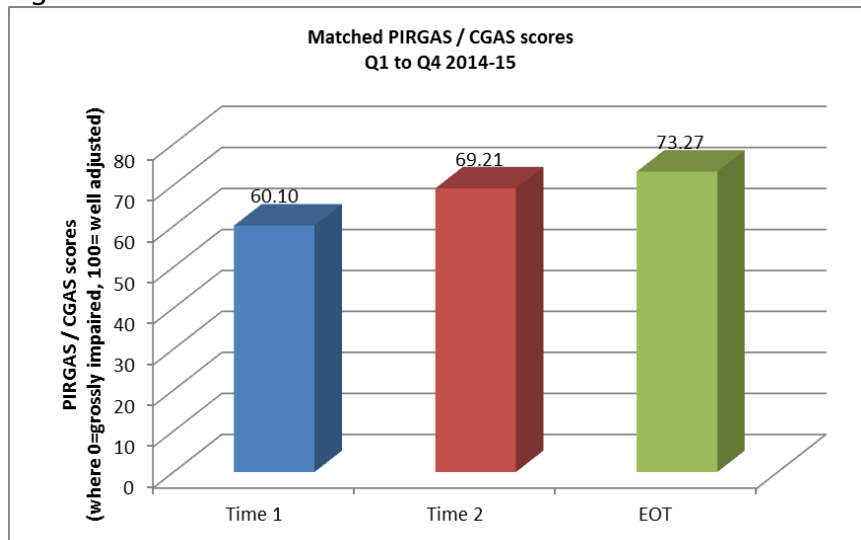


### Parent-Infant Relationship Global Assessment Scale (PIR-GAS) and Children Global Assessment Scale (CGAS):

Integrated Early Years Service: The PIR-GAS scores are assigned by the therapist used to assess child-parent (or carer) relationship on a 100-point scale. The C-GAS scores are assigned by the therapist working with children aged 4 years and over, CGAS and PIRGAS scores are presented together in figure 15. There were n=126 T1 scores, n=67 T2 scores and n=11 End of Treatment

scores. The mean score at T1 was 60.10, the mean score at T2 was 69.21 (change 9.0) and the mean score at End of Treatment was 73.27 (change 4.1)

Figure 15





## Board of Directors : May 2015

**Item: 11**

**Title :** Annual Report and Accounts

**Note:**

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

**Purpose:**

The Annual Report and Accounts have been compiled in accordance with the *NHS Foundation Trust Annual Reporting Manual 2014/15*, issued by Monitor.

The report has been reviewed by the management committee on 14<sup>th</sup> May and will have been seen by the audit committee in May, as well as having been reviewed by our external auditors.

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

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

- Quality
- Communications
- Finance

**For :** Approval

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





## Board of Directors : 26 May 2015

**Item : 12**

**Title : Annual Quality Report**

### **Summary:**

We are asking the Board to approve the Quality Report on behalf of the Chief Executive and Chairman, in order that the Chief Executive and Chairman can 'sign off' the Quality Report.

For Directors to decide whether they are in a position to provide this assurance, it will be necessary for Directors take steps to satisfy themselves on the criteria included on the attached paper, which they need to consider when reviewing the Draft Quality Report (Appendix 1).

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

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

- Quality
- Patient / User Experience
- Safety

**For : Approval**

**From : Quality Standards and Reports Lead**

## Appendix 1

### Statement of Directors' Responsibilities in Respect of the Quality Report

#### 1. Introduction

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

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

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- 2.1. In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:**
- 2.2. The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance.**

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

- 2.3. The content of the Quality Report is not inconsistent with internal and external sources of information including:**

- Board minutes and papers for the period April 2014 to May 2015.
- Papers relating to Quality reported to the board over the period April 2014 to May 2015.
- Feedback from commissioners dated 14 May 2015.
- Feedback from governors dated 11 May 2015.

- Feedback from local Healthwatch organisations dated 18 May 2015.
- Feedback from Overview and Scrutiny Committee dated 18 May 2015.
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. We have produced an annual complaints report dated April 2015 covering 2014/15, which was presented to the Board in April 2015.
- The 2014 national staff survey, received by the Trust in February 2015.
- The Head of Internal Audit's annual opinion over the trust's control environment dated 20 May 2015.
- CQC Intelligent Monitoring Report dated 4 March 2015

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

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

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

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

#### **2.5. There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.**

Data validation forms, which form part of the Framework for Data Quality and Reporting have been completed for each data entry in the Quality Report, and signed off by the relevant Director. These forms outline the systems for recording the data; process for obtaining the data; data validation processes, where relevant; assurances over data quality; gaps/risks in data assurance, and action plans to address risks and/or provide assurance, where required. These data validation forms have been reviewed by the Director of Quality and Patient Experience who

undertakes the internal quality assurance process for the data reported in the Quality Report, identifying gaps and risks in data assurance and providing recommendations for improving data quality. The Trust has fully implemented its assurance process via the CQSG, which has been in operation since July 2010. We consider therefore that there are proper controls in place, which are subject to review and which work effectively in practice.

**2.6. The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;**

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

**2.7. The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at [www.monitor.gov.uk/annualreportingmanual](http://www.monitor.gov.uk/annualreportingmanual)) as well as the standards to support data quality for the preparation of the Quality Report (available at [www.monitor.gov.uk/annualreportingmanual](http://www.monitor.gov.uk/annualreportingmanual)).**

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

By order of the board

NB: sign and date in any colour ink except black

.....Date.....Chairman

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

# Quality Report

2014/2015



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## Introduction

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

## Core Purpose

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

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

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



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

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

- The experience that our patients have of the way they are dealt with by our administrative teams and by our clinical staff.
- The way we collect, report and use information about the outcome of patients' treatment.
- The effectiveness of the wide variety of treatments our patients receive from us.
- The experience patients and students have when they visit us, including the accessibility, lay-out, condition and décor of our buildings and rooms and the facilities we offer.
- The way we communicate information about our clinical and educational services to patients and students and to organisations which purchase those services from us.
- The way we collect, protect and store information about our patients.
- The way we engage with patients, students, our Members, the general public, our Governors and all our stakeholders in order to keep them informed and to take their views into account.
- The way we keep all members of our workforce highly motivated, well trained and effective in order to deliver the best possible services.

### **How are we doing?**

Our continued effort and commitment to improve quality has resulted in positive outcomes for our Quality Priorities for 2014/15 namely, for demonstrating the effectiveness of our clinical services; for us improving access to information about our clinical services for patients and for the emphasis we have placed on hearing the patient's voice. You can read about more about these achievements in Part 2.

## How we monitor our performance

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

The Clinical Quality, Safety, and Governance Committee (CQSG) is a Board appointed committee with Trust and Non-Executive Director members and Governors which meets quarterly to receive and consider assurance of progress against requirements and action plans across the core of our quality improvement agenda, and to review work stream reports submitted to this committee. These key work streams, which are at the heart of our quality commitment, cover areas such as clinical effectiveness, patient experience, safety and staff training, with quarterly reports to the Board of Directors. These work streams are:

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

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

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

One of the major roles of the Council of Governors during 2014/15 has been to ensure that they are fully involved in both contributing to and monitoring the Trust's quality agenda. The influence of the Council of Governors is interwoven in all the key decision making processes and they do this in a variety of ways:

By Governors' attendance at key committee meetings and fora including

- PPI Meeting
- Clinical Quality, Safety, and Governance Committee (CQSG)
- Equalities Committee
- Quality Stakeholders Meeting

- Governors Clinical Quality Meeting
- By considering the quality agenda at all of their Council meetings.
- By visiting and where possible observing the work of the different departments and services and attending Trust Board Meetings.
- In particular, the Governors Clinical Quality Meetings continue to provide an important forum for Governors and key Trust staff to focus on the quality agenda for the Trust and ways for improving quality.

### **Our priorities for 2015/16**

In line with our Operational Plan, services will be re-designed, taking into account quality maintenance and improvement.

We have joined the NHS Benchmarking Network and we will continue to make use of benchmarking data for our Child and Adolescent Mental Health Service.

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

Our Quality Priorities for 2015/16 will focus on:

- Continuing to demonstrate further positive changes for patients, as a consequence of the psychological intervention/treatment they receive from the Trust.
- Increasing the involvement of service users across our work including increasing representation on interview panels and working to ensure that this is a positive and valuable experience for the service users who volunteer to do this.
- Developing a quarterly PPI newsletter for Trust staff and service users to include updates on patient stories.
- For the PPI team to improve its presence on the Trust website.

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

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

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

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



Paul Jenkins  
Chief Executive

# TOPS Tavistock Outreach in Primary Schools



## What is the project?

We work with families who prefer to be seen in school and/or when other interventions have not been successful. We offer children and their families a range of tailored therapeutic interventions following initial assessment meetings.

The project helps to reduce anxieties about stigma and blame in the wider community, promoting the idea that help with complex emotional difficulties can be an ordinary part of community life.

## Who is the service for?

We see children aged 3 to 11 and their families. Typically these children are experiencing severe difficulties with expressing/coping with their emotions and may behave in ways that are extremely upsetting and hard to manage, for themselves, their families and schools.

As well as working with individual children and their families, we work closely with teachers and education staff. Teachers are helped to understand the underlying meaning of pupil behaviour, identify children more easily who are at risk and feel more confident about their work with troubled pupils who require more support and attention.

## Outcomes

From TOPS latest 2014/2015 evaluation and audit report:

100% of the parents and 88% of the children aged 9 to 11 said that overall the help received from TOPS was "good".

100% of parents and 75% of children aged 9 to 11 said that their views and worries "were taken seriously".

95% of parents and 100% of children aged 9 to 11 said that they found it "easy to talk".

95% of parents and 94% of children aged 9 to 11 felt they were "listened to".

From parents and children who received therapy:

*"It really helped coming to do the sessions."*  
– child

*"They listened to me and gave me good advice."*  
– child

*"My concerns were listened to. It made me feel better."*  
– mum

*"I was satisfied with how seriously they had taken my child's problem."*  
– mum

## 1.1. Achievements in Quality

We are proud to report that, in addition to our Quality Priorities, during the year 2014/15 we achieved the following:

- An Independent evaluation of the Family Drug and Alcohol Court led by Brunel University and funded by the Nuffield Foundation found that parents who had been through the FDAC process as opposed to ordinary care proceedings were more likely to stop misusing substances and, if they did so, more likely to be reunited with their children. FDAC families who were reunited at the end of proceedings had lower rates of neglect or abuse in the first year following reunification than reunited families who had been through ordinary care proceedings.
- We are delighted to announce that our pioneering City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) has been shortlisted in the category 'Mental Health Team' for the BMJ Awards 2015. The BMJ Awards are the UK's premier medical awards programme, recognising and celebrating the inspirational work done by doctors and their teams.
- Gloucester House Day Unit (which is a school for children with emotional difficulties and challenging behaviour) has undertaken a transformation of its service to offer a significantly lower cost model and managed to reduce costs by almost 30%. The Unit was awarded 'outstanding' status in every Ofsted category that was inspected. This achievement highlights how well the school is performing and their level of excellence and expertise in educating this complex and vulnerable group of children and young people.
- We were delighted we were successful in winning bids for number of new services including the management of Family Drug and Alcohol Courts (FDAC) in Milton Keynes and Buckinghamshire and a new treatment service for Anti-Social Personality (ASPD) Disordered Patients to be coordinated by the Portman Clinic.
- British Red Cross/Tavistock Partnership won an award for excellence & innovation. This is a prestigious national award that acknowledged the creativity of this new and exciting project.
- The Trust held a 'Time to Talk' event in September in support of the 'Time to Change' programme. Time to Change is a national programme run by the charities Mind and Rethink Mental Illness, setup to create a positive shift in public attitudes towards mental health

problems and promote better understanding to combat discrimination.

- Dr Jonathan Campion, Director for Public Mental Health, South London and Maudsley Trust was invited by the Trust to provide a talk on the link between smoking and mental health illness. As smoking cessation has become an essential target for public health, the Trust considered it important to invite a speaker with such extensive experience in this area.
- The Trust applied and was selected to be a Stonewall Health Champion and through this Department of Health funded scheme we have been provided with free consultation from Stonewall for a year. This has led to different developments within the Trust to promote an LGBT (Lesbian, Gay, Bisexual, and Transgender) friendly environment for staff, students and service users. For example, posters have been put up around the Trust, leaflets provided in the Adolescent and Young Adult Service waiting room and children's books with stories containing different types of family have been placed in the children's waiting room. A successful first LGBT and friends staff meeting was held in December and further events are planned for 2015.



## 1.2 Overview of Quality Indicators 2014/15

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

Target	RAG Status*	Achievement	Page Number
Child and Adolescent Mental Health Service Outcome Monitoring Programme			
For 75 % of patients to complete the Goal-Based Measure (GBM) at Time 1 and Time 2 (ideally with at least 2 targets).		73%	15
For 75% of patients to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on 2 targets (goals).		75%	15
Adult Outcome Monitoring Programme			
For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.		53%	16
Access to Clinical Service and Health Care Information for Patients and Public			
To ensure that information from the patient story is on the patient section of the website.		Achieved	17
To run a Visual Straw Poll on awareness of the patient stories.		Achieved	17
Based on the feedback from the Visual Straw Poll, to revise the communications campaign to publicise patient stories if necessary.		Achieved	17
Patient and Public Involvement			
To run at least two staff trainings on having services users on panels.		Achieved	19
To have at least three interviews with service users on the panel.		Achieved	19
To take a minimum of three real patient stories to the Trust Board in one of the following ways: a patient visiting the Board, the Board seeing a video or a transcript of the description of the journey.		Achieved	19
Patient Safety Indicators			
NHS Litigation Authority Level		Level 2 achieved Feb 2011	35
Patient Safety Incidents		15	37
Monitoring of Adult Safeguard Alerts		0	38
Safeguarding of Children – Level 1 Training		97%	40
Safeguarding of Children – Level 2 Training		100%	
Safeguarding of Children – Level 3 Training		94%	
Clinical Effectiveness Indicators			
Monitor number of staff with PDPs		97.5%	44



Patient Experience Indicators		
Complaints received	14	46
Patient Satisfaction		
Percentage of patients that rated the overall help they had received as good:		
Quarter 1	93%	46
Quarter 2	92%	
Quarter 3	91%	
Quarter 4	93%	
Did Not Attend Rate		
Trust Wide – First Attendances	7.8%	48
Trust Wide – Subsequent Appointments	7.7%	48
Waiting Time Breaches**		
Trust Wide – Number of patients waiting for first appointment for 11 or more weeks	36	50
Internal Causes	13	
External Causes	23	
Trust Wide – Percentage of patients waiting for first appointment for 11 or more weeks	1.9%	50
Internal Causes	0.7%	
External Causes	1.2%	
Other Achievements		
IG Assessment Report overall score	96%	32
Maintaining a High Quality, Effective Workforce		
Attendance at Trust Wide Induction Days	90%	38
Completion of Local Induction	98%	39
Attendance at Mandatory INSET Training	98%	39

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

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

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

### 2.1. Priorities for Improvement

#### Progress against 2014/15 Quality Priorities

Looking back, this section describes our progress and achievements against the targets we set for each quality priority for 2014/15.

#### Clinical Effectiveness (Clinical Outcome Monitoring)

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

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

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

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

##### What measure and why?

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

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

As a result, we set the following targets (in the table below), which also represent the CQUIN (see Glossary) targets we had agreed with our commissioners for 2014/15.

For CAMHS, Time 1 refers to the Pre-assessment stage, where the patient is given the Goal-Based Measure to complete with their clinician when they are seen for the first time, where the patient decides what would like to achieve. Then, the patient is asked to complete this form again with their clinician after six months or, if earlier, at the end of therapy/treatment (known as Time 2), indicating whether or not they have achieved their goal.

1. Child and Adolescent Mental Health Service Outcome Monitoring Programme			
Targets for 2014/15	2012/13	2013/14	2014/15
1. For 75 % of patients to complete the Goal-Based Measure (GBM) at Time 1 and Time 2 (ideally with at least 2 targets)*.	76%	79%	73%
2. For 75% of patients to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on 2 targets (goals)**.	99%	73%	75%***

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

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

\*\*\* For 2014/15 when those patients who only set one goal at Time 1 and who improved on that one goal are included, the improvement rate increases to 82%.

## How have we progressed?

1. Unfortunately, this year we fell slightly short of the target of 75%, by achieving 73% for the return rate of forms for the Goal-Based Measure completed by patients/service users, in conjunction with clinicians, at both Time 1 and Time 2.
2. However, we are very pleased to have achieved the target, for 75% of patients to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on 2 targets (goals), which is an improvement on last year when we achieved 73%. This is an important target as it enables us to demonstrate positive changes for patients as a consequence of the psychological intervention and/or treatment they have received from the Trust.

## Priority 2: Adult Outcome Monitoring Programme

### What measure and why?

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

For the Adult Service, we used the CORE form again for the current year, building on the knowledge we have gained since 2012, with patients previously referred to the Adult Service. We set the following targets, which also represent the CQUIN (see Glossary) target we had agreed with our commissioners for 2014/15.

2. Adult Outcome Monitoring Programme			
Targets for 2014/15	2012/13	2013/14	2014/15
1. For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients over the age of 25.	*	*	53%

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

### How have we progressed?

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

We are pleased to report that we exceeded our target, as 53% of patients who completed the CORE forms at Time 1 and Time 2 showed an improvement in their Total CORE score from the Pre-assessment to the End of Treatment stage. Again, we consider this to be a very positive result as it enables us to demonstrate positive changes for patients as a consequence of the

psychological intervention and/or treatment they have received from the Trust\*\*.

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

#### What are we measuring and why?

3. Access to Clinical Service and Health Care Information for Patients and Public	
Targets for 2014/15	2014/15 Outcome
1. To ensure that information from the patient story is on the patient section of the website.	The target was achieved.
2. To run a Visual Straw Poll on awareness of the patient stories.	The target was achieved.
3. Based on the feedback from the Visual Straw Poll, to revise the communications campaign to publicise patient stories if necessary.	The target was achieved.

We set the following targets for 2014/15:

#### Target 1

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

#### Measure Overview

In 2014/15 a new initiative was launched to take patient stories to the Board of Directors. Patients would be invited to share their story at a Board of Directors meeting. The purpose of the patient stories initiative was to enable Board members to hear first-hand about our services from those who use them so that they can be improved. Part of this initiative was to include the stories of those patients who consented on the Trust website, so that members of the public might also have a better sense of patient journeys within our services.

\*\*The NHS Mandate commits NHS England to playing 'a full part in delivering the commitments that at least 15% of adults with relevant disorders will have timely access to services, with a recovery rate of 50% by 2015.'

### How have we progressed?

This target was achieved. A news article regarding the first two patient stories was posted on the website on 13<sup>th</sup> October 2014. The article reports on the first two people to attend the Board of Directors meetings and invites further volunteers to come forward. Two patients have consented to their full story being shared on the website. These stories will be added as part of the refresh programme which is taking place and will be posted by the end of Quarter 1 in 2015/16.

### Target 2

To run a Visual Straw Poll on awareness of the patient stories.

#### Measure Overview

The Visual Straw Poll was used to survey awareness and knowledge of the Patient Stories initiative.

### How have we progressed?

This target was achieved. A Visual Straw Poll was run from 20<sup>th</sup> October 2014 to the 3<sup>rd</sup> November 2014 posing the question 'Did you know you can come to our Board of Directors meeting and share your story?' A total of 78 tokens were posted. 39 people responded 'yes', 30 responded 'maybe' and 9 responded 'no'.

As a sub-heading to the question respondents were encouraged to leave their contact details in the post box by the general office if they wished to share a patient story. However, no contact details were received.

### Target 3

Based on the feedback from the Visual Straw Poll, to revise the communications campaign to publicise patient stories if necessary.

#### Measure Overview

In order to ensure the patients' stories were accessible, the Communications Strategy around this initiative was reviewed based on the results of the Visual Straw Poll.

## How have we progressed?

This target was achieved. In addition to the news article posted on the website an article reporting on the first patient to share their story at the Board of Directors meeting was included in the autumn 2014 Members' Newsletter. A poster and leaflet advertising patient stories and providing details of how to get involved have been created and displayed in Trust waiting rooms and notice boards and taken to relevant events.

## Priority 4: Patient and Public Involvement

4. Patient and Public Involvement	
Targets for 2014/15	2014/15 Outcome
1. To run at least two staff trainings on having services users on panels.	The target was achieved.
2. To have at least three interviews with service users on the panel.	The target was achieved.
3. To take a minimum of three real patient stories to the Trust Board in one of the following ways: a patient visiting the Board, the Board seeing a video or a transcript of the description of the journey.	The target was achieved.

We set the following targets for 2014/15:

### Target 1

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

### Measure Overview

Over the past two years the Trust has been working towards increasing user input into staff interviews. The PPI Committee agreed to the development of a structure for service users to be involved in the recruitment and selection processes for staff appointments with patient contact. Part of this process involved preparing and supporting staff with this new initiative. The PPI team arranged two training sessions for staff with an external trainer in order to prepare staff who were involved in the recruitment and selection of new staff.

## How have we progressed?

This target was achieved. Two staff training sessions have taken place on having service users on interview panels. The training sessions took place on

23<sup>rd</sup> September 2014 and 15<sup>th</sup> October 2014 and were facilitated by Elizabeth Neill Youth Engagement and Training Coordinator from YoungMinds. Both sessions were well attended.

## Target 2

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

### Measure Overview

The Trust is committed to service user input on interview panels and the PPI team committed to facilitating the recruitment of service users to sit on three interview panels during the first year of this initiative.

### How have we progressed?

This target was achieved. Eleven interviews have been held with service users on the panel, which has involved helping service users prepare for the interviews and obtaining feedback from the service user and de-briefing them following the interviews.

## Target 3

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

### Measure Overview

Following the first patient story to be presented at the July Board meeting, the Board agreed that this was a valuable initiative and proposed that a minimum of three more patient stories should be shared at Board meetings within the year.

### How have we progressed?

This target was achieved. Five patient stories have been taken to the Trust Board. Two adult patients and one parent of a young patient attended the Board in person to share their story. One adult patient provided a transcript which was presented to the Board by a member of the PPI team and two adolescent service users from the North Camden Service shared their stories via a short video which was shown to the Board.





## What is the project?

We are committed to involving patients, relatives and the public in the work we provide in order to ensure that we're responsive to users of our services and the community.

We gather feedback from a range of sources, both formal and informal, including:

- Patient surveys
- A confidential feedback box
- Feedback to our Patient Advice and Liaison Service (PALS)
- Focus groups
- Events, such as lectures and open days
- User representation on committees

## Who is the service for?

We welcome involvement from patients and their families, students and anyone else interested in our work. The public is able to contribute to our development through:

- Joining our patient and public involvement forum
- Getting involved in committees or groups
- Working on a short-term project that needs a patient's viewpoint
- Reviewing our leaflets and advising on their content and language
- Giving us general feedback

## Outcomes

In 2014-15 we have achieved our target of at least three service users visiting the Board of Directors to tell their story. We also achieved our target of at least three service users taking part in interview panels. We are continuing to further develop our PPI strategies through holding interactive patient events and staff conferences.

From people who had received therapy:

“ It helped so much to have someone to talk to. ”

“ My points of view are listened to and taken into account. ”

“ Very professional consultants, knowledgeable and understanding. ”

“ Understanding and emotional support. ”

## Quality Priorities for 2015/16

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

Camden CCG (Clinical Commissioning Group, see Glossary) and our clinical commissioners from other boroughs have played a key role in determining our priorities through review of the 2014/15 targets and detailed discussion to agree CQUIN targets for 2015/16.

Our Stakeholders Quality Group has been actively and effectively involved in providing consultation on clinical quality priorities and indicators. This group includes patient, Governor and non-executive director representatives along with the Patient and Public Involvement (PPI) Lead, Quality Reports and Standards Lead and the Trust Director. The Governors Clinical Quality Group has played a key role in helping us to think about some of our quality priorities for next year. In addition, this year having a representative from Healthwatch Camden join the PPI Committee has made a useful contribution to this process.

### Clinical Effectiveness (Clinical Outcome Monitoring)

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

We have agreed with our commissioners, as part of our CQUIN target for 2015/16, to raise the return rate (see Glossary) from 75% to 80% for patients (attending CAMHS who qualify for the CQUIN) who complete the Goal-Based Measure (GBM) with their clinician at the Pre-assessment stage (known as Time 1) and after six months or, if earlier, at the end of therapy/treatment (known as Time 2). We have set this as one of our Quality Priority targets.

For our second target, we have agreed with commissioners to continue with one of the CQUINs (see Glossary) targets from 2014/15, which we have also set as one of our Quality Priority targets namely, for 75% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).

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

### Targets for 2015/16

1. For 80% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at the Pre-assessment stage (known as Time 1) and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).
2. For 75% of patients who complete the Goal-Based Measure (GBM) to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on at least two targets (goals).

### Measure Overview

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

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

### Monitoring our Progress

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

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

## Priority 2: Young Adult and Adult Outcome Monitoring Programme

For 2015/16, we plan to continue to focus on evaluating the change for adult patients (over 25 years of age) from the Pre-assessment phase to the End of Treatment phase, but this year we plan to extend this target down to young adults (aged 18 to 25) as a way of evaluating our clinical effectiveness for the group of patients (aged 18 and above) who qualify for the CQUIN (see Glossary).

We have set the following target for 2015/16, which also represents the CQUIN (see Glossary) target we have agreed with our commissioners (TBC)

### 2. Young Adult and Adult Outcome Monitoring Programme

#### Target for 2015/16

1. For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.

## Measure Overview

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

## Monitoring our Progress

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

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

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

We have set the following targets for 2015/16:

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

##### Targets for 2015/16

1. PPI team to develop a quarterly PPI newsletter for Trust staff and service users to include updates on patient stories
2. PPI Newsletters to be available on the Trust website
3. Following launch of the newsletter, a Visual Straw Poll to be run on awareness of the newsletters

#### Target 1

The PPI team will develop and launch a quarterly PPI newsletter for Trust staff and service users to include updates on patient stories.

#### Measure Overview

There is a great deal of service user involvement work going on within the Trust but it is often not well publicised. A quarterly newsletter will summarise all of the initiatives and projects that have taken place within the previous quarter and also advertise projects that people can get involved in. The patient stories initiative will be one of the projects that is reported on.

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

The quarterly newsletter will be posted on the Trust Website.

#### Target 2

PPI newsletters to be available on the Trust Website and Intranet.

#### Measure Overview

As part of our review of how we communicate with patients, the Adult Reference Group have suggested that PPI team will need to improve its presence on the Trust website.

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

PPI newsletters will be posted on the website.

### Target 3

Following the launch of the newsletter a Visual Straw Poll to be run on awareness of the newsletter.

#### Measure Overview

A question on the Visual Straw Poll will be used to evaluate awareness and knowledge of the PPI quarterly newsletter.

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

The evidence will be the results of the Visual Straw Poll.

#### Monitoring our Progress

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

### Priority 4: Patient and Public Involvement

We have set the following measures and targets to monitor our performance during 2015/16:

#### 4. Patient and Public Involvement

##### Targets for 2015/16

1. To provide a service user for every clinical interview panel that requests a service user panel member.
2. To gain feedback from the service users who participate in interview panels. Feedback will be gained regarding three areas: preparation for the panel, participating in the panel and the debrief process. The PPI team will contact every service user who participates on an interview panel.

### Target 1

To provide a service user for every clinical interview panel that requests a service user panel member.

### Measure Overview

The PPI team has provided interview panel training sessions for service users who have volunteered to participate and now have a pool of service users who can sit on interview panels. The PPI team will assist and support any member of staff who requests a service user panel member, to identify a service user to sit on their interview panel.

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

The PPI team will maintain their local spreadsheet containing details of interview panels that have taken place including a service user on the interview panel.

### Target 2

To gain feedback from the service users who participate in interview panels. Feedback will be gained regarding three areas: preparation for the panel, participating in the panel and the debrief process. The PPI team will contact every service user who participates on an interview panel.

### Measure Overview

We are committed to including service users on panels and wish to ensure that it is a positive and valuable experience for those who participate, so will plan to making changes to the process based on the feedback we receive.

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

The evidence will be feedback reports maintained by the PPI team. The PPI team will contact service users to ask them about their experience of being on an interview panel.

### Monitoring our Progress

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



# Tottenham Thinking Space Project



## What is the project?

This project aims to bring people together to talk and think about life in Tottenham, what is good and what could be better. It was funded by Haringey Directorate of Public Health after the 2011 riots, to pilot a community mental health intervention based on a model developed in Brazil by Adalberto Barreto called "community therapy". It is a group therapeutic model which seeks to enable people to better understand themselves, develop relationships and support each other to improve themselves and their local community.

## Who is the project for?

The project is for all who live in Tottenham. However it 'reaches out' to engage the most disadvantaged residents. Since its launch in October 2013, in response to the views of participants, the Project has developed four Thinking Spaces: A weekly Thinking Space open to all; a weekly Tea & Coffee morning for isolated women in partnership with Tottenham Green Holy Trinity Church; a fortnightly Men's Group and a fortnightly Women's Health & Well-being group.

## Outcomes

There have been a number of initiatives taken by participants in the project, for example, the mums who participate in the mums tea & coffee mornings organised a programme of activities to help themselves and local families cope with the long summer school holidays last year. One mother who has struggled with depression exhibited her art work on 'post-natal depression' using the forum of Thinking Space to discuss the challenges and experience of post-natal depression and recovery. Other participants have been inspired to become volunteers in the project and others have moved from unemployment into employment/training.

### From participants of the Tottenham Thinking Space Project:

“ We can look out for each other. It's a shared thing. That's what community should be about in Tottenham. ”

“ I think it's brilliant that it's broken those walls down and now I have a lot more trust of people in the area. ”

“ It's enhanced my life. To realise that there are other people in a common situation, like myself, and realising that just by sharing my experiences that might help someone else. ”

“ Being part of a group where you are widening each other's perspectives, learning about the importance of really listening. ”



## 2.2 Statements of Assurance from the Board

*For this section (2.2) of the Report the information is provided in the format stipulated in the Annual Reporting Manual 2014/15 (Monitor).*

During 2014/15 The Tavistock and Portman NHS Foundation Trust provided and/or sub-contracted six relevant health services.

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

The income generated by the relevant health services reviewed in 2014/15 represents 100 % of the total income generated from the provision of relevant health services by The Tavistock and Portman NHS Foundation Trust for 2014/15.

### Participation in Clinical Audits and National Confidential Enquiries

During 2014/15 1 national clinical audit and 2 national confidential enquiries covered relevant health services that The Tavistock and Portman NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust was eligible to participate in during 2014/15 are as follows:

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

The national clinical audits and national confidential enquiries that The Tavistock and Portman NHS Foundation Trust participated in during 2014/15 are as follows:

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

The national clinical audits and national confidential enquires that The Tavistock and Portman NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed below alongside the

number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- **Confidential inquiry into Homicide and Suicide:** we responded to one request for a review report of an adult male who had taken his life. The male had been seen at the Trust.
- **Confidential Inquiry into Maternal Deaths:** the auditors did not approach the Trust to complete an audit form in 2014/15
- **National Audit into Psychological Therapies:** no data collection was required in 2014/15, the Trust received a copy of the second report of this audit in 2013

The Trust received and reviewed the report of the National Confidential Inquiry into Homicides and Suicides in 2014/15 and in response The Tavistock and Portman NHS Foundation Trust has produced the following documents for staff to improve the quality of healthcare provided: 'Prevention of suicide procedure' and 'Assessment and management of self harm procedure', both which will be circulated to staff, available on the Trust Website and promoted at mandatory training events and at team meetings.

The reports of 9 local clinical audits were reviewed by the provider in 2014/15 and The Tavistock and Portman NHS Foundation Trust has plans in place to improve care as a result of the learning from these audits.

Audit topics included compliance with case note standards involving 3 audits and one re-audit; audit of patients attending the Fitzjohns unit; audit of prescribing practice in children and adolescent services; audit of care in the FAKCT (Fostering Adoption & Kinship Care Team); audit of care in the EIS (Early Intervention Service); audit of care of patients receiving intensive treatment in the Adolescent and Young Adult Service

Actions include:

- Continued improvement in record keeping
- Use the initial learning from audit of adult 'intermittent therapy' service along side other data to inform service redesign work in Adult services.
- Learning from the 'prescribing audit' will inform development of the electronic records format which will be rolled out in 2015/16.

- Further changes to information collected at assessment to ensure key data is available (e.g. inclusion of 'duration' as a standard question in Fitzjohns unit assessments).

### Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by The Tavistock and Portman NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 282. Throughout the year, the Trust has been involved in 5 studies; 3 were funded (of which 0 were commercial trials), and 2 were unfunded.

### The use of the CQUIN Framework

A proportion of The Tavistock and Portman NHS Foundation Trust income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between The Tavistock and Portman NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2014/15 and for the following 12 month period is available electronically at <http://www.tavistockandportman.nhs.uk/about-us/governance/commissioning-quality-and-innovation-cquin>

The total financial value for the 2014/15 CQUIN was £249,156 and The Tavistock and Portman NHS Foundation Trust expects to receive £244,522. (The Trust received £257,775 in 2013/14).

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

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

The Care Quality Commission has not taken enforcement action against The Tavistock and Portman NHS Foundation Trust during 2014/15.

The Tavistock and Portman NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2014/15.

In March 2014 the Trust underwent a routine inspection by the Quality Commission (CQC). We continue to hold full registration with the CQC without restriction. The full report is available on the CQC website, [www.cqc.org.uk](http://www.cqc.org.uk).

### Information on the Quality of Data

The Tavistock and Portman NHS Foundation Trust did not submit records during 2014/15 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This is because The Tavistock and Portman NHS Foundation Trust is not a Consultant-led, nor an in-patient service.

The Tavistock and Portman NHS Foundation Trust Information Governance Assessment Report overall score for 2014/15 was 96% and was graded green.

The Tavistock and Portman NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2014/15 by the Audit Commission.

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

- The Trust has agreed to streamline all clinical data collection and reporting across the Trust. For this purpose the Trust has introduced the Quality Team with a remit to ensure that processes and procedures are in place, across the Trust including outreach services, to ensure we meet our local and nationally agreed targets. They will also promote the Trust's quality agenda with a robust campaign of posters, training, events etc. highlighting our current CQUIN and KPIs (Key Performance Indicators) and the work required to achieve them.
- The Quality team meets with department managers on a monthly basis to go through the department's quality performance dashboard in relation to CQUINS, KPIs and any locally agreed targets. Action plans are put in place, where targets are identified to be weak or insufficient, so that improvements can be made in time to achieve the targets for quarterly reporting.
- In order to provide assurance to the Trust's Quality Lead and Trust Board, a senior committee has been established, the Data Analysis and Reporting Committee (DARC) to look at clinical data in line with the Trust's overall strategic plans and to enable the Trust to benchmark services both internally and externally.

- As reported previously we are in the process of moving to an electronic patient administration system, Carenotes, which will further assist us to streamline our data collection and reporting providing us with a paperless system with clinicians directly entering patient clinical data.

## 2.3 Reporting against core indicators

Since 2012/13 NHS foundation Trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC)\*.

As specified by Monitor:

‘For each indicator the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods should be presented in a table. In addition, where the required data is made available by the HSCIC, a comparison should be made of the numbers, percentages, values, scores or rates of each of the NHS foundation Trust’s indicators with:

- the national average for the same and
- those NHS Trusts and NHS foundation Trusts with the highest and lowest for the same.’

However, the majority of the indicators included in this section (“Reporting against core indicators”) are not relevant to the Trust.

**Core Indicator No. 22** covers ‘The Trust’s ‘Patient experience of community mental health services’ indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period.’

Although, we have reported on patient satisfaction elsewhere in the Quality Report on page 46, the questions included in the Experience of Service Questionnaire (ESQ), which we use with patients we see in the Trust to obtain feedback on their experience of our services, cannot be directly compared with the questions derived from the Annual Report on Patient Experience from community mental health services.

However, we believe that with the positive feedback we have received from patients in 2014/15 (93% of patients in Quarter 1; 92% of patients in Quarter 2; 91% of patients in Quarter 3 and 93% of patients in Quarter 4 rated the

\*Please refer to pp13-16 of “Detailed requirements for quality reports 2014/15” ([www.gov.uk/monitor](http://www.gov.uk/monitor))

help they had received from the Trust as 'good') means that we would score very positively for patient experience when compared to other mental health Trusts.

**Core Indicator No. 25** covers "The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death". Again, the data for this indicator can be found elsewhere in the Quality Report on page 37.

## Part 3: Other Information

This section contains information relevant to the quality of relevant services provided by The Tavistock and Portman NHS Foundation Trust during 2014/15 based on performance in 2014/15 against indicators selected by the Board in consultation with stakeholders.

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

This includes an overview of the quality of care offered by the Trust based on our performance on a number of quality indicators within the three quality domains of patient safety, clinical effectiveness and patient experience. Where possible, we have included historical data demonstrating how we have performed at different times and also, where available, included benchmark data so we can show how we have performed in relation to other Trusts. These indicators include those reported in the 2012/13 and 2013/14 Quality Reports along with metrics that reflect our quality priorities for 2014/15. In this section, we have highlighted other indicators outside of our quality priorities that the Trust is keen to monitor and improve.

The Trust Board, the CQSG, along with Camden CCG and our clinical commissioners from other boroughs have played a key role in monitoring our performance on these key quality indicators during 2014/15.

#### Patient Safety Indicators

##### NHS Litigation Authority Level

Indicator	2012/13	2013/14	2014/15
NHS litigation Authority Level		Level 2 achieved (Feb 2011)	

##### What are we measuring?

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



# Refugee Service



## What is the project?

The Child and Family Refugee Team offers culturally sensitive talking therapies service to families and a range of community outreach projects. The team also offers consultation to health and social care staff on collaborative practice with refugee families.

In order to ensure that our service is as non-stigmatising, culturally sensitive and accessible as possible, we have practitioners who are from refugee communities. We work closely with interpreters and we draw on the knowledge of a network of community partners.

Our community outreach projects enable us to access families who would view more traditional mental health services as too stigmatising.

## Who is the service for?

The Refugee Service provides a culturally sensitive service to children, young people and their families from refugee and asylum seeking communities in Camden and other London boroughs. The service has developed particular expertise in working with separated children seeking asylum.

## Outcomes

Of the ESQ forms we received in 2014/15, 100% families said it was true that their "views and worries" were taken seriously, 97% said they would "recommend" the service to a friend and 95% "felt listened to". 94% felt that they were "treated well".

From families who had received therapy:

“ I am very pleased with the service we received. ”

“ My child's behaviour has improved so much. ”

“ It was so helpful to have someone listen and help with ideas. ”

“ You were there to help me and give me the confidence and ideas. ”



## Patient Safety Incidents

Indicator	2012/13	2013/14	2014/15
Patient Safety Incidents	30	42	15

### What are we measuring?

The Trust uploads details of all incidents that are reported that meet the requirements for registration on the NHS National Reporting and Learning System (NRLS). The NRLS definition of an incident that must be uploaded is as follows:

‘A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.’

The Trust has a low rate of ‘*patient safety*’ incidents due to the nature of its patient services, (we provide psychological therapies, we do not undertake any physical interventions, and are an out-patient service only). All 15 incidents reported in 2014/15 were in the “no harm/low harm” category, and were therefore rated as suitable for local review only.

Most of the reportable incidents relate to ‘pupil on pupil’ behaviour incidents i.e. when one pupil physically or emotionally ‘attacks’ another pupil which occurred in the Trust’s Specialist Children’s Day Unit, which is a school for children with emotional difficulties and challenging behaviour. Under the NRLS these are classed as patient to patient incidents and are therefore reportable

During the year the Trust did investigate a small number of serious patient incidents (for example, suicide of patients known to or being treated by the Trust). These incidents are not included in the above data as in these cases the patients were also known to another Mental Health Trust, which undertook the role of lead investigator

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

## Monitoring of Adult Safeguards

Indicator	2012/13	2013/14	2014/15
Monitoring of Adult Safeguard Alerts	0	0	0

### What are we measuring?

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

In 2014/15, no adult safeguarding referrals were made.

## Attendance at Trust-wide Induction Days

Indicator	2012/13	2013/14	2014/15
Attendance at Trust Wide Induction Days	77%	94%	90%

### Measure Overview

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

### Targets and Achievements

We are pleased to report that 90% of staff joining the Trust in 2014/15 attended the Trust-wide induction.

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

## Local Induction

Indicator	2012/13	2013/14	2014/15
Completion of Local Induction	95%	97%	98%

### Measure Overview

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

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

### Targets and Achievements

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

We are very pleased to report that we received 98% returned forms to show that the local induction had been completed by almost all of staff joining the Trust in 2014/15.

### Attendance at Mandatory INSET Training

Indicator	2012/13	2013/14	2014/15
Attendance at Mandatory INSET Training*	93%	95%	98%

\*Staff are expected to attend training every two years. In order to achieve this 100% attendance is expected over a two year period. Therefore, the figure reported shows the % of staff up to date with mandatory training at 31 March 2015.

## Measure Overview

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

## Targets and Achievements

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

Again, we are very pleased to report that 98% of our staff who were required to attend INSET training had done so within the previous two years and that the attendance rate has improved further since last year.

## Safeguarding of Children

Indicator	2012/13	2013/14	2014/15
Safeguarding of Children – Level 1 Training	*	94%	97%
Safeguarding of Children – Level 2 Training	**	88%	100%
Safeguarding of Children – Level 3 Training	82%	89%	94%

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

\*\* Not reported.

## What are we measuring?

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

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

To ensure that as a Trust we are protecting children and young people who may be at risk from abuse or neglect, the Trust has made it mandatory for all clinical staff in Child and Adolescent services and other clinical services working

predominantly with children, young people and parents to receive Level 3 Safeguarding of Children training once every three years.

## Targets and Achievements

The Trust places great importance on all staff receiving relevant safeguarding training and so we are very pleased that when compared with last year there has been an improvement in attendance for all three levels of Child Safeguarding training. By March 2015, 97% of staff received Level 1 training and 100% of staff attended Level 2 training. In addition, 94% of staff requiring Level 3 training had attended this training

## Staff Survey

### Introduction

The National NHS Staff Survey is completed by staff annually and took place between October and December 2014. The Trust's results from this year's survey continue to be positive overall and indicate that staff still consider the Trust to be a good employer.

### Summary of Performance

Some of the key highlights from the Staff Survey are summarised below:

The Trust's overall staff engagement score is once again higher than the national average (national average is 3.72 and the Trusts score is 3.97, measured on a scale of 1 – 5, 5 being highly engaged and 1 poorly engaged) and also better than the Trust's score of 3.91 in 2013.

Some of the other areas where the Trust received the best scores include:-

- *Staff recommending the Trust as a place to work and receive treatment*
- *Low numbers of staff experiencing harassment, bullying and abuse from patients, public and staff*
- *Staff witnessing errors, near misses and incidents*
- *Staff job satisfaction*
- *Staff feeling pressure to attend work while unwell*
- *Staff feeling their roles make a difference to patients*

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

- *staff indicating that they are working extra hours*

We believe that this is linked with the very positive score we received for 'staff job satisfaction' and 'staff feeling their roles make a difference to patients' with us having a very committed and engaged staff group. Notwithstanding this, there is on-going work within the Trust to improve job planning which forms part of the annual appraisal process, so that staff can work together with managers to ensure that they are making effective use of their working time and so reduce the number of staff who work extra hours.

- *staff receiving health and safety and equality and diversity training*

The National NHS Staff Survey includes questions about 'annual training' in these areas. However, as the Trust provides refresher training for all staff every two years, it means that performance against this indicator for the Staff Survey will be low (compared to other Trusts). Nevertheless, although equality and diversity training is offered to staff throughout the year, in addition to the mandatory Induction and INSET day training (which includes health and safety and equality and diversity training). In the future the Trust plans to mainstream equalities training with a focus on increasing staff attendance.

- *staff experiencing discrimination at work and equal opportunities in career progression or promotion*

To address some of the concerns raised by staff regarding experiencing discrimination at work, the Trust will consider providing regular diversity training sessions at team meetings and raise awareness through use of email alerts, briefing hand-outs, flyers and awareness sessions, either in teams or at directorate meetings. In addition, the current strategies and interventions to support and assist staff in reporting bullying, harassment or discrimination will be promoted further. Regarding equal opportunities in career progression or promotion, the Trust will review ethnicity statistics and data relating to staff promotions and staff progression and if disparities exist, devise an action plan to address these. If no disparities exist, ensure Trust data on promotions and appointments is shared regularly with staff, in order to address this perception.

Staff response rates have also reduced further this year from 47% in 2013 to 38% in this survey, (202 out of 535 staff); this is below the national average of 42%.

The reasons for this are not entirely clear, but possibly related to the fact that this year, for the first time, the Staff Survey was run via an online confidential survey system, where staff were sent a code and a link to access the survey via email. Whereas in previous years staff were required to

complete a paper (hardcopy) survey which possibly might have been more difficult to overlook than the electronic staff survey used this year.

The three priorities for the coming year identified by the Trust's Management Team, some of which has been informed by the findings from the Staff Survey include the following:

1. Continuing to tackle issues of bullying and harassment.
2. Mainstreaming equalities training with a focus on increasing staff attendance.
3. Ensuring that improvements continue in internal communication processes to ensure that staff are informed of and able to contribute to developments across the Trust.

A copy of the 2014 National NHS staff survey for The Tavistock and Portman NHS Foundation Trust is available at

[http://www.nhsstaffsurveys.com/Caches/Files/NHS\\_staff\\_survey\\_2014\\_RNK\\_full.pdf](http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2014_RNK_full.pdf)

## Infection Control

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

The Trust organised on site access to flu vaccination for staff in the autumn of 2014.

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



## Clinical Effectiveness Indicators

### Monitor Number of Staff with Personal Development Plans

Indicator	2012/13	2013/14	2014/15
Monitor number of staff with Personal Development Plans	84%	96%	97.5%

#### What are we measuring?

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

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

#### Targets and Achievements

We are very pleased to report that 97.5% of staff had attended an appraisal meeting with their manager and agreed and completed a PDP for the upcoming year by the 31 March 2015 deadline, which is an improvement on the performance for this indicator in 2013/14.

#### Range of Psychological Therapies

Over the years, the Trust has increased the range of psychological therapies available, which enables us to offer treatment to a greater range of patients, and to offer a greater choice of treatments to all of our patients. We have established expertise in systemic psychotherapy and psychoanalytical psychotherapy for patients of all ages and continue to support staff development and innovative applications of these models. This is in addition, to Group Psychotherapy, Couples Therapy and therapeutic work with parents.

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



of staff from across the Trust have been developing their skills in mindfulness based interventions and are now providing colleagues with opportunities to learn about this approach. We have continued to support training in Interpersonal Therapy (IPT) through which a number of staff across the Trust have completed practitioner level training and a smaller number have achieved supervisor status. We continue to offer specialist supervision and training in Cognitive Behaviour Therapy (CBT) for CAMHS staff and specialist supervision and training for CBT for Post Traumatic Stress Disorder for the Adult and Adolescent Trauma Service. An increasing number of staff have been trained in Eye Movement Desensitisation and Reprocessing (EMDR) for children with Post Traumatic Stress Disorders. Over the last year 12 staff members have been trained in EMDR for over 18s. This training was provided in response to an increased identified need for this form of intervention. In addition, a group of staff have been trained in Dynamic Interpersonal Therapy (DIT), now recognised as an approved treatment within the Improving Access to Psychological Therapies Programme. This innovative therapy was developed by a member of our staff in partnership with colleagues at the Anna Freud Centre, London. Further applications of the model are in development such as a version adapted for adolescents and young adults. We continue to develop our work in a range of other models including Relationship Development Intervention (RDI) and Mentalisation Based Therapy (MBT).

Our priority for the coming year remains to continue to train staff to increase their capacity to identify and present treatment choices, taking into account relevant NICE guidance where available.

## Clinical Outcome Monitoring

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

See Part 2.1 (Priority 1).

### Outcome Monitoring – Adult Service

See Part 2.1 (Priority 2).

### Outcome Monitoring – Portman Clinic

Please go to weblink <http://www.tavistockandportman.nhs.uk/about-us/governance/commissioning-quality-and-innovation-cquin> to review the Portman CQUIN targets and achievements for 2014/15.

## Patient Experience Indicators

### Complaints Received

Indicator	2012/13	2013/14	2014/15
Complaints received	16	12	14

### What are we measuring?

The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. As in previous years the number of formal complaints received by the Trust in 2014/15 remains low at 14, this compares to 16 in 2012/13 and 12 in 2013/14.

All formal complaints received relate to aspects of clinical care, as in previous years we have received no complaints about environment, facilities or other non-clinical issues.

In order to maintain confidentiality of the complainants, given the small numbers of complaints, the Trust does not provide the details of these complaints. Each complaint was investigated under the Trust's complaints procedure and a letter of response was sent by the Chief Executive to each complainant. During the year there were no complaints referred to the Mental Health Ombudsman.

We endeavour to learn from each and every complaint, regardless of whether it is upheld or not. In particular, each complaint gives us some better understanding of the experience of our services for service users, a critical contribution to all of our service development. In addition, for 2015/16 the Trust is committed to ensure that all staff are fully aware of the different ways that patients can raise concerns and we have recently launched a short guidance note for staff to help them support their patients with raising concerns.

### Patient Satisfaction

Indicator	Q1	Q2	Q3	Q4
Patient rating of help received as good	93%	92%	91%	93%

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

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

### Targets and Achievements

Results from the Experience of Service Questionnaire found that 93% of patients in Quarter 1 (April to June 2014), 92% of patients in Quarter 2 (July to September 2014) and 91% of patients in Quarter 3 (October to December 2014) and 93% of patients in Quarter 4 (January to March 2015) rated the help they had received from the Trust as 'good'.

For this financial year, this patient satisfaction target was also a CQUINs Target for CAMHS, please see table below for the quarterly patient satisfaction percentages:

Indicator	Q1	Q2	Q3	Q4
CAMHS Number of service users reporting satisfaction with the service (rated the help they had received from the Trust as 'good'.)	85%	92%	91%	94%

Compared to other Trusts using the Patient Survey, our results reveal a consistently high level of patient satisfaction with our Trust's facilities and services. This includes clinical services and staff along with reception and security staff and anyone else who the patient has interacted with during their visit. Feedback from patients has provided us with an understanding of areas we need to work to improve for the year ahead. We will continue to work with the clinical directorates to improve patient satisfaction with the explanation they receive regarding help available at the Trust. This includes the verbal and written information they receive prior to their first visit to the Trust, as well as involvement of patients in decisions about their care and treatment.

## Did Not Attend Rates <sup>(1,2)</sup>

Indicator	2012/13	2013/14	2014/15
<b>Trust-wide</b>			
First Attendance	9.6%	10.3%	7.8%
Subsequent Appointments	8.9%	8.7%	7.7%
<b>Adolescent and Young Adult</b>			
First Attendance	9.5%	7.7%	8.9%
Subsequent Appointments	13.7%	14.3%	14.8%
<b>Adult</b>			
First Attendance	7.3%	7.5%	8.5%
Subsequent Appointments	7.6%	9.1%	7.3%
<b>Camden Child and Adolescent Mental Health Service (Camden CAMHS)</b>			
First Attendance	13.6%	14.1%	8.8%
Subsequent Appointments	10.1%	8.1%	7.1%
<b>Developmental (including Learning and Complex Disability Service)</b>			
First Attendance	3.0%	2.0%	5.7%
Subsequent Appointments	7.4%	6.9%	7.3%
<b>Portman</b>			
First Attendance	4.6%	7.9%	2.7%
Subsequent Appointments	11.0%	9.1%	8.3%
<b>Other Child and Adolescent Mental Health Service (Other CAMHS)</b>			
First Attendance	4.5%	6.4%	3.8%
Subsequent Appointments	4.8%	5.8%	4.1%

1. Please note that our patient administration system (PAS) is a 'live system' and therefore with data cleansing and the addition of missing data taking place after quarter end, the final outturn figures for DNA and waiting time may be slightly different to quarterly performance figures published in year.
2. DNA figures for the City & Hackney Primary Care Psychotherapy Consultation Service (PCPCS) have not been included due to a different DNA target being agreed with the City and Hackney (PCPCS) and their commissioners.

## What are we measuring?

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

## Targets and Achievements

We are very pleased to report that there has been a decrease in the Trust-wide DNA rates both for first attendances and for subsequent/follow-up appointments, compared with last year. Namely, there has been a decrease in DNA rates for first attendances (7.8%) compared with 2013/14 (10.3%) and a decrease in DNA rates for subsequent/follow-up appointments (7.7%) compared with 2013/14 (8.7%).

We believe that this has been as a consequence of the on-going and concerted efforts undertaken by all services to reduce the number of appointments patients fail to attend. For example, by offering a greater choice concerning the times and location of appointments; emailing patients and sending them text reminders for their appointments, or phoning patients ahead of appointments as required. By comparison, the average DNA rate reported for mental health Trusts is around 14%.<sup>3</sup>

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

It is important to note that the Trust reports DNAs that are recorded on our electronic administrative data base Rio. Information is uploaded onto Rio by administrators who rely on clinicians to inform them of the outcome for each patient. On occasions data validation audits have demonstrated that we were unable to review a paper entry that linked to the Rio record of DNA. This is as a result of a number of different paper sources of data being used (e.g. clinical records; diary sheets and emails to administrators). We have added this comment to our report to show the steps we take to validate data. We continue to impress on staff the importance of making a record in the paper file for each appointment whether or not the patient attends. However, currently the Trust is in the process of moving to an Integrated Digital Care Record (IDCR) namely Carenotes, which will reduce the number of steps to recording DNA (i.e. the clinician will record outcome directly) and we anticipate that our data reliability will be increased.

3. Mental Health Benchmarking Club, April 2010, Audit Commission: <http://www.nhsbenchmarking.nhs.uk/index.php>

## Waiting Times <sup>(4,5)</sup>

Indicator	2012/13	2013/14	2014/15
<b>Trust Wide – Number of patients waiting for first appointment for 11 or more weeks</b>	118	65	36
Internal Causes	27	18	13
External Causes	88	47	23
Unknown Causes	3	N/A	N/A
<b>Trust Wide – Percentage of patients waiting for first appointment for 11 or more weeks</b>	6.1%	4.1%	1.9%
Internal Causes	1.4%	1.1%	0.7%
External Causes	4.5%	2.9%	1.2%
Unknown Causes	0.2%	N/A	N/A

4. The figures for 2012/13 exclude the Gender Identity Disorder Service, as this Service has a Department of Health Referral to Treatment target (RTT) of 18 weeks.

5. For 2012/13, the 3 cases falling into the category of 'unknown causes' originated from Quarter 1 and Quarter 2. However, since Quarter 3, the responsibility for collating and interrogating the waiting time data has been transferring to the CAMHS and SAAMHS managers, which has helped to improve the accuracy of the waiting time data as these managers work more closely with the clinical teams within their directorates.

## What are we measuring?

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

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

During 2014/15, 36 (1.9%) patients had to wait for eleven weeks or longer for their first appointment. Clinical and administrative staff work hard to minimise the length of time that patients have to wait before they are seen and we are pleased to report that this is a significant improvement on the 65 (4.1%) figure from 2013/14. There were both factors external to the Trust, concerning 23 (1.2%) patients, and internal to the Trust, for 13 (0.7%) patients, which contributed to these delays. The Trust waiting times, will continue to be monitored and improved where possible, especially for internal delays.

To help address the breaches of the eleven week target, at the end of each quarter a list is drawn up for each service of those patients who had to wait eleven weeks or longer for their first appointment, together with reasons for this. The services where

the breach has occurred are requested to develop an action plan to address the delay(s) and to help prevent further breaches.

### 3.2 Performance against relevant Indicators and Thresholds

The majority of the mental health indicators set out in the Compliance Framework/Risk assessment framework are not applicable to The Tavistock and Portman NHS Foundation Trust, as they relate to inpatient and/or medical consultant lead services which the Trust does not provide. However, the 'mental health identifiers' (NHS number; date of birth; postcode; current gender; Registered General Medical Practice organisation code, and Commissioner organisation code) apply to the Trust and in 2014/15 by achieving 99% data completeness for these mental health identifiers, the Trust exceeded the 97% threshold for completeness of data.

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



# Mind Matters



## What is the project?

The first Mind Matters event took place on 6 August 2014 and involved a series of interactive workshops whereby young people were able to talk about what it means to have a mind. The programme engaged young people in a conversation about psychological, philosophical, and scientific understandings of what makes a mind. The programme gave an opportunity for them to express thoughts on pressures in their lives, such as: exams, self-perception, social media, and how and when to ask for help with how they're feeling.

## Who was the project for?

The event included 15-19 year olds who were curious in exploring what it means to have a mind and to try mindfulness exercises aiming to calm busy minds and help us accept the range of thoughts and emotions our minds might encounter.

## Outcomes

The day rounded up with a discussion about how to manage if things do feel more difficult. Each participant took away a resource pack crammed with useful ways to look after their minds and a list of young-people friendly services. We learned a lot from the young people who attended, whose feedback was very positive overall.

16 young people attended the workshop and 12 of the participants completed a feedback form. Five commented that the techniques learnt helped them to relax and calm down. Six people left positive comments saying that the activities were fun and the day was well organised and interesting.

From young people who attended:

“ I really liked it. Calmed my mind. ”

“ Interesting! Something I'd never heard of and would consider trying at home. ”

“ Allowed me to listen to other people's opinions about social networking. ”

“ It was good and raised awareness of possible online situations. ”



## Part 4: Annexes

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

#### Comments from Camden Clinical Commissioning Group (CCG)

NHS Camden Clinical Commissioning Group (CCG) is responsible for the commissioning of health services from Tavistock and Portman (T&P) NHS Foundation Trust on behalf of the population of Camden and associated commissioners. NHS Camden Clinical Commissioning Group welcomes the opportunity to provide this statement on T&P Trust's Quality Accounts. We confirm that we have reviewed the information contained within the Account and checked this against data sources where this is available to us as part of existing contract/performance monitoring discussions and is accurate in relation to the services provided. We have taken particular account of the identified priorities for improvement for T&P and how this work will enable real focus on improving the quality and safety of health services for the population they serve.

We have reviewed the content of the Account and confirm that this complies with the prescribed information, form and content as set out by the Department of Health. We believe that the Account represents a fair, representative and balanced overview of the quality of care at T&P. We have discussed the development of this Quality Account with T&P over the year and have been able to contribute our views on consultation and content.

We are pleased to see the T&P's chosen priority areas for improvement and ambition to focus on quality to be further embedded in 2015/16, and how this work will enable real focus on improving the quality and safety of health services for the population they serve.

#### **Priority 1: Children and Adolescent Mental Health Service (CAMHS)**

##### **Outcome Monitoring.**

#### **Priority 2: Adult Outcome Monitoring Data.**

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

#### **Priority 4: Patient and Public Involvement.**

It is also pleasing to see the Trust is extending the focus on quality, as it is now part of the national benchmarking network.

Overall we welcome the vision described within this Quality Account and agree on the priority areas. There are still areas for improvements to be made and as commissioners NHS Camden CCG will continue to work with T&P continuously and monitor these areas to improve the quality of services provided to patients.

**Trust Response:** *We appreciate the comments provided by Camden Clinical Commissioning Group (CCG) and look forward to working closely in 2015/16 with our colleagues in the Clinical Quality Review Group (CQRG) in our on-going work to continue to improve the quality of our services.*

### Comments from our Governors

Governors from all constituencies have again been involved in setting the quality agenda through the discussions at Council of Governor's meetings and attendance at the Governors' Clinical Quality Meetings. They have been fully consulted over the selection of priorities and setting the local indicators. We are pleased that the Trust is working hard to maintain and improve the high quality of all its services.

We just had two questions: i) concerning the percentage of returned CORE forms at Times 1 and 2 and ii) the percentage of patients who returned the ESQ?

**Trust Response:** *We greatly value the significant contribution of our Governors and their on-going role in helping us to take forward the quality agenda for the Trust, with their continued commitment to exploring different ways for evaluating and improving quality. We are pleased to provide further information on the data for the CORE and ESQ as follows:*

#### Regarding i), Concerning the percentage of returned CORE forms at Times 1 and 2:

In 2014/15 144 cases were discharged, meeting the criteria for the CORE EOT target. Of these 144 cases, 57% had a pre-assessment (Time 1) form completed, 38% had a 'not applicable' reason recorded and 3% still have the form status as 'due'. For the End of Treatment time point (Time 2), of the 144 cases 30% had a form completed, 29% had a 'not applicable' reason recorded and 37% still have the form status as 'due'.

#### Regarding ii), The percentage of patients who returned the ESQ:

The ESQ report provides data on all ESQs completed within the time frame. This means that for some individuals there may be more than one form completed, and in some services the form is completed by multiple informants (children and parent measures). Due to the sensitive nature of the questions this measure, completion is completely voluntary. For this reason it is impossible to tell how many forms have been given within the time period. Instead the calculations are

based on the number of forms we have received back. The calculation was developed by the PPI committee and involves a point system where those with the response 'certainly true' are allocated 2 points, those with the response 'partly true' are allocated 1 point and those with the response 'not true' are allocated zero points. This is then calculated as a percentage of the total points available.

*The breakdown of the figures for each Quarter is as follows:*

Q1 - Unfortunately the breakdown of Quarter 1 is not available due to a change in procedure between Q1 and Q2.

Q2 - In Quarter 2, 319 ESQs were completed. 13 were excluded from the calculations: 8 had missing data for the question, and 5 had the response 'do not know'. Of the 306 included in the calculation 263 responded 'certainly true', 39 responded 'partly true' and 4 responded 'not true'.

Q3 - In Quarter 3, 226 ESQs were completed. 18 were excluded from the calculations: 10 had missing data for the question, and 8 had the response 'do not know'. Of the 208 included in the calculation 176 responded "certainly true", 26 responded "partly true" and 6 responded "not true".

Q4 - In Quarter 4, 244 ESQs were completed. 11 were excluded from the calculations: 5 had missing data for the question, and 6 had the response 'do not know'. Of the 233 included in the calculation 204 responded 'certainly true', 26 responded 'partly true' and 3 responded 'not true'.

### **Joint statement by Camden Healthwatch and the Camden Health and Adult Social Care Scrutiny Committee**

Camden Healthwatch and the Camden Health and Adult Social Care Scrutiny Committee (HOSC) welcome the opportunity to comment on Tavistock & Portman NHS Foundation Trust's (TPFT) Quality Account for 2014/15 and their priorities for quality improvements in 2015/16.

- Firstly, it is encouraging to see the proportion of service users who are happy with their service, and also the low DNA rate for the Trust. It is clear that many service users feel they receive a good service from the Trust. As some of the services the Trust deliver are not in Camden, these comments focus mainly on the extent to which patients are involved in the Trust, and options for improving this. On this, we would like the Trust to do more in future reports to make it clear which of its services are offered in Camden

to allow Camden residents to more easily make a judgement about the quality and safety of the services offered.

**Trust Response:** *Because the Annual Quality Report is a review of all our clinical services provided by the Trust, which span over 20 contracts, it is not possible to provide more detailed information for specific boroughs within this Quality Report. However, the Trust has regular meetings with Camden commissioners, including the quarterly Clinical Quality Reference Group meeting, where the information on the quality and safety of services is reviewed. In addition, the Trust is willing to undertake to make this data available on our website in future for Camden residents or other CCGs as well.*

- We feel that some of the Trust's targets could be more stretching. For example, the target of an improvement in CORE scores for 50% of patients could be seen to mean that the Trust expects half of patients not to see an improvement in this area

**Trust Response:** *As this is the first time we set this CQUIN target with our commissioners, we agreed to set the target at 50%, but where in fact we achieved 53%, for those patients eligible for the CQUIN, who demonstrated an improvement in their Total CORE score from the Pre-assessment to End of Treatment phase. In consideration of the complexity and chronicity of presenting difficulties for many of our adults patients, we believe that this is a good outcome. In addition, this exceeded the NHS Mandate target which commits NHS England to playing 'a full part in delivering the commitments that at least 15% of adults with relevant disorders will have timely access to services, with a recovery rate of 50% by 2015.' However, we will continue to work with our patients to optimise the number who benefit from the treatment they receive from the Trust.*

- While most of the targets set for 2014/15 have been achieved, in some areas there has been a decrease in performance from last year and we would encourage the Trust to examine why this may be the case and addressing where possible. For example, in 2012/2013, 99% of patients in the CAMHS service had achieved a 75% improvement in their score on the GM, from Time 1 to Time 2, on 2 targets. In 2014/15, this had decreased to 75% of patients. This may be due to an increase in numbers of patients, but it would be good to know.

**Trust Response:** *In 2012/13 the target was just one goal, where 99% of patients achieved an improvement on the Goal-Based Measure from Time 1 to Time 2 on for the goal they had set at Time 1. In 2013/14, the target was increased to two goals, which proved more challenging, but where 73% of patients achieved an improvement at Time 2 for the two goals they had agreed with their clinician at Time 1. However, as we hadn't managed to achieve our target of 75% in 2013/14, we agreed with commissioners to retain this target for 2014/15 and we are pleased that 75% of patients achieved an improvement in their score on the GBM from Time 1 to Time 2 for both (two) targets in 2014/15.*

- The Trust do not wish to discuss complaints in detail in the account in order to protect patient confidentiality. While patient anonymity should be respected, we suggest that the Trust give some examples or themes of lessons they have learned as a result of complaints.

**Trust Response:** *We regularly review the complaints received but each of the few complaints received usually covers a unique set of circumstances. We are putting in place measures to gather informal complaints and concerns which we expect to give us more data on which base an appraisal of themes. Where applicable changes are made based on lessons learned from complaints, as exemplified in the table below:*

Topic	What was upheld	Lessons learned
Delay in name added to waiting list	This was an administration error	Team systems reviewed and staff reminded of their responsibilities
Failure to share Serious incident report with family member	This issue was raised following an inquest of an adult patient, at the time of the investigation the Trust was unaware of the family member who raised a complaint as the patient had not provided any details. The Trust did accept that we should have made a copy of the report available to the family member in the context of disclosure for the inquest	The Trust has made an amendment to the serious incident procedure to include consideration for involvement of family members/carers when details have been provided by the patient
Breach of confidentiality when sharing information with GP	Failure to take account of the patient's wishes when communicating with the GP	Asking a patient whether or not they wish the trust to communicate with their GP is a standard part of all assessments, staff in this team were reminded of this requirement and the need to refer back to the decision when considering communication

- Focusing on patient and public involvement, it is pleasing to note the Trust is utilising a range of strategies to involve service users in their work. In addition, Healthwatch Camden have been pleased to be on the Trust's Patient and Public Involvement (PPI) committee this year and believes the quality account is a fair and fitting report. Our experience of their PPI and PPI staff are that they are doing their best to involve and engage with people as well as the wider community. However, it is to be noted that at the time of writing, two of the Trust's PPI priorities were not in the accounts, which makes it difficult to comment on.

**Trust Response:** *The Trust agrees that it has been very helpful for Healthwatch Camden to be on the Trust's Patient and Public Involvement (PPI) committee and hope that this will continue. Every year the PPI committee sets a series of priorities for the upcoming year, which would include those Trust's PPI Quality Priorities outlined in the Quality Report. However, not all of the Trust's PPI priorities would be included in the Quality Report (Accounts).*

- Of the priorities that are stated, having service users on interview panels, and feedback, and newsletters, are good priorities, and it's encouraging that they have achieved their targets. However, these targets are outputs not outcomes and in future accounts, we would encourage the Trust to talk about the improvements to service delivery that have been achieved as a result of these outputs to ensure that the Trust's focus is not merely on process (ie creating newsletters, for example) but the impact that the newsletters will have.

**Trust Response:** *This is helpful feedback and we agree a focus on outcomes is important. One of the aims of the news letter was to disseminate good practice initiatives, where outcomes will be discussed.*

Overall, this is a positive report representing a lot of hard work by the Trust and its staff. The people who use the Trust's services in Camden should feel reassured.



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

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - o Board minutes and papers for the period April 2014 to May 2015.
  - o Papers relating to Quality reported to the board over the period April 2014 to May 2015.
  - o Feedback from commissioners dated 14 May 2015.
  - o Feedback from governors dated 11 May 2015.
  - o Feedback from local Healthwatch organisations dated 18 May 2015.
  - o Feedback from Overview and Scrutiny Committee dated 18 May 2015.
  - o The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009. We have produced an annual complaints report dated April 2015 covering 2014/15, which was presented to the Board in April 2015.
  - o The 2014 national staff survey, received by the Trust in February 2015.

o The Head of Internal Audit's annual opinion over the trust's control environment dated 20 May 2015.

o CQC Intelligent Monitoring Report dated 4 March 2015

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at [www.monitor.gov.uk/annualreportingmanual](http://www.monitor.gov.uk/annualreportingmanual)) as well as the standards to support data quality for the preparation of the Quality Report (available at [www.monitor.gov.uk/annualreportingmanual](http://www.monitor.gov.uk/annualreportingmanual)).

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

By order of the board

NB: sign and date in any colour ink except black

.....Date.....Chairman

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



## 4.3 Independent Auditors Report

(TBA)





## Appendix – Glossary of Key Data Items

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

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

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

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

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

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

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

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

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

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

**Did Not Attend (DNA) Rates** - The DNA rate is measured for the first appointment offered to a patient and then for all subsequent appointments. There is an 10% upper limit in place for the Trust, which is the quality standard outlined in our patient services contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

**LGBT** - Lesbian, Gay, Bisexual, and Transgender community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Patient Feedback** - The Trust does not participate in the NHS Patients Survey but conducts its own survey annually, as it has been exempted by the Care Quality Commission from using the NHS Patient Survey, with the recognition that the nature of the services provided by the Trust differ to other mental health Trusts.

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



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

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

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

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

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

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

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

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

**Safeguarding of Children Level 3** - The Trust has made it mandatory for all clinical staff from Child and Adolescent Mental Health Services, GIDS, Portman Child and Adolescent Service and the Adolescent and Young Adult Directorate to be trained in Safeguarding of Children Level 3, where staff are required to attend Level 3 training every 3 years. (In addition, all other Trust staff regularly attend Safeguarding of Children Training, including Level 1 and 2 training.)

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

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

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

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

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

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

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

**Trust Membership** - As a foundation Trust we are accountable to the people we serve. Our membership is made up of our patients and their families, our students, our staff and our local communities. Members have a say in how we do things, getting involved in a variety of ways and letting us know their views. Our members elect Governors to represent their views at independent Boards where

decisions about what we do and how we do it are made. This way we can respond to the needs of the people we serve.

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

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

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



## Board of Directors : May 2015

**Item :** 15

**Title :** Follow up to Staff Survey 2013 – Action Plan Update

**Summary:**

A paper detailing the actions required following the results of the 2013 National Staff Survey, and the subsequent internal survey conducted in CAMHS, regarding bullying and harassment was presented to the Board in November 2014.

This paper is written to assure the Board of progress against the action plan.

This report has been reviewed by the following Committees:

- Management Committee on 14 May 2015.

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

- Staffing

**For :** Noting

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

## Follow up to Staff Survey – Action Plan Update

### 1. Introduction

- 1.1 The National Staff Survey which took place between October and December 2013 and the confidential CAMHS survey undertaken in September 2014 identified some issues regarding bullying and harassment in the Trust
- 1.2 An action plan for addressing these issues was brought to the Trust Board meeting in November 2014.
- 1.3 This paper provides updates on progress against each of the agreed actions.

### 2. Recommended Actions

- 2.1 The table below details the recommended actions with updates on progress to date:

Recommended Action	Update
Issues pertaining to inappropriate behaviour at work will be discussed at Mandatory Trust Training events (INSET and induction). Presentations at these events will highlight clearly what can be classed as bullying and how this can impact on staff and service provision.	Raising awareness of reporting concerns including bullying and harassment has been included in both INSET and induction events with effect from 1 January 2015.
A confidential support service will be put in place, with a confidential support telephone line managed and run by external consultants.	The independent confidential support telephone line provided by Care First went live on 1 March 2015. Details of the service were communicated to all staff in an email from Paul Jenkins on 6 March 2015.
Regular emails will also be sent to staff with information on how to raise concerns, alongside strong statements stating that the Trust takes issues of bullying and harassment seriously.	Human Resources team will be working with the Communications team to prepare regular email briefings.  In addition, the Raising Concerns and Whistleblowing Procedure was reviewed in February 2015 and includes the process for raising concerns.

The Staff Advice and Consultation Service (SACS) has also been recently re-launched and a revised staff list with 30 consultants is now available on the Trust intranet.	Information on the service is available on the intranet in the Staff Benefits section of the Human Resources page.
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### 3. Conclusion

It is recommended that these actions continue to be reviewed as the impact of the actions may take some time to be realised. However, it is encouraging to note that in the 2014 National Staff Survey, the Trust's scores in relation to bullying and harassment are significantly lower than the national average for Mental Health Trusts.

Karen Merchant  
Interim Human Resources Consultant  
5 May 2015





## Board of Directors : May 2015

**Item :** 16

**Title :** Update on actions plans for the Duty of Candour and Fit and Proper Person Test.

**Summary:**

This report provides an update on the action plan presented at the February 2015 Board of Directors meeting on the Duty of Candour and FPPT.

This report has been reviewed by the following Committees:

- Management Team, May 2015

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

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

- Quality
- Patient / User Experience
- Patient / User Safety

**For :** Noting

**From :** Gervase Campbell, Trust Secretary

## Update on Action Plans for the Duty of Candour and Fit and Proper Person Test

### 1. Introduction

- 1.1 The 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 came into force in April 2015.
- 1.2 The Board first considered the Duty of Candour and the Fit and Proper Person Test (FPPT) in October 2014, and in February 2015 received an update and action plan. This report gives an update on progress on the action plan.

### 2. Action plans for Duty of Candour and FPPT.

- 2.1 Actions were proposed at the Board meeting in February to meet the requirements of the Fit and Proper Person Test and Duty of Candour. Below is an update on progress with those actions:

Action	Due Date	For	Comments
Whistleblowing clause included in contracts	n/a	ST	Completed 2014
Updated whistleblowing policy	n/a	ST	Completed 2014
Board to be updated on progress on DoC	May 2015	GC	Completed May 2015
Annual complaints report at the Board to be accompanied by whistleblowing report	April 2015	GC	Completed April 2015
DoC to be included in Trust wide Inductions	Feb 2015	NN	Completed Feb 2015
DoC to be included in INSET training	May 2015	NN	Completed May 2015
DoC to be included in Clinical Inductions	Sept 2015	IH	This will be included in the next clinical induction, in September.
Complaints information posters to be displayed in Trust	March 2015	PK	Completed March 2015
Publishing summary of complaints quarterly	April 2015	PK	Quarterly summary given to CCG CQRG, but will not be published publicly due to the small numbers making confidentiality problematic.
'Worries and Concerns' list to inform risk register	April 2015	LL	The first iteration of the worries and concerns list has been considered by the Management

			Team and none of the points raised were suitable for inclusion on the risk register. Further work is being done on gathering concerns, responding to them centrally, and using them to review the risk register as an ongoing process.
Central 'Action Plan' review committee to be considered	March 2015	RS	We have reviewed the need for an additional system to consider and review progress on action plans arising from SUIs but have concluded that there would be no particular benefit from adding to the existing mechanisms for review via the PSCR work-stream, safe-guarding committee and director level review.
Lessons learnt (from Worries and Concerns, or incident reporting) to be shared via the 'Quality News'	March 2015	LL	Some lessons learnt from incident reports will be addressed in the next issue of the QN, due out in the summer, and lessons learnt from incidents or worries/concerns will be a regular feature each time.
'Being Open' policy has been updated	n/a	PK	Completed
SUI and Incident Reporting policies have been updated	n/a	PK	Completed.
Bullying and Harassment policy has been updated	Feb 2015	ST	Completed Feb 2015
HR to routinely consider bullying and harassment cases for openness considerations	n/a	ST	Completed
External helpline to consider openness considerations	Feb 2015	ST	Completed. Helpline was put in place in Feb 2015
Training available on managing bullying and harassment to include openness and duty of candour	n/a	ST	Completed
Capability and Disciplinary procedures covers professional standards and the duty of candour	n/a	ST	Completed

### 2.1.1 Action plan for Fit and Proper Person Test

Action	Due Date	For	Comments
Pre-employment checks for new directors and members of MT strengthened to meet needs of FPPT	n/a	ST	Completed.
FPPT of current Directors and MT to be done	Sept 2015	ST	FPPT have been done this year for the Chair and all NEDs and will be used to inform the appraisals being conducted now. FPPT for the Executive Directors and members of the management

			team have been started and will be completed by September.
Appraisals of Directors and MT to cover FPPT	2015	ST	Processes are being put in place to incorporate this within the 2015/16 appraisal cycle.
Directors & MT to sign declaration of good standing	2015	GC	Completed in March 2015
FPPT clause to be included in Dir.'s and MT contracts	2015	ST	Contracts have not yet been revised. Work will be concluded by the end of the year: specific contracts will be issued to NEDs; amendments will be issued to executive directors; and a clause will be incorporated into the contracts of any new appointments.

### 2.1.2 Further Actions Required for DoC/FPPT

Action	Due Date	For	Comments
Communication and awareness raising required over the Duty of Candour, and also for Raising Concerns and Whistleblowing	June 2015	PJ/AG	Email went out from the Governance Manager to all staff at the end of 2014 on raising concerns. Further communication from the CEO will go out on these topics after this board meeting.

## 3. Conclusion

3.1 The board are asked to note the progress on the action plans.

Gervase Campbell  
Trust Secretary  
May 2015

## Board of Directors : May 2015

**Item :** 17

**Title :** 'Freedom to Speak Up' review and action plan

**Summary:**

This report provides an update on, and an additional set of actions coming from, the recommendations of the Francis review, 'Freedom to Speak Up'.

This report has been reviewed by the following Committees:

- Management Team, May 2015

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

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

- Quality
- Patient / User Experience
- Patient / User Safety

**For :** Noting

**From :** Gervase Campbell, Trust Secretary

## Update on the 'Freedom to Speak Up' Recommendations

### 1. Introduction

- 1.1 The 'Freedom to Speak Up' review was published on the 11<sup>th</sup> February. This is the review that Sir Robert Francis undertook looking at whistleblowing and with the aim of creating a culture of openness and honest reporting within the NHS.
- 1.2 The Board briefly discussed the report in February 2015, when we circulated the letter from David Bennett, Chief Executive of Monitor, to all NHS Managers briefing them on the importance of the report. That letter was also circulated to the Leadership Team to pass on to managers so it could be discussed within teams.
- 1.3 This report gives an update on the action plan and details of the Trust's response to the recommendations of the 'Freedom to Speak Up' review.

### 2. Freedom to Speak Up Recommendations

- 2.1 The review contained 41 recommendations grouped under 18 principles. 15 of these were aimed at commissioning organisations, or the Department of Health, and so were not relevant to Trusts and provider organisations.
- 2.2 The Trust Secretary reviewed the remaining 26 recommendations with the Director of Quality and Patient Experience, to assess where we could improve the way we worked. It was found that in most cases we were already complying with the recommendation, but some of the recommendations seemed to provide useful ways to improve our practice.
- 2.3 The full list of provider relevant recommendations and responses is included in Appendix 1.
- 2.4 The most important actions required coming out of the report are listed below:

Recommendation	Action	Due	For
1.1 Culture of Safety	Management Team to agree to sign up to the 'Sign up to Safety' campaign, and Jesssica Yakeley is working on an action plan for this.	June 2015	LL/ JY
5.1 Publicly Celebrate Raising Concerns	Louise Lyon is working with the CQC board and the management team on a way to make better use of the concerns raised informally, and the 'worries and concerns' list gathered by Rhona Hobday. Feedback on this should be given to the Trust within the next edition of the Quality News newsletter.	Summer 2015	LL
7.1 Facilitate Formal	Processes for formal concerns are in place. More	June	LL

and Informal Raising of Concerns	work is needed on centrally gathering and sharing informal concerns and the lessons learnt. Louise Lyon is working on this with the Management Team and CQC Board.	2015	
10.1 All Staff to Receive Training in Raising Concerns	HR already provide in depth course on raising concerns, but the topic will also be included in INSET and Inductions as part of the Incident Reporting/Duty of Candour element so that all staff receive it.	2015	ST
11.1a Appoint a 'Freedom to Speak Up' Guardian	Rather than someone already involved within the governance structure, the CEO will appoint an independent senior clinician or HoD to this role, to give support to those who wish it in raising concerns.	Summer 2015	PJ
11.1b Nominate a NED to receive concerns directly	Suggest that Edna Murphy, who is already the NED linking with complaints, should be the named NED for receiving concerns.	June 2015	AG
11.1c Nominate an Executive Director to receive reports directly	Suggest that Louise Lyon, in her role as Director of Quality and Patient Experience, should be the named executive director for receiving concerns.	June 2015	PJ
11.1c Nominate one manager in each department to receive reports directly	Given the size of our Trust it would make sense that we do not nominate a manager in each department, but instead nominate the Director of CYAF, the Director of Adult and Forensic Services, the Director of Education and Training, and the Director of Finance - which formalises our current ad hoc process.	June 2015	PJ
18.2 E&T Courses to Include Training on Raising and Handling Concerns	It was agreed at the Training Executive on the 6 <sup>th</sup> of May that raising and handling concerns would be included in courses in the future, and are working up a proposal for direct training, as well as Moodle based and handbook information.	2015	BR
n/a	Update the existing 'Raising Concerns and Whistleblowing' policy, and the relevant training, to reflect the new contact people detailed above, and transfer ownership of the policy from the Director of CGF to the Director of Quality and Patient Experience.	July 2015	GC

### 3. Conclusion

- 3.1 The board are asked to note the response to the recommendations of the report and the actions planned to improve our culture of openness.

Gervase Campbell  
Trust Secretary





## Action Plan in Response to the Recommendations of the 'Freedom to Speak Up' Review

Principle	Action	Details	Comments	Action	For
PRINCIPLE 1: Culture of Safety: Every organisation involved in providing NHS healthcare should actively foster a culture of safety and learning, in which staff feel safe to raise concerns.	1.1	Boards should ensure that progress towards this (culture of safety) is measured, monitored and published regularly	The Trust already has a robust culture, but this is of paramount importance so more can be done to encourage it, and to monitor it.	Sign up to the "Sign Up To Safety" campaign to measure and improve open culture.	LL/ JY
PRINCIPLE 2: Culture of raising concerns: Raising concerns should be a part of the normal routine business of any	2.1	All NHS organisations should have an integrated policy and common procedure for employees to formally report incidents or raise concerns.	Action 2.2 is for NHS England and Monitor to produce a standard integrated policy - wait until this is available to use to integrate our policies. In the meantime, we do have	Wait for national standard policy to be produced, then review and integrate our policies in line with it.	GC
PRINCIPLE 3: Culture free from bullying: Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.	3.1	All NHS organisations should be proactive in detecting and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns.	Board actively responded to B&H result in 2013 Staff Survey by conducting further research, publicising the issue, and introducing B&H helpline.	Continue to monitor B&H in Staff Survey.	ST
PRINCIPLE 3: Culture free from bullying: Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.	3.3	Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.	Covered by existing FPPT test and references	Complete	n/a
PRINCIPLE 4: Culture of visible leadership: All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.	4.1	Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns, informally and formally.	We are a small Trust, and staff do have access to senior managers and the CEO, but we can do more to demonstrate and evidence this.	Work on way to demonstrate that we encourage open access, provide evidence	LL

Principle	Action	Details	Comments	Action	For
PRINCIPLE 5: Culture of valuing staff: Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to issues.	5.1	Boards should consider and implement ways in which the raising of concerns can be <b>publicly celebrated</b> .	Louise Lyon is working on considering the 'worries and concerns list'. Once this is done feedback can be given to the Trust via Quality News etc.	Raise awareness of importance of raising concerns with email from CEO/Chair, and follow up with reporting on feedback in Quality News.	PI/ LL/ GC
PRINCIPLE 6: Culture of reflective practice: There should be opportunities for all staff to engage in regular reflection of concerns in their work.	6.1	All NHS organisations should provide the resources, support and facilities to enable staff to engage in reflective practice with their colleagues and their teams.	This is part of our clinical practice, embodied in supervision meetings for example. We are much better at this than some other Trusts, but there is a perception amongst staff that it is under threat.	This is essential to our clinical excellence, so it must continue to be monitored and protected, and built into all new models of practice.	LL/ RH
PRINCIPLE 7: Raising and reporting concerns: All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.	7.1	Staff should be encouraged to raise concerns informally and work with colleagues to find solutions.	Raising informal concerns is encouraged and well used. More work may be needed on centrally recording the informal concerns so that issues can be publicised and learning can be shared throughout Trust.	Louise Lyon and CQC group are working on ways to better gather and use informal concerns.	LL
PRINCIPLE 7: Raising and reporting concerns: All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.	7.2	All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with good practice.	Formal avenues are clear, and in place. Good system in place and working.	none needed	n/a
PRINCIPLE 8: Investigations: When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.	8.1	All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice.	Good system in place and working	none needed	n/a

Principle	Action	Details	Comments	Action	For
PRINCIPLE 9: Mediation and dispute resolution: Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.	9.1	All NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to: address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern; and, Every NHS organisation should provide training compliant with national standards, based on a curriculum devised by HEE and NHS England in consultation with stakeholders in accordance with good practice.	Experience and resources for alternative dispute resolution exist within HR and the Trust more widely. HR and union staff are trained in mediation.	nothing further needed.	n/a
PRINCIPLE 10: Training: Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them	10.1		Specific training course are provided by HR. It will now also be addressed within the incident reporting element of mandatory training (inset and induction).	INSET and Induction presentations to include guidance on raising concerns.	ST
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling	11.1	Boards of NHS organisations should ensure their procedures for raising concerns offer a variety of personnel, internal and external, to support staff who raise concerns including: a) an independent person (a 'Freedom to Speak Up Guardian') appointed by the chief executive	The guidance explains that this should be an internal role that people can turn to as an independent and impartial source of advice. Suggest that we appoint outside the governance structure, so perhaps a HoD or the Director of TC.	CEO to appoint to the role.	PJ
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling	11.1	b) a nominated non-executive director to receive reports of concerns directly from employees (or from the Freedom to Speak Up Guardian) and to make regular reports to the Board		Suggest Edna Murphy for this role, as she is the NED link to complaints and whistleblowing.	PJ
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and	11.1	c) at least one nominated executive director to receive and handle concerns		Suggest s Louise Lyon to this role.	PJ

Principle	Action	Details	Comments	Action	For
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling	11.1	d) at least one nominated manager in each department to receive reports of concerns	We are a small Trust, and it is unnecessary to have separate appointees for each department. All managers are able to receive reports and escalate or ask advice as needed. In practice this role is already held by the Director of CYAF and the Director of AFS.	Make explicit in the policy the roles of the director of CYAF and the director of E&T and the Finance and HR Directors.	GC
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and	11.1	e) a nominated independent external organisation (such as the Whistleblowing Helpline) for staff	We have two nominated helplines (the NHS and the Public Organisations) in the	nothing further needed.	n/a
PRINCIPLE 11: Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling	11.2	All NHS organisations should have access to resources to deploy counselling and other means of addressing stress and reducing the risk of resulting illness after staff have raised a concern	We have our Staff Advice and Consultation Service (SACS) in place.	nothing further needed.	n/a
PRINCIPLE 12: Support to find alternative employment in the NHS: Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should offer support.	12.2	All NHS organisations should actively support a scheme to help current and former NHS workers whose performance is sound to find alternative employment in the NHS.	No NHS wide scheme exists yet.	Wait for NHS wide scheme to be created.	GC
PRINCIPLE 13: Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.	13.1	Quality Accounts should include quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the action taken in respect of them and feedback on the outcome.	We have very few formal concerns/whistleblowing incidents at present, but there is no reason not to report on them in the annual quality accounts	Louise Lyon and Justine McCarthy woods to include details of formally reported concerns in the next quality accounts.	LL/ JMW

Principle	Action	Details	Comments	Action	For
PRINCIPLE 13: Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.	13.2	All NHS organisations should be required to report to the National Learning and Reporting System (NLRS), or to the Independent National Officer described in Principle 15, their relevant regulators and their commissioners any formally reported concerns/public interest disclosures or incidences of disputed outcomes to investigations. NLRS or the Independent National Officer should publish regular reports on the performance of organisations with regard to the raising of and acting on public interest concerns; draw out themes that emerge from the reports; and identify good practice.	We already use the NLRS to report incidents (that reach the relevant threshold). There is no reason why we shouldn't also report formally raised concerns (whistleblowing), if this is requested by NLRS.	If NLRS requests this then we will comply and report on formally raised concerns.	PK
PRINCIPLE 13: Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.	13.3	a) CEOs should personally review all settlement agreements made in an employment context that contain confidentiality clauses to satisfy themselves that such clauses are genuinely in the public interest.	We have not used any confidentiality clauses, and do not intend to.	nothing further needed.	n/a
PRINCIPLE 13: Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.	13.3	b) All such settlement agreements should be available for inspection by the CQC as part of their assessment of whether an organisation is well-led.	We have not used any confidentiality clauses, and do not intend to.	nothing further needed.	n/a
PRINCIPLE 13: Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.	13.3	c) If confidentiality clauses are to be included in such settlement agreements for which Treasury approval is required, the trust should be required to demonstrate as part of the approval process that such clauses are in the public interest in that particular case.	We have not used any confidentiality clauses, and do not intend to.	nothing further needed.	n/a

Principle	Action	Details	Comments	Action	For
PRINCIPLE 14: Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for:  poor practice in relation to encouraging the raising of concerns and responding to them	14.1	Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.	This is covered within our Bullying and Harrassment procedure, and our Raising Concerns and Whistleblowing policy.	nothing further needed.	n/a
<ul style="list-style-type: none"> <li>the victimisation of workers for making public interest disclosures</li> <li>raising false concerns in bad faith or for personal benefit</li> <li>acting with disrespect or other unreasonable behaviour when raising or responding to concerns  inappropriate use of confidentiality clauses.</li> </ul>	14.2	Trust boards, COC, Monitor and TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person to hold an appointment as a director or equivalent in accordance with the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 regulation 5.	Evidence that is available would be discovered via FPPT, references, and interview - but it is a difficult area and it is hard to see how else evidence on the topic could be found.	HR to consider further whether there are other sources of evidence that could be looked at.	ST
<ul style="list-style-type: none"> <li>raising false concerns in bad faith or for</li> </ul> PRINCIPLE 14: Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for:  poor practice in relation to encouraging the raising of concerns and responding to them	14.3	All organisations associated with the <b>provision</b> , oversight or regulation of healthcare services should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led.	Current recruitment practices should uncover any evidence in this area, but that evidence may not be readily available.	HR to include guidance on questions on experience of raising concerns/whistleblowing in the interview pack for management posts.	ST
<ul style="list-style-type: none"> <li>the victimisation of workers for making public interest disclosures</li> <li>raising false concerns in bad faith or for</li> </ul>					

Principle	Action	Details	Comments	Action	For
PRINCIPLE 18: Students and trainees: All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.	18.2	All training for students and trainees should include training on raising and handling concerns.	Will Bannister confirmed on the 24/4/ that he would get the subject on the agenda of the Training Executive.	E&T executive to consider how to include in courses.	BR





## Board of Directors : May 2015

**Item : 18**

**Title : Savile Report Recommendations – Action Plan**

### **Summary:**

Kate Lampard QC published a report on the lessons learnt from the Savile enquiry, and the secretary of state accepted 13 of the recommendations it contained, of which 10 apply to foundation trusts.

Monitor have asked us to assess the relevance of its recommendations to our own organisation and take any action necessary to protect patients, staff, visitors and volunteers. They have asked that we let them have our action plan by the 15th June, and confirm that the recommendations of the report have been reviewed by the Board.

This paper gives a list of the recommendations, and a draft of the action plan that will be returned to Monitor.

This report has been reviewed by the following Committees:

- Management Team, 14<sup>th</sup> May 2015.

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

- Patient / User Safety

**For : Approval**

**From : Trust Secretary**

## Recommendations of the Savile Report

### 1. Introduction

- 1.1 Kate Lampard QC published a report on the lessons learnt from the Savile enquiry, and the secretary of state accepted 13 of the recommendations it contained, of which 10 apply to foundation trusts.
- 1.2 Monitor have asked us to assess the relevance of its recommendations to our own organisation and take any action necessary to protect patients, staff, visitors and volunteers. They have asked that we let them have our action plan by the 15th June, and confirm that the recommendations of the report have been reviewed by the Board.
- 1.3 This paper gives a list of the recommendations, and a draft of the action plan that will be returned to Monitor. paragraph 2

### 2. Recommendations

- 2.1 The recommendations of the report are detailed in the table below. The Board are asked to review these recommendations.

<u>Recommendation</u>
R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.
R2 All NHS trusts should review their voluntary services arrangements and ensure that: <ul style="list-style-type: none"> <li>• they are fit for purpose;</li> <li>• volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and</li> <li>• all voluntary services managers have development opportunities and are properly supported.</li> </ul>
R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.
R5 All NHS hospital trusts should undertake regular reviews of: <ul style="list-style-type: none"> <li>• their safeguarding resources, structures and processes (including their training programmes); and</li> <li>• the behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.</li> </ul>

R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.
R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.
R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.
R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.
R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.
R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts, (and where applicable, independent hospital and care organisations), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11.
R14 Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12.

### 3. Action tracker to return to Monitor

3.1 Details of the draft action tracker to be returned to Monitor are in Appendix 1.

Gervase Campbell  
Trust Secretary  
May 2015

## Appendix 1

### Savile Report Recommendations - Draft Action Tracker

Report on actions in response to Kate Lampard's report into Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile				
Tavistock and Portman NHS Foundation Trust.				
Recommendation	Issue identified	Planned Action	Progress to date	Due for completion
R1 (Policy for VIP visits)	The Trust has very few VIP visits, so this is not a major issue. However, a gap has been identified in not having a single written policy covering visits/access more widely, including for example contractors, school groups, conference attendees.	Site access/visitor procedure to be written, to include section on VIPs.	Initial discussions with Director of CGF and Director of Marketing and Communications	June 2015
R2 (Review voluntary service arrangements)	Currently volunteers are covered by Trusts Honorary Contract procedure that lists examples of categories covered by the process.	If required the Procedure could specifically make reference to Volunteers as one category falling within its remit.	Planned following MT's decision	TBC following MC
R4 (Safeguarding training every 3 years)	All staff and volunteers/ honoraries to undergo appropriate safeguarding training every 3 years, no issue identified.	Continue current processes	Achieved	n/a
R5 (Regular reviews of safeguarding)	The Medical Director, who is also the Named Doctor for child protection, regularly reviews safeguarding resources, structures and processes, and the behaviours and responsiveness are reviewed via the CQSG reports to the Board and via the Trusts safeguarding committee on which the Trust Chair is the Non-executive Director. External scrutiny comes via the Designated professionals, the Local Safeguarding Children's Board, Ofsted	Continue current systems of review	Achieved	n/a

	inspections and the NCL clinical quality review group. Current systems are therefore felt to be adequate.				
R7 (DBS checks for all staff and volunteers)	DBS checks are already done for all staff and honoraries where required.	Continue current processes	Achieved	n/a	
R9 (Policy on internet access for visitors)	Policy is in place to cover staff usage of Internet but not visitors.	Adjust existing documentation to cover all potential users.	None	Jul-15	
R10 (Recruitment processes for contact & agency staff)	Recruitment processes for contract and agency staff up to standard. Agency staff working for the Trust will have had an appropriate DBS disclosure, where appropriate by their employing Agency.	Continue current processes, reviewing with staff side as required.	Achieved	n/a	
R11 (Recruitment practices robust and consistent)	Trusts Recruitment policy details the pre- employment checks necessary to be carried out before an offer of job can be made, and policies are reviewed regularly.	Continue current schedule of reviews.	Achieved	n/a	
R12 (policies related to risk in association with donors /celebrities)	The Trust does not currently have, and does not anticipate having, any significant association with celebrities or major donors, and so this is not a risk at present for the Trust. If such an association were to be suggested in the future, it would need to be scrutinised carefully and approved by the CEO once all relevant due diligence had been done.	No action is required.	n/a	n/a	
R13 (Monitor/CQC to ensure compliance with 1,2,4,5,7,9,10,11)	Not applicable to Trust.	n/a	n/a	n/a	
R14 (Monitor to ensure compliance with 12.)	Not applicable to Trust.	n/a	n/a	n/a	

I confirm that this NHS foundation trust Board reviewed the full recommendations in Kate Lampard's lessons learnt report

SIGNED:

CE NAME:

## Board of Directors : May 2015

**Item :** 19

**Title :** Corporate Governance Statement – declaration of compliance with condition G6 of our licence from Monitor.

**Summary:**

Monitor requires us to complete an annual self-certification declaring whether the Trust is compliant with general condition 6 of our licence.

The Board of Directors is invited to approve the two statements, details of which are given in the paper.

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

- Quality
- Risk
- Finance

**For :** Approval

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

## Corporate Governance Statement

### 1. Introduction

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

### 2. Statements in declaration

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

#### 2.2 The first statement is:

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

#### 2.3 The second statement is:

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

- 2.4 The board of directors is invited to confirm these two statements on the basis of:
- 2.4.1 Regular reports on quality, performance, finance and governance received throughout the year, including the quarterly declarations.
  - 2.4.2 The annual quality report and annual accounts presented to this meeting, together with the reports of the external auditors on both of them.
  - 2.4.3 The annual reviews of the risk register and board assurance framework.
  - 2.4.4 The recent review and revision of the structure and terms of reference of the Clinical Quality, Safety and Governance Committee.

### 3. Views of the Governors

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

Simon Young  
Deputy Chief Executive and Director of Finance



## Board of Directors : May 2015

**Item :** 20

**Title :** Corporate Governance: Use of Trust Seal

**Purpose:**

This report includes:

- Details of a use of the Trust seal, for the Westminster Family Service, for approval.

**For :** Approval

**From :** Gervase Campbell, Trust Secretary

## Corporate Governance Report – Use of Trust Seal

### 1. Use of the Trust Seal

- 1.1 The Trust's constitution states that the Board of Directors is responsible for approving use of the Trust Seal before it is affixed to any document. Where it is not possible to get approval in advance, the use must be reported to the Board of Directors at their next meeting.
- 1.2 On the 6<sup>th</sup> May 2015 the Trust sealed an agreement with the City of Westminster reducing the length of the contract to provide the Westminster Family Service one year to 31<sup>st</sup> October 2015. This was in order to support Westminster Council in their wish to reconfigure services and to begin a procurement of these. The agreement was sealed by Mr Paul Jenkins, CEO, and Mr Simon Young, Deputy CEO and Director of Finance. The sealing was witnessed by Mr Gervase Campbell, Trust Secretary.
- 1.3 The contract itself was agreed by the usual management processes, this is only coming to the Board because Westminster requested we use our seal as well as signing it.
- 1.4 The Board are asked to approve this use of the Trust Seal.

Gervase Campbell  
Trust Secretary  
May 2015

**BOARD OF DIRECTORS (PART 1)**

Meeting in public

Tuesday 26<sup>th</sup> May 2015, 14.00 – 16.00

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

**AGENDA**

PRELIMINARIES				
1.	Chair's Opening Remarks Ms Angela Greatley, Trust Chair		Verbal	-
2.	Apologies for absence and declarations of interest Ms Angela Greatley, Trust Chair	To note	Verbal	-
3.	Minutes of the previous meeting Ms Angela Greatley, Trust Chair	To approve	Enc.	p.1
3a.	Outstanding Actions Ms Angela Greatley, Trust Chair	To note	Enc.	p.9
4.	Matters arising Ms Angela Greatley, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	Trust Chair's and NEDs' Report Non-Executive Directors as appropriate	To note	Verbal	-
6.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To note	Enc.	p.10
7.	Finance & Performance Report Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	late	-
8.	Training and Education Report Mr Brian Rock, Director of Education & Training; Dean	To note	Enc.	p.12
9.	CQSG Report, Quarter 4, 2014/2015 Dr Rob Senior, Medical Director	To approve	Enc.	p.16
10.	Service Line Report – Camden CAMHS Mr Andy Wiener, Associate Clinical Director CAMHS	To note	Enc.	p.23
11.	Annual report and Accounts a. Annual Report b. Annual Accounts c. Letters of Representation Mr Simon Young, Deputy Chief Executive & Director of Finance & Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.56 p.166
12.	Annual Quality Report Dr Justine McCarthy Woods, Quality Lead	To approve	Enc.	p.175
13.	Developing a 2 year Strategic Plan Consultation Mr Paul Jenkins, Chief Executive	To discuss	late	-

14.	<b>Documentary Films Proposal</b> Ms Laure Thomas, Director of Marketing and Communications	To note	late	-
15.	<b>HR Action Plan from 2013 Staff Survey update</b> Ms Susan Thomas, Director of Human Resources	To note	Enc.	p.250
16.	<b>Duty of Candour &amp; FPT: Action Plan update</b> Mr Gervase Campbell, Trust Secretary	To note	Enc.	p.253
17.	<b>‘Freedom to Speak Up’ Report</b> Mr Gervase Campbell, Trust Secretary	To note	Enc.	p.257
18.	<b>Jimmy Savile Recommendations Report</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.267
19.	<b>Annual Governance Statement (part 1)</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.273
20.	<b>Use of Trust Seal</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.275
21.	<b>Patient Story – video of patient</b> Anthony Newell, Patient Experience Manager	To note	-	-
<b>CONCLUSION</b>				
22.	<b>Any Other Business</b>		Verbal	-
23.	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"><li>• Tuesday 9<sup>th</sup> June 2015: Directors’ Conference 12.00pm – 5.00pm, Lecture Theatre</li><li>• Tuesday 23<sup>rd</sup> June 2015: Board of Directors Meeting 2.00pm – 5.00pm, Board Room</li><li>• Thursday 25<sup>th</sup> June 2015: Council of Governors Meeting 2.00pm – 5.00pm, Board Room</li><li>• Tuesday 14<sup>th</sup> July 2015: Leadership Group 12.00pm – 5.00pm, Lecture Theatre (tbc)</li></ul>		Verbal	-