

## Board of Directors Part One

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

2.00pm–4.00pm  
Tuesday 28<sup>th</sup> April 2015

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



## BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 28<sup>th</sup> April 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.10
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.11
7.	<b>Finance &amp; Performance Report</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.13
8.	<b>Training and Education Report</b> Mr Brian Rock, Director of Education & Training; Dean	To approve	Enc.	p.25
9.	<b>Quarter 4 Governance Statement</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.30
10.	<b>Quarter 4 Quality Report</b> Dr Justine McCarthy Woods, Quality Lead	To note	Enc.	p.35

11.	<b>Draft Annual Quality Report</b> Dr Justine McCarthy Woods, Quality Lead	To discuss	Enc.	p.52
12.	<b>Century Films Documentary Update</b> Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.113
13.	<b>Complaints Report</b> Mr Paul Jenkins, Chief Executive	To note	Enc.	p.119
14.	<b>Whistleblowing Report</b> Mr Gervase Campbell, Trust Secretary	To note	Enc.	p.126
15.	<b>Corporate Governance – External Contacts Review and Use of Trust Seal</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.128
<b>CONCLUSION</b>				
16.	<b>Any Other Business</b>		Verbal	-
17.	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"> <li>Wednesday 20th May 2015: Extra-ordinary meeting of the Council of Governors, afternoon, Lecture Theatre</li> <li>Tuesday 26<sup>th</sup> May 2015: Board of Directors Meeting, 2.00pm – 5.00pm, Board Room, Tavistock Centre</li> <li>Tuesday 9<sup>th</sup> June 2015: Directors' Conference 12.00am – 5.00pm, Lecture Theatre</li> </ul>		Verbal	-

# Board of Directors

## Meeting Minutes (Part One) Tuesday 31<sup>st</sup> March 2015, 2.00 – 4.20pm

Present:			
Ms Angela Greatley Trust Chair	Prof. Dinesh Bhugra NED (arrived at item 8)	Mr Simon Young Deputy CEO & Director of Finance	Dr Rita Harris CYAF Director
Mr David Holt Non-Executive Director	Mr Paul Jenkins Chief Executive	Ms Lis Jones Nurse Director	Ms Louise Lyon Director of Quality, Patient Experience and A&FS
Dr Ian McPherson Non-Executive Director & Vice Chair of Trust	Ms Edna Murphy NED	Mr Brian Rock Director of Education and Training, Dean	Dr Rob Senior Medical Director
Attendees:			
Mr Gervase Campbell Trust Secretary (minutes)	Mr Namdi Ngoka, Associate Director of HR (item 11, 12)	Dr Sally Hodges Associate Clinical Director (item 13,14)	Ms Claire-Louise Leyland, Governor
Ms Mary Burd, Governor			
Apologies:			
Ms Jane Gizbert NED			

### Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor changes to be made to the minutes	GC	Immd.
2	7	Communicate year end financial situation to staff	SY & PJ	April
3	10	Arrange a broad equalities and Time to Change event	PJ & LL	July
4	11	Proposal for 360 to be taken to the leadership group for discussion and refining	ST	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.

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 – (action plan on 'Freedom to Speak') – in progress, will come to May

board.

AP3 – (list of NED visits to be kept by Trust Secretary) – this list had been started.

AP4 – (coordination of NED visits) – this strand of work was in hand with Ms Lyon and the CQC board.

AP5 – (survey analysis) – this was included in today's meeting

AP6 – (paper on PPI) – will come to either May or June board.

No further matters arising.

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

Ms Greatley noted that the annual mental health confederation conference had been interesting and useful.

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

Mr Jenkins noted that Century Films had almost completed the research period at the Trust, and had secured a firm commission from Channel 4. There would be a formal paper on the proposal at the April board, including full details of safeguards for patients and confidentiality. Mr Holt commented that it would be important to make clear the benefits to patients of the documentary, and Mr Jenkins confirmed that this was their starting point in considering the proposal, and there were great potential benefits in reducing stigma amongst young people.

Mr Jenkins commented on the sharing good practice event held on the 17<sup>th</sup> March, which had been a great success, especially the 'market place' where various teams showed what they were doing, the quality of which was inspiring. Mr David Gilbert, the consultant who had helped arrange the event, would produce a report and following that a strategy paper for PPI would come to the board in May or June.

The second meeting of the mission and values group had been held, and Mr Jenkins was working on a draft version that could be circulated for consultation to staff and governors. He noted that this work would provide a backstop to the two year strategy document.

The Board **noted** the report.

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

Mr Young noted that there was little change in the underlying business of the Trust from last month. The arrangements for holding the FNP income had been confirmed, which was good news. Mr Holt asked whether the deferred costs matched the deferred income, and Mr Young confirmed that this was the case and they were deferring income to match the expected

costs in the coming year.

Mr Young noted the Voluntary Severance Scheme had accepted 15 applications, and as the decisions had been made the costs would be accrued, and the saving made were important for next year's budget.

Dr McPherson noted that as some other Trusts were in deficit it was important to communicate the year end position clearly, to explain that it was a good position to be in and reflected hard work. Mr Rock commented that it was important for staff to be helped to understand the situation, especially in the context of the VSS. Mr Young agreed it was important, and noted that the year end surplus represented about 1.5% of income and was neither excessive nor unique. It was agreed that Mr Young and Mr Jenkins would communicate the situation to staff.

AP2

The Board **noted** the report.

## 8. 2015/16 Budget

Mr Young reported that the budget for the coming year was balanced, with a small surplus and contingency included. There were some large changes from the current year, and significant uncertainties stemming from income that could not be agreed in advance, such as consulting, but also areas where income should have been confirmed under NHS rules but had not been as commissioners were behind schedule.

Mr Young noted the main changes from the current revised budget, shown in the first table of appendix A, which were the CAMHS increase due to the FDAC national roll out and GIDS contract increase, the FNP reduction, which was scheduled into the original tender, and the move of communications into Education and Training.

[Prof. Bhugra arrived at the meeting]

Concerning growth, Mr Young noted that although the FDAC national unit contract was great, having the initial funding only for one year was problematic and Mr Jenkins had met with Dr Harris and Mr Bambrough to discuss the financial risks in future years, agreeing ways to share the risks with partner organisations and reduce them through use of secondments and one-year employment contracts. Mr Young noted that the GIDS expansion meant larger premises were needed and the cost would be borne by the service.

Looking at the Capital Budget Mr Young noted that the surplus, in combination with lower capital spending in previous years, allowed relatively more to be spent in the coming year, and detailed the four

projects that had been approved already, and the new projects for approval as part of the budget.

Turning to the table on page 6, Mr Young assured the board that the Trust would be in a strong cash position throughout the year and explained how the VSS payments, GIDS payments, and potential implementation costs were allowed for.

Mr Young recommended the Budget and Capital Budget to the Board.

Ms Murphy asked whether there were staff expenditure controls to ensure that the savings expected of the VSS would be realised. Mr Young confirmed that there were strong controls, and that the Trust did not face the out of hours difficulties that often led to excessive agency costs. Mr Holt noted that in some Trusts because of the potential implication of headcount reductions on quality and safety, the equivalent of the CQSG signed off savings proposals, and asked if the Trust had something similar. Mr Young clarified that because of the size of the Trust the quality impact of savings plans were discussed at directorate level and then presented to the Productivity Board by the director. Ms Lyon added that a lot of the actual savings would be in Education and Training, so the risks were non-clinical, and Dr Harris added that the associate deans had been closely involved. Mr Young added that these were net savings and there was provision for limited return on reduced hours and grades, to cover particular tasks and conserve expertise.

Prof. Bhugra queried the increase in Education and Training costs, section 4.5. Mr Young explained that this was due to a transfer of the communications function into E&T rather than an overall increase. Prof. Bhugra also noted the IDCR cost seemed high, and Mr Young explained that it included additional hardware, and also the capitalised cost of the staff involved in the project, and was within the agreed project plan.

Mr Holt and Mr Young clarified a number of points on the cash position, allowing for unanticipated restructuring costs, renewal of the facility, and that very little of the income related to contracts that were due for renewal within the year.

Mr Jenkins commented that it was nice to be in a position to look at a balanced budget for the coming year, and noted that it was due to a great deal of hard work careful judgements about cost and quality by the finance team and managers more widely in the Trust.

The Board **approved** the income and expenditure budget and the capital



budget for 2015/16, and their use for the draft operational plan for submission to Monitor.

## 9. Training and Education Report

Mr Rock introduced his report by noting that the Portfolio Manager roles were out to advert, and interviews would be held in April. The outcome of the QAA visit was that the Trust was judged to have made acceptable progress with monitoring, reviewing and enhancing its higher education provision, and a full report on the would come to the Board in April.

Mr Rock noted that the Student Information Management System had gone out to tender, but sadly no bids had been received. The project board would be reconstituted and would reflect on what had happened and look to engaging further with suppliers, starting with a supplier meeting in April.

Concerning the regional strategy, Mr Rock noted that all the regional partners had joined them for a day event at the Trust, with some very positive discussions held, and these would be followed up by inviting regional representatives to attend the validation events with the University of Essex.

Mr Rock reported that discussions and developments with University of Essex were progressing well, and they were in a strong position to open all courses to recruit at Essex in 2016. A joint meeting with UoE and UEL was scheduled in May to look at the possibilities for an earlier teach out. A communication for students was being prepared and would go before the validation event.

Dr McPherson clarified that the social work course would remain with UEL, and the D65 with Middlesex, as planned.

Mr Holt suggested that if there were any lessons that could be learnt from the issues around Care Notes, they should be incorporated early into the ICT project for E&T.

The Board **noted** the report.

## 10 Annual Equalities Report

Ms Lyon introduced the report, suggesting that an endorsement of the suggested priorities for the coming year would be welcomed. Ms Greatley commented that with so many potential issues, it was important to choose and prioritise each year.

Dr McPherson noted the reference to Time to Change in section 5.3, and wondered if the board could receive an update on that initiative. Ms Greatley confirmed that it would be revisited as part of a broader equalities event for the Trust.

**AP3**

The Board **noted** the report, and endorsed the priorities for the coming year.

## 11 HR Proposal on 360 Feedback for Managers

Mr Ngoka introduced the report, noting that it was the outcome of a suggestion from Mr Holt of an additional method of addressing bullying and harassment following presentation of the action plan in May 2014. Mr Ngoka suggested that feedback from peers might help managers with their behaviour and their development, and should be introduced for members of the Leadership Group.

The Board had a detailed discussion of the merits of respondents being identified or anonymous. Mr Ngoka noted that with a small Trust, and with small teams, it was often unworkable to have an anonymous system. A number of the NEDs felt that anonymity was important to a successful system, and that it was also important that it was clearly aimed at leadership development rather than performance management. Mr Jenkins commented that he felt it should not be anonymous, as we wanted to be an organisation that knew how to give and receive feedback.

Mr Jenkins suggested that the best way to resolve the question was to take it to the Leadership Group themselves to discuss, as they wanted to encourage a set of behaviours, and the only way to do this would be to engage people in the process, and then they could judge the system by its outcomes.

**AP4**

Ms Greatley summarised that HR would take a proposal to the Leadership Group to discuss and refine.

The Board **noted** the report.

## 12 Analysis of 2014 Staff Survey

Mr Namdi introduced the report, which analysed the response to the staff survey conducted in October and December 2014, the results of which came out in February. He highlighted the areas where the Trust had done well, especially staff engagement and job satisfaction, as well as the areas where the Trust needed to improve and the suggested action plans to tackle these.

Ms Greatley commented that the response rate was not good, and that needed to be worked on. Prof. Bhugra asked whether a reward could be offered, and Mr Ngoka noted they had tried that previously but with little effect. Mr Holt asked whether it was possible to monitor the response rate and prompt staff if it was low, and Mr Ngoka noted that they did this already, and had chased responses via departments when they had recognised they were low. Dr Harris noted that there had been more surveys than normal this year, and staff were 'surveyed out'.

Dr McPherson commented that some of the results reflected our unusual staffing mix, so comparisons to previous years were more helpful than comparison externally. He noted that the BME results were concerning, but also that they showed a mix of responses and the impact of small numbers had to be recognised. Mr Holt added that the equalities and diversity results were something that needed to be worked on in the coming year, and the completion date of June 2016 seemed too distant, especially considering another survey would have been completed before then, and suggested earlier milestones could be incorporated. Ms Greatley commented that this result tied in to the agreed priorities of the Equalities Committee and they should coordinate their response with HR, which Ms Lyon agreed with.

Ms Greatley thanked Mr Ngoka for the report, and for producing it so quickly, and noted that this was the last meeting he would be attending as he was leaving the Trust. The Board thanked him for all his work over the years and wished him well in the future.

The Board **noted** the report.

### **13 Patient Story – film clip, CAMHS**

The Board watched a short film of two young CAMHS patients discussing their treatment and experience, both with the Trust and with other organisations. The film had been recorded about 6 weeks earlier in support of a tender bid, and the patients had put themselves forward rather than being selected.

Dr McPherson commented that the video was a good way to capture younger people, or others for whom attending the board would be uncomfortable. Ms Greatley added that having the patients talk to each other, rather than to the directors, had made them more open in a similar

way that the interview format used at the AGM had. Mr Jenkins added that there was no one way to hear stories, but this had a lot of merits, especially the sense of the young people doing things rather than having them done to them.

Ms Murphy commented that it was great to see what was important from the patient's perspective, especially being involved in agreeing their therapies, and engagement, which were both issues that had been discussed at the board, but also their comments on the how important friendly receptionists were. Ms Jones noted their appreciation for alternative locations, the outreach services; Mr Holt noted their appreciation for never having had one of our clinicians cancel on them; Ms Lyon noted how they appreciated the opportunity to be involved beyond their treatment, which was a testament to PPI.

#### **14 Service Line Report – CYAF Complex Needs**

Dr Hodges introduced the report, noting the complexity of the service line, and noting that the coming year would be very full, with some services retendering, including possibly Haringey. Ms Greatley commented that the report illustrated the Unique Selling Point of the Trust; these services are at the heart of what we do that is unique.

Ms Lyon commented that the report had been helpful in setting out the dilemmas about specialist services and how the Trust could maintain them in the face of pressures. Dr McPherson praised the report, noted that the financial deficit for the service line was large, and wondered if there were any plans that envisioned addressing it. Ms Hodges commented that it was hard to tease out the issue as the budget was not disaggregated yet, but they were doing a lot of work with the staff on being as cost effective as possible, and some of the issues applied more widely across the Trust.

Dr Senior noted the large number of commissioners that had to be dealt with, and the costs that entailed. He commented that these were flagship services and their value should be recognised and cross-subsidised if necessary. Dr Harris noted that the services were hugely special and innovative, but were not actually run by the most senior and expensive staff – for example the drug and alcohol workers in YPDAS- so it was not possible to cut costs much more, though they could disaggregate them. She noted that the work Dr Hodges was doing in aligning team objectives to directorate objectives and so up to the Trust level to demonstrate impact was an innovative way to manage the service.

Ms Greatley affirmed the recognition of the excellence of the services, and the board's understanding of the complexity and difficulty involved, and thanked Dr Hodges for her report.

The Board **noted** the report.

#### **15 AOB and notice of future meetings**

Ms Greatley noted the valuable discussion over lunch, and it was agreed that Ms Lyon would plan something similar for the Governors.

Part one of the meeting closed at 4.10pm



# Outstanding Action Part 1

Action Point No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
3	Apr-14	8. Annual Complaints Report	Time to respond to be added to future complaints reports	Jane Chapman	April 2015	Incorporated into April 2015 report.
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	
4	Jan-15	10. Quality Report	Add further details of Child Safeguarding Training to Quality Report	Justine McCarthy Woods	Apr-15	Incorporated into 2015 Q4 report.
6	Jan-15	13.CQC Update	NEDs to be invited to link with a KLOE lead for CQC	Louise Lyon	Feb-15	
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	
4	Feb-15	5. Trust Chair Report	Coordination of NED visits with PPI and CQC work	Louise Lyon	Apr-15	
6	Feb-15	14. Patient Story Review	Paper on PPI development to come to the board	Paul Jenkins	Jun-15	





## Board of Directors : April 2015

**Item :** 6

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

**Summary:**

This report provides a summary of my activities and key issues affecting the Trust since the last meeting of the Board of Directors in March.

**For :** Discussion

**From :** Chief Executive

## Chief Executive's Report

### 1. Essex CAMHS tender

- 1.1 Following agreement by email from Directors to proceed we submitted our tender for the Essex CAMHS service on 10<sup>th</sup> April. I would like to offer my appreciation of the enormous amount of work which went in this from staff across the organisation
- 1.2 We expect to hear the outcome of the tender in early May. A special meeting of the Council of Governors has been organised for 20<sup>th</sup> May to consult with them, in the event of us being successful and prior to final Board approval to proceed with any contract. We are also in contact with Monitor about this.

### 2. GIDS Media coverage

- 2.1 Just after Easter the Gender Identity Development Service (GIDS) were at the centre of media interest concerning an increase in referrals for under 11s. The media coverage was far reaching and the team was quick to respond to incoming queries. The interest stemmed from an initial [BBC news story](#). We were involved with this story and provided the BBC with facts, figures and comment. A full summary of coverage will be circulated to you via the monthly media report. A further opportunity to more explicitly put forward the work of this service will come with a Channel 4 documentary Century Film are producing and have been laying the ground works for some time now. We are looking to enter into a formal agreement soon and more details of how this work is progressing will come out of the May Board.
- 2.2 More generally, we've made significant progress in improving media relations and we're more agile than ever before in engaging with the press, however I am keen that we do more. Our relatively new Communications and Marketing Director will be developing a communications strategy which will pinpoint ways to proactively engage with the press. As part of this, we are also looking at increasing our bank of media spokespeople.

Paul Jenkins

Chief Executive

20<sup>th</sup> April 2015

## Board of Directors : April 2015

**Item :** 7

**Title :** Finance and Performance Report

**Summary:**

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

At the end of the financial year the Trust is reporting a surplus of £1,479k before restructuring; £1,439k above the budgeted surplus of £40k.

The surplus has increased by £187k due to backdated clinical income, offset by non-recurrent increases to expenditure on short term projects across the organisation.

After restructuring costs of £935k, mostly from the recent voluntary severance scheme, the surplus for the year is £544k.

The cash balance at 31 March was £2,761k, well ahead of Plan due to the size of the surplus, lower than anticipated capital expenditure, additional old year receipts, and the accrual for voluntary severance payments.

Based on the 2014/15 results, our financial continuity of service risk rating is expected to remain 4. Based on the 2015/16 plan submitted to Monitor on 7 April, the rating will reduce to 3 during the year, which remains satisfactory. (This is reviewed further in the paper relating to the Governance Declaration.)

This report has been reviewed by the Management Team on 16 April.

**For :** Information.

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

## 1. **External Assessments**

### 1.1 **Monitor**

- 1.1.1 Monitor has confirmed that for quarter 3, the Trust has retained a green governance rating and the Continuity of Service Risk Rating (CoSRR) remained at 4, above Plan.
- 1.1.2 Based on the draft accounts for the year, it is expected that the Governance rating and the CoSRR will remain unchanged in quarter 4. The 2015/16 Plan gives a projected CoSRR of 3, which remains satisfactory.

## 2. **Finance**

### 2.1 **Income and Expenditure 2014/15 (Appendices A, B and C)**

- 2.1.1 In the draft accounts for the year, the trust is reporting a surplus of £1,479k before restructuring costs, and £544k after restructuring. Income is £1,068k above budget, and expenditure £345k below budget.
- 2.1.2 The favourable movement in month on income of £1,144k (compared to budget) is primarily due to Clinical which was £1,092k above budget. This was due to GIDU income being £607k favourable which included the backdated over-performance for the final quarter. Central clinical block contracts were £194k above budget and CAMHS was £172k favourable due to Day Unit and other small projects.
- 2.1.3 The expenditure budget was over spent in month by £1,087k. Finance is £321k over budget in month mainly due to an increase in the doubtful debt provision to allow for possible non-payment of some outstanding invoices. Education and Training were overspent by £195k in March using non-recurrent HENCEL funding; Estates were £156k over budget following the completion of the non-recurrent environment improvement projects; Complex Needs were overspent £91k also on non-recurrent projects and GIDU was £53k overspent in month due to backdated prescribing costs. The annual leave provision was reduced by £37k due to a fall in the cost of average annual leave carried forward by staff.
- 2.1.4 As noted previously, the Service Line analysis (Appendix C) does not yet reflect the recent restructuring. The higher surplus for SAMHS includes the GID over-performance. Reporting for the new year will be based on the new structures.
- 2.1.5 Voluntary Severance Scheme payments have been accrued for 17 members of staff. This has increased restructuring costs to £935k for the year.

## 2.2 Cash Flow (Appendix D)

- 2.2.1 The actual cash balance at 31 March was £2,761k which is a decrease of £1,544k in month, due to the HEE funding for the whole quarter having been paid in advance in January. The position is £1,890k above plan, due to lower than anticipated capital expenditure, and payments for 2013/14 NHS contracts which were excluded from the plan, in addition to the 2014/15 surplus.

		Cash Flow year-to-date		
		Actual	Plan	Variance
		£000	£000	£000
Opening cash balance		2,757	2,757	0
Operational income received				
NHS (excl HEE)		17,835	17,566	269
General debtors (incl LAs)		9,012	8,362	650
HEE for Training		12,076	11,156	920
Students and sponsors		2,800	3,025	(225)
Other		0	0	0
		41,723	40,109	1,614
Operational expenditure payments				
Salaries (net)		(16,222)	(16,997)	775
Tax, NI and Pension		(12,543)	(12,660)	117
Suppliers		(11,278)	(9,594)	(1,684)
		(40,043)	(39,251)	(792)
Capital Expenditure		(1,354)	(2,316)	962
Interest Income		12	5	7
Payments from provisions		0	(11)	11
PDC Dividend Payments		(334)	(421)	87
Closing cash balance		2,761	871	1,890

## 2.3 Better Payment Practice Code

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

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

- 2.4.1 Appendix E reports the SoFP at 31 March, compared to the Plan figures for the year.
- 2.4.2 Property, Plant and Equipment was £1m below plan due to a number of capital projects being either delayed or deferred until the next financial year. Trade and other receivables are over plan due to £1m GIDU over performance invoices for the year not yet settled; and also the final period invoices were issued behind the timetable due to staffing issues.
- 2.4.3 Trade and Other Payables are £2.3m above plan which is mainly due to the Voluntary Severance accrual of £800k plus a number of non-recurrent projects across the Trust in March.

2.4.4 The balances on reserves are explained by the following table:

	Income and Expenditure Reserve	Revaluation Reserve
	£'000	£'000
Opening balance, April 2014	2229	8,840
Surplus for the year	544	
Transfer relating to depreciation	77	-77
Closing balance, March 2015	2,850	8,763

## 2.5 Capital Expenditure

2.5.1 Up to 31 March, expenditure on capital projects was £1,354k. This included £419k on the Refurbishment/Relocation project and £389k on the IDCR project.

2.5.2 The capital budget for the year was £2,317k in total.

Capital Projects 2014/15	Budget	Actual YTD March 2015
	£'000	£'000
33 Daleham Gardens	35	29
Portman Windows	70	24
Seminal Room Improvement	55	53
Build Management Systems	-	16
Fire door	-	2
Board Room air conditioner	-	7
Passenger lift	45	65
Studios	120	76
Boiler at the Portman Clinic	25	-
Library refurbishment	-	25
Relocation/Refurbishment Project	600	419
Modular Building		14
Others	25	-
<b>Total Estates</b>	<b>975</b>	<b>731</b>
IT Infrastructure	350	193
IDCR Project	529	389
DET Records Management	164	42
FNP Website and Records System	300	-
<b>Total IT</b>	<b>1,343</b>	<b>624</b>
<b>Total Capital Programme</b>	<b>2,318</b>	<b>1,354</b>

### 3. **Training**

#### 3.1 **Income**

- 3.1.1 Training income is £1,157k below budget in total after twelve months. Details are below. Since FNP expenditure was significantly below budget, the Trust negotiated for £994k of this year's funding to be held for future years.
- 3.1.2 If we exclude FNP, then training income is £127k below target cumulatively. This is mainly due to an LCCPD shortfall of £180k which has been offset by HEFCE and short course income.
- 3.1.3 The National Training Contract was increased in Qtr3 by short term funding of £166k to support development projects. The full year budget has been revised accordingly. £90k of this funding will now be deferred into 2015/16.

<b>LDA income (lines 4-7 appendix B)</b>	<b>YTD Budget £'000</b>	<b>YTD Actual £'000</b>	<b>YTD Variance £'000</b>
NHS London Training Contract	7,420	7,425	5
Child Psychotherapy Trainees	2,148	2,099	-49
Junior Medical Staff	957	972	15
Postgraduate Medical and Dental (budget incl. study leave)	94	57	-37
<b>Sub Total</b>	<b>10,619</b>	<b>10,554</b>	<b>-66</b>
<b>Fees and academic income (lines 8-11 Appendix B)</b>			
DET	1,362	1,332	-30
CAMHS	3,033	3,278	245
FNP	4,469	3,439	-1,030
SAAMHS	1,787	1,562	-225
TC	257	204	-52
<b>Sub Total</b>	<b>10,907</b>	<b>9,815</b>	<b>-1,092</b>
<b>Grand Total</b>	<b>21,527</b>	<b>20,369</b>	<b>-1,157</b>

### 4. **Patient Services**

#### 4.1 **Activity and Income**

- 4.1.1 Overall clinical income is £1,884k above the revised budget for the year due to GIDU over performance.

	Budget	Actual	Variance	
	£000	£000	%	Comments
Contracts - base values	13,417	14,080	4.9%	GIDU and MBT income deferred from 13/14. In addition to new projects
Cost and vol variances	325	1,296	298.8%	GIDU and Barnet over performance
NPAs	131	226	72.3%	
Projects and other	1,056	1,223		Income matched to costs, so variance is largely offset.
Day Unit	647	761	17.6%	
FDAC 2nd phase	854	801	-6.2%	Income matched to costs, so variance is largely offset.
Court report	28	15	-48.2%	
Total	16,459	18,402		

- 4.1.2 Total contracted income for the year is in line with budget. Part of the budgeted income for the year is dependent on meeting our CQUIN<sup>†</sup> targets agreed with commissioners and achievement is reviewed on a quarterly basis.
- 4.1.3 Cost and volume elements have over-performed in most cases, with the most significant being GID at £1,134k: part of this was allowed for in the budget.
- 4.1.4 Income for named patient agreements (NPAs) was £95k above budget; due in part to the end of treatment for patients from an area previously covered by contract.
- 4.1.5 Court report income was £13k below budget.
- 4.1.6 Day Unit Income target was reduced by £210k in 2014/15 and is £114k above target after March.
- 4.1.7 Project income was £167k above budget for the year. When activity and costs are slightly delayed, we defer the release of the income correspondingly.

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



## 5. **Consultancy**

- 5.1 TC are £118k net below their budgeted target for the year. This consists of expenditure £61k above budget, TC training fee income £52k below budget and consultancy income £5k below budget.
- 5.2 Departmental consultancy is £72k above budget after twelve months. The majority of the favourable variance is within SAMHS which is £107k above plan due to the BUPA Project. There has been a related increase in Complex Needs expenditure.

Carl Doherty  
Deputy Director of Finance  
21 April 2015

[illegible]

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST										APPENDIX B			
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2014-15													
All figures £000						Mar-15			CUMULATIVE			FULL YEAR 2014-15	
		BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	OPENING BUDGET	REVISED BUDGET				
INCOME													
1	CENTRAL CLINICAL INCOME	597	826	229	7,213	7,690	477	7,054	7,213				
2	CAMHS CLINICAL INCOME	377	608	231	3,944	4,300	355	3,987	3,944				
3	SAAMHS CLINICAL INCOME	446	1,137	691	5,302	6,412	1,110	4,398	5,302				
4	NHS LONDON TRAINING CONTRACT	638	640	2	7,420	7,425	5	7,254	7,420				
5	CHILD PSYCHOTHERAPY TRAINEES	179	133	(46)	2,148	2,099	(49)	2,148	2,148				
6	JUNIOR MEDICAL STAFF	80	85	5	957	972	15	1,022	957				
7	POSTGRADUATE MED & DENT'L EDUC	8	5	(3)	94	57	(37)	94	94				
8	DET TRAINING FEES & ACADEMIC INCOME	81	17	(64)	1,362	1,332	(30)	1,739	1,362				
9	FAMILY NURSE PARTNERSHIP	372	371	(2)	4,469	3,439	(1,030)	4,469	4,469				
10	CAMHS TRAINING FEES & ACADEMIC INCOME	256	285	29	3,033	3,278	245	2,274	3,033				
11	SAAMHS TRAINING FEES & ACADEMIC INCOME	190	132	(58)	1,787	1,562	(225)	1,530	1,787				
12	TC TRAINING FEES & ACADEMIC INCOME	37	14	(23)	257	204	(52)	282	257				
13	TC INCOME	100	168	68	925	920	(5)	925	925				
14	CONSULTANCY INCOME CAMHS	6	3	(3)	87	52	(35)	110	87				
15	CONSULTANCY INCOME SAAMHS	40	146	106	480	587	107	492	480				
16	R&D	10	8	(3)	123	213	90	123	123				
17	OTHER INCOME	86	68	(18)	776	902	126	1,159	776				
TOTAL INCOME		3,504	4,648	1,144	40,377	41,445	1,068	39,059	40,377				
EXPENDITURE													
18	COMPLEX NEEDS	299	390	(91)	3,575	3,506	69	3,560	3,575				
19	PORTMAN CLINIC	127	136	(9)	1,474	1,393	81	1,225	1,474				
20	GENDER IDENTITY	126	179	(53)	1,506	1,498	8	1,253	1,506				
21	DEV PSYCHOTHERAPY UNIT	9	17	(7)	113	164	(52)	114	113				
22	NON CAMDEN CAMHS	395	469	(74)	4,110	4,324	(214)	4,231	4,110				
23	CAMDEN CAMHS	361	400	(39)	4,391	4,458	(67)	4,350	4,391				
24	CHILD & FAMILY GENERAL	46	64	(18)	526	566	(40)	503	526				
25	FAMILY NURSE PARTNERSHIP	339	294	45	4,066	3,338	728	3,575	4,066				
26	JUNIOR MEDICAL STAFF	83	77	6	993	943	50	966	993				
27	NHS LONDON FUNDED CP TRAINEES	179	183	(4)	2,148	2,158	(9)	2,148	2,148				
28	TAVISTOCK SESSIONAL CP TRAINEES	2	1	0	19	26	(7)	19	19				
29	FLEXIBLE TRAINEE DOCTORS & PGMDE	26	16	9	306	268	37	394	306				
30	EDUCATION & TRAINING	258	453	(195)	3,641	3,468	174	3,447	3,641				
31	VISITING LECTURER FEES	125	104	21	1,229	1,257	(28)	1,229	1,229				
32	CAMHS EDUCATION & TRAINING	120	135	(15)	1,433	1,563	(130)	1,429	1,433				
33	SAAMHS EDUCATION & TRAINING	129	140	(11)	1,189	1,175	15	939	1,189				
34	TC EDUCATION & TRAINING	0	4	(4)	0	11	(11)	0	0				
35	TC	66	124	(58)	787	848	(61)	815	787				
36	R&D	20	57	(37)	241	133	107	169	241				
37	ESTATES DEPT	173	335	(162)	2,072	2,286	(214)	2,078	2,072				
38	FINANCE, ICT & INFORMATICS	162	483	(321)	1,942	2,361	(419)	2,326	1,942				
39	TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	87	146	(60)	989	1,056	(67)	998	989				
40	COMMERCIAL DIRECTORATE	62	132	(70)	837	832	5	738	837				
41	HUMAN RESOURCES	57	65	(8)	685	725	(40)	632	685				
42	CLINICAL GOVERNANCE	80	46	34	702	669	33	587	702				
43	PROJECTS CONTRIBUTION	0	0	0	0	0	0	(73)	0				
44	DEPRECIATION & AMORTISATION	46	56	(10)	550	608	(58)	550	550				
45	IFRS HOLIDAY PAY PROV ADJ	8	0	8	100	0	100	100	100				
46	PRODUCTIVITY SAVINGS	0	0	0	0	0	0	(134)	0				
47	INVESTMENT RESERVE	10	0	10	120	0	120	120	120				
48	CENTRAL RESERVES	14	0	14	177	0	177	315	177				
TOTAL EXPENDITURE		3,408	4,504	(1,097)	39,921	39,634	286	38,603	39,921				
OPERATING SURPLUS/(DEFICIT)		97	144	47	456	1,811	1,355	456	456				
49	INTEREST RECEIVABLE	0	1	1	5	13	8	5	5				
50	DIVIDEND ON PDC	(35)	42	77	(421)	(344)	77	(421)	(421)				
SURPLUS/(DEFICIT)		62	187	125	40	1,479	1,439	40	40				
51	RESTRUCTURING COSTS	0	828	(828)	0	935	(935)	0	0				
SURPLUS/(DEFICIT) AFTER RESTRUCTURING		62	(642)	(704)	40	544	504	40	40				

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NHS Foundation Trust

APPENDIX D													
2014/15 Plan	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	2,757	5,732	4,794	3,240	4,488	3,337	1,761	3,811	2,736	1,362	3,167	2,395	2,757
Operational income received													
NHS (excl HEE)	2,908	1,468	1,239	1,414	1,338	1,308	1,299	1,337	1,309	1,299	1,338	1,309	17,566
General debtors (incl LAs)	671	502	506	663	737	537	721	692	769	664	1,032	868	8,362
HEE for Training	2,567	142	79	2,567	143	79	2,567	142	79	2,567	143	79	11,156
Students and sponsors	325	150	150	100	0	200	800	250	100	750	100	100	3,025
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
	6,471	2,262	1,974	4,744	2,218	2,124	5,387	2,421	2,257	5,280	2,613	2,356	40,109
Operational expenditure payments													
Salaries (net)	(1,346)	(1,346)	(1,408)	(1,407)	(1,408)	(1,428)	(1,459)	(1,445)	(1,442)	(1,436)	(1,436)	(1,436)	(16,997)
Tax, NI and Pension	(991)	(995)	(1,045)	(1,053)	(1,053)	(1,053)	(1,068)	(1,092)	(1,081)	(1,079)	(1,075)	(1,075)	(12,660)
Suppliers	(1,159)	(860)	(966)	(934)	(709)	(709)	(709)	(709)	(709)	(709)	(709)	(709)	(9,594)
	(3,496)	(3,201)	(3,419)	(3,394)	(3,170)	(3,190)	(3,236)	(3,246)	(3,232)	(3,224)	(3,220)	(3,220)	(39,251)
Capital Expenditure	0	0	(100)	(100)	(200)	(300)	(100)	(250)	(400)	(250)	(166)	(450)	(2,316)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	0	1	0	1	0	1	0	0	1	0	1	0	5
Payments from provisions	0	0	(9)	(2)	0	0	0	0	0	0	0	0	(11)
PDC Dividend Payments	0	0	0	0	0	(211)	0	0	0	0	0	(210)	(421)
Closing cash balance	5,732	4,794	3,240	4,488	3,337	1,761	3,811	2,736	1,362	3,167	2,395	871	871
2014/15 Actual/Forecast	April £000	May £000	June £000	July £000	August £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	March £000	Total £000
Opening cash balance	2,757	4,441	3,357	4,330	5,086	3,884	2,647	5,695	5,369	3,936	5,917	4,305	2,757
Operational income received													
NHS (excl HEE)	1,852	1,312	3,498	691	1,548	987	2,385	1,750	880	1,323	655	954	17,835
General debtors (incl LAs)	1,016	564	412	442	971	466	815	1,093	639	764	669	1,161	9,012
HEE for Training	2,443	78	128	2,552	17	162	2,993	77	295	3,049	200	82	12,076
Students and sponsors	277	104	98	105	105	396	738	184	136	491	100	66	2,800
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
	5,588	2,058	4,136	3,790	2,641	2,011	6,931	3,104	1,950	5,627	1,624	2,263	41,723
Operational expenditure payments													
Salaries (net)	(1,344)	(1,396)	(1,401)	(1,275)	(1,290)	(1,285)	(1,342)	(1,356)	(1,356)	(1,379)	(1,403)	(1,395)	(16,222)
Tax, NI and Pension	(1,033)	(1,052)	(1,060)	(1,093)	(1,011)	(1,018)	(1,005)	(1,058)	(1,048)	(1,051)	(1,065)	(1,049)	(12,543)
Suppliers	(1,499)	(679)	(660)	(607)	(1,240)	(524)	(1,316)	(1,010)	(949)	(1,085)	(664)	(1,045)	(11,278)
	(3,876)	(3,127)	(3,121)	(2,975)	(3,541)	(2,827)	(3,663)	(3,424)	(3,353)	(3,515)	(3,132)	(3,489)	(40,043)
Capital Expenditure	(29)	(16)	(43)	(60)	(303)	(247)	(221)	(7)	(31)	(132)	(105)	(160)	(1,354)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	1	1	1	1	1	1	1	1	1	1	1	1	12
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	0	0	0	0	0	(175)	0	0	0	0	0	(159)	(334)
Closing cash balance	4,441	3,357	4,330	5,086	3,884	2,647	5,695	5,369	3,936	5,917	4,305	2,761	2,761

Appendix E				
	Plan	Actual	Variance	Actual
STATEMENT OF FINANCIAL POSITION	31 March 2015	31 March 2015	31 March 2015	31 March 2014
	£000	£000	£000	£000
<b>Non-current assets</b>				
Intangible assets	101	52	(49)	101
Property, plant and equipment	15,749	14,775	(974)	13,981
<b>Total non-current assets</b>	<b>15,850</b>	<b>14,827</b>	<b>(1,023)</b>	<b>14,082</b>
<b>Current assets</b>				
Inventories				
Trade and other receivables	3,426	5,480	2,054	5,435
Cash and cash equivalents	871	2,761	1,890	2,756
<b>Total current assets</b>	<b>4,297</b>	<b>8,241</b>	<b>3,944</b>	<b>8,191</b>
<b>Current liabilities</b>				
Trade and other payables	(2,833)	(5,150)	(2,317)	(4,436)
Provisions	0	(6)	(6)	(6)
Tax payable	(619)	(640)	(21)	(618)
Other liabilities	(2,049)	(2,124)	(75)	(2,606)
<b>Total current liabilities</b>	<b>(5,501)</b>	<b>(7,920)</b>	<b>(2,419)</b>	<b>(7,666)</b>
<b>Total assets less current liabilities</b>	<b>14,646</b>	<b>15,148</b>	<b>502</b>	<b>14,607</b>
<b>Non-current liabilities</b>				
Loans	0	0	0	0
Provisions	(64)	(62)	2	(65)
<b>Total non-current liabilities</b>	<b>(64)</b>	<b>(62)</b>	<b>2</b>	<b>(65)</b>
<b>Total assets employed</b>	<b>14,582</b>	<b>15,086</b>	<b>504</b>	<b>14,542</b>
<b>Financed by (taxpayers' equity)</b>				
Public Dividend Capital	3,474	3,474	0	3,474
Revaluation reserve	8,840	8,763	(77)	8,840
Income and expenditure reserve	2,268	2,849	581	2,228
<b>Total taxpayers' equity</b>	<b>14,582</b>	<b>15,086</b>	<b>504</b>	<b>14,542</b>

## Board of Directors : April 2015

**Item : 8**

**Title:** Training & Education Programme Management Board  
April 2015 report

**Purpose:**

To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 13<sup>th</sup> April 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

## April 2015

### **1. Introduction**

- 1.1 The Training & Education Programme Management Board (TEPMB) had its seventh meeting on 13 April 2015.

### **2. Technology Enhanced Learning (TEL) Strategy**

- 2.1 Simon Kear, Head of the TEL unit, presented a strategy document for consideration. This outlined key areas of focus for the TEL unit, including areas already in development, including the transition to the online submission of written work and ensuring that students in associate centres have equality of access to student resources. Newer technologies, including web streaming to facilitate distance learning engagement in live teaching fora, were also being explored.
- 2.2 There was an engaging and constructive discussion that included emphasis of the centrality of the student experience and the importance of human contact. The cultural changes required in the Trust were also discussed.
- 2.3 Attention was drawn to the issues with Wi-Fi in the building experienced by students that made it particularly difficult for Visiting Lectures to access work online. Simon Kear was exploring solutions with our Director of IM&T, Toby Avery.
- 2.4 Overall, the document was thought to be clear, well-organised and a pleasure to read. Paul Jenkins thought the vision, aims and objectives were good. Broadly speaking, the strategy should be aimed at promoting an increase in our student numbers, strengthen our regional strategy and help mobilise additional capacity to expand through distance and blended options.
- 2.5 Simon Kear was asked to develop an implementation that addressed barriers and risk and identified any resource/investment implications for consideration by the TEPMB in June 2015.

### **3. QAA report**

- 3.1 Louis Taussig, Head of Academic Quality, presented a brief report on the outcome of the recent QAA visit in February 2015.



- 3.2 He reported that there had been a good outcome in that the Trust was deemed to be making acceptable progress (second highest of four possible outcomes).
- 3.3 The quality of our teaching was thought to be excellent. There were a number of areas of notable improvement including the increase in the number of faculty members who are members of the Higher Education Academy and our student admission and assessment processes were commended.
- 3.4 There were specific areas noted for improvement most notably in the area of increased professionalism and consistency across all areas of the portfolio. While good practice and adherence to policies was evidenced, the review team saw some examples of policies not being implemented; of areas where, in default of a central policy, individual programmes were devising their own individual solutions; and of discrepancies both in academic and in administrative practice. Employer engagement was another notable area for further development.
- 3.5 In light of the migration of a significant proportion of our portfolio to Essex University, the QAA will instigate a review visit in the next 12 months, possibly in this calendar year. Louis Taussig will engage with the QAA to discuss the possibility of having the review take place next year.
- 3.6 Louis Taussig will draw up an action plan for addressing the substantive areas of needed improvement. It is largely expected that operational oversight will reside for many of these improvements with the Academic Governance and Quality Assurance Committee in conjunction with the Training Executive.
- 3.7 The TEPMB will take overall ownership of the action plan, which will be brought back to the meeting in due course.

#### **4. University of Essex Partnership**

- 4.1 Brian Rock reported that we are progressing well with the partnership arrangements with Essex. The meetings with the University have been very productive.
- 4.2 Work in most of the six work streams is underway. However, the focus remains on the validation – interim and full – that has been agreed with Essex to ensure that all our courses are open for recruitment in AY 15/16. have been agreed and these are discussed at the monthly meetings.
- 4.3 A three way meeting with UEL and Essex is planned for 15 May 2015 where final discussions will take place to agree the teach-out and

transitions

arrangements.

- 4.4 UEL have advised that they may wish to retain the Social Work Doctorate and are working on proposals that will be considered at the above meeting.
- 4.5 Will Bannister advised that Essex have conveyed their wish for the Trust to enrol students without subsequent registration with Essex. This is contrary to our current arrangements with UEL and, in fact, would represent a departure from our current arrangement with Essex for the courses they currently validate. There are three areas of identifiable concern: the Trust carrying undue liability for students; the financial and resource implications for the Trust in terms of Higher Education Statistics Agency (HESA) returns; and the limiting of the student experience in relation to access to Essex University facilities and support (though this in all likelihood is expected to be minimal given the geographical distance but it might have implications for student cards, etc.).
- 4.6 This is a significant development that will be taken up at the next Partnership Board meeting with Essex in May 2015.

## **5. Risk Register**

- 5.1 Further work on the risk register was undertaken following suggestions made at the previous TEPMB.
- 5.2 It was noted that risks around the Essex partnership in terms of recruitment for the entire long course portfolio had reduced and that the risks around the national contract should be increased to ensure visibility of this key issue.

## **6. ICT update**

- 6.1 Will Bannister, Associate Director (DET), updated the TEPMB on the ICT procurement. The I.T.T closed on 20 March and attracted no bids.
- 6.2 The Project Board, which has been refreshed, and is chaired by Brian Rock and now involves Toby Avery and other system users, has been fully engaged in understanding this development and re-establishing a credible and realistic process.
- 6.3 There are various factors thought to be at play though there does seem to be a gap in supplier engagement following the capability assessments conducted in Nov/Dec 2014. Active steps are being taken to engage with potentially suitable suppliers. In this regard, a supplier engagement event is being organised for 24 April 2015. The TEPMB discussed the inevitable

challenges of these process and the collaborative nature of the dialogue with possible suppliers.

- 6.4 The Project Board was supported in continuing to work with the project team in setting a realistic timeline with the recognition that the system needs to be updated.
- 6.5 Brian Rock has requested the undertaking of a Threats and Vulnerability Assessment of our current hardware and software arrangements to ensure that we fully understand and the business continuity risks.

## **7. Visiting Lecturers – Employment Claim**

- 7.1. This issue is being robustly engaged with by our HR Director, Susan Thomas, and our Associate HR Director, Namdi Ngoka. They will be meeting with the Trust's solicitors and the claimants in May 2015.
- 7.2. We expect to have a clearer picture of what is to be done following this meeting.

## **8. Marketing**

- 8.1 Laure Thomas, Director of Marketing & Communications, provided a brief update of her work since beginning in role around six weeks ago. She conveyed focusing on addressing areas to support our current student recruitment drive and putting in place a medium term strategy for creating a more solid foundation for recruitment in subsequent years.
- 8.2 The Trust will be advertising for a substantive student recruitment manager, who will be required to input to a more developed recruitment function that draws on the expertise of course administrators.
- 8.3 The website needs further development. Laure has created a Web Reference Group to review and support developments in this regard. She will be developing an online prospectus to draw together key information about the Trust's offer that will help shape future web developments. This met with support from the TEPMB. Mention was also made of the requirement to communicate our ability to offer bespoke courses too. Staff profiles in the domain of education and training will be added to increase the attractiveness and profile of our distinctive pool of expertise.

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



## Board of Directors : April 2015

**Item : 9**

**Title : Quarter 4 Governance statement**

### **Purpose:**

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

#### For Finance

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

#### For Governance

The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.

#### Otherwise

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

At the Management Team on 16 April, members confirmed that they are not aware of any risk to compliance with the financial and governance conditions of our licence.

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

- Risk
- Finance
- Quality

**For : Approval**

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

## Quarter 4 Governance Statement

### 1. **Introduction**

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

### 2. **Finance declaration**

- 2.1 The Trust has submitted a draft Operational Plan, based on the 2015/16 Budget approved by the Board last month. The Monitor template calculated the following results for the two metrics which comprise the continuity of service risk rating (CoSRR):
  - Our Capital Service Cover rating is projected to be 4 for all quarters of 2015/16.
  - Our Liquidity rating is projected to be 3 or 2 for all quarters of 2015/16.
- 2.2 The two elements are each given a 50% weighting, and the result is rounded up to obtain the overall CoSRR. So with the lowest of the ratings predicted, our CoSRR will be 3, which remains satisfactory.
- 2.3 Details of the calculation are given in Appendix 1.
- 2.4 For the Capital Service Cover rating to fall to 3, the Trust's surplus/deficit would have to be some £225k (pro rata) below Plan at some point in the year. If this occurred, the overall rating would still be 3.
- 2.5 For the Liquidity rating to fall to 1, the combination of the Trust's surplus and its capital expenditure would have to be some £500k worse than Plan. This is significantly less likely to occur, and there could be scope to avoid it through delaying capital expenditure if necessary.
- 2.6 Based on the budget, and allowing a reasonable margin for potential variation, we are able to affirm that we anticipate that the trust will continue to maintain a continuity of service risk rating of at least 3 over the next 12 months.

### 3. **Governance Declaration**

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

- 3.1.1 The Monitor template for our quarterly return sets out a list of targets and indicators, in line with the Risk Assessment Framework. The targets and indicators which apply to this Trust are given in the

table on the next page.

- 3.1.2 All targets and indicators are being met; and plans are sufficient to ensure that they continue to be met. Further details are given below. The Trust should therefore continue to receive a green governance rating.

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

### 3.2 Care Quality Commission registration

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

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

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

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

### 3.4 Data Completeness

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

	Cumulative to Month 10, final	Cumulative to Month 11, provisional
Valid NHS number	99.70%	99.56%
Valid Postcode	99.95%	100.00%
Valid Date of Birth	100.00%	100.00%
Valid Organisation code of Commissioner	99.36%	99.32%
Valid Organisation code GP Practice	99.06%	99.11%
Valid Gender	99.85%	99.85%

## 4. Other matters

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

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

Simon Young  
Deputy Chief Executive and Director of Finance  
20 April 2015



## Appendix 1

### 2015/16 Continuity of Service Risk Rating (draft Operational Plan)

#### a) Capital Service Cover

	cumulative to:	Q1	Q2	Q3	Q4
		£000	£000	£000	£000
Surplus		14	28	41	55
Dividend		105	210	316	421
Depreciation		194	387	581	775
Restructuring Costs		0	0	0	0
Revenue available for Capital Service		313	625	938	1,251

Ratio: Revenue available for Capital Service / Dividend                      **3.0      3.0      3.0      3.0**

Thresholds: for rating 4, 2.5; for rating 3, 1.75; for rating 2, 1.25

**Capital Service Cover Rating    4              4              4              4**

#### b) Liquidity

	Q1	Q2	Q3	Q4
	£000	£000	£000	£000
Debtors and Accrued Income	3,624	4,124	4,294	2,994
Prepayments	250	250	250	250
Cash	4,036	1,677	683	1,824
Creditors (Trade and Tax)	-1,650	-1,650	-1,650	-1,650
Accruals	-3,250	-2,500	-2,500	-2,000
Dividend Payable	-105	0	-105	0
Deferred Income	-3,000	-2,750	-2,000	-2,500
Current Provisions	-6	-6	-6	-6
Working Capital	-101	-855	-1,034	-1,088

Operating Expenses (cumulative)  
(excluding Restructuring Costs)                      10,405      20,810      31,215      41,620

Liquidity Ratio    **-0.9      -7.4      -8.9      -9.4**  
(Working Capital / Operating Expenses x 360 days/year)

Thresholds: for rating 4, 0 days; for rating 3, -7 days; for rating 2, -14 days

**Liquidity Rating    3              2              2              2**

**Overall Risk Rating    4              3              3              3**



# Board of Directors : April 2015

**Item :** 10

**Title :** Quarterly Quality Report for the Board of Directors for Quarter 4, 2014/2015.

**Purpose:**

The report provides an update of the Quality Indicators for Quarter 4, 2014/15.

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 has been reviewed by the following Committees:

- Management Team on 16/4/2015

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

*(delete where not applicable)*

- Quality
- Patient / User Experience
- Safety

**For :** Approval

**From :** Justine McCarthy Woods, Quality Standards and Reports Lead



# Quarterly Quality Report for the Board of Directors

Quarter 4, 2014-2015

April 2015

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## Section One: Quality Key Performance Indicators Table

Quality Key Performance Indicators																			
No.	Target	Monitoring	Progress										% Progress for 2014/15				Actions for Next Quarter		
			Q1		Q2		Q3		Q4		Q1	Q2	Q3	Q4					
I	Waiting time no more than 11 weeks (77 days from receipt of referral) excluding exceptions where this is outside of the Trust's control. 1	Quarterly	N	%	N	%	N	%	N	%	1	0.2%	0	0%	10	2.3	3	0.3	
II	Adult DNA rates. Target = no greater than 10%	Quarterly	7%		8.5%		6%		8%										
III	Patient Satisfaction (Adult + CAMHs): Target 90% or more report satisfied with the service.	Quarterly	N	%	N	%	N	%	N	%	263	93%	319	92%	221	91%	230	93%	
IV	Quality and Development of staff: Target 90% of staff to have a PDP.	Quarterly	97%		97%		97%		97%										
V	Sickness and absence rates. Target:<2% = green, (2-6% = amber; >6 = red).	6 monthly	N/A		0.92%		N/A		0.82%		N/A				N/A				
VI	Trust Service cancellation rates. Target: <5% = green (5-9% = amber, >10% = red).	Quarterly	1.4%		1.7%		2.6%		3.3%										
VII	% of staff with up-to-date mandatory for infection control. Target > 95% = green (80-95% = amber; < 80% = red).	Annually									N/A		97%		N/A		97%		
VIII	% response to complaints within 25 days. Target: > 95% green (80-95% = amber, <80% = red.)	Monthly	Jan 14		Feb 14		Mar 14				50% (1/2)		100% (0/0)				n/a		Overall for Q4: 50% (1/2)

<sup>1</sup> The waiting times figure does not include GIDs as they have a separate target as part of their National Contract

IX	Trust's contribution to statutory assessments to be completed within 6 weeks. Target = 95%.	Annually	<b>TBC</b> Audit completed currently being signed off.										N/A	N/A	
X	Number and % of children reporting satisfaction with the service (as measured against CHI-ESQ). Target 70%.	Quarterly	N	%	N	%	N	%	N	%	N	%			
			208	85%	178	92%	157	91%	159	94%					

Quality Service Developments											
No	Target	Monitoring	Progress				% Progress for 2014/15				Actions for Next Quarter
							Q1	Q2	Q3	Q4	
1	Attendance at Child Safeguarding Training, levels 1, 2 & 3. Target = 85%	Quarterly	Q1	Q2	Q3	Q4					
			L1- 95% L2- 90% L3- 94%	L1 – 97% L2 – 92% L3 – 91%	L1 - 98% L2 – 98% L3 – 97%	L1 - 97% <sup>2</sup> L2 – 100% L3 – 94% <sup>3</sup>					
2	Attendance at Adults at Risk Safeguarding Training. Target = 85%	Quarterly	95%	97%	98%	97%					
3	Trust-wide DNA Rate. Target no greater than 10%	Quarterly	8%	9%	7%	7%					

<sup>2</sup> Level 1: Reason for non-attendance: 4 Mat/CB, 3 unable to attend Nov INSET Day and provided with exemptions from Director, 3 sick on Nov INSET Day and 7 new starters (4 had 2 day pre-planned conference FNP staff at the Trust Induction Feb 2015) All now have dates to attend the next events.

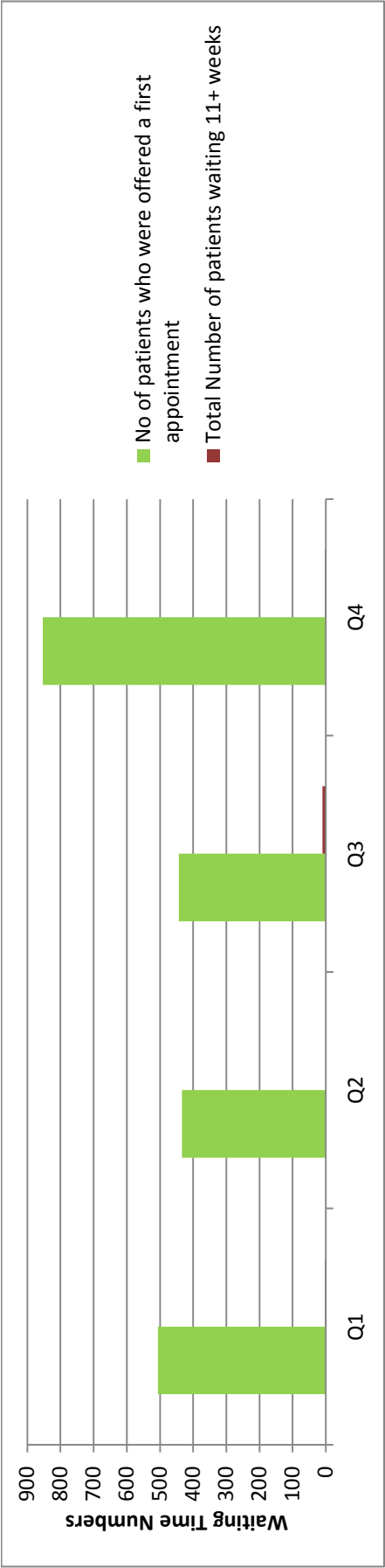
<sup>3</sup> Level 3: Reason for non-attendance: 2 returns from Mat Leave/Career Break, 3 Based in Leeds new starters, and 12 are new starters. All have dates to attend the next events.



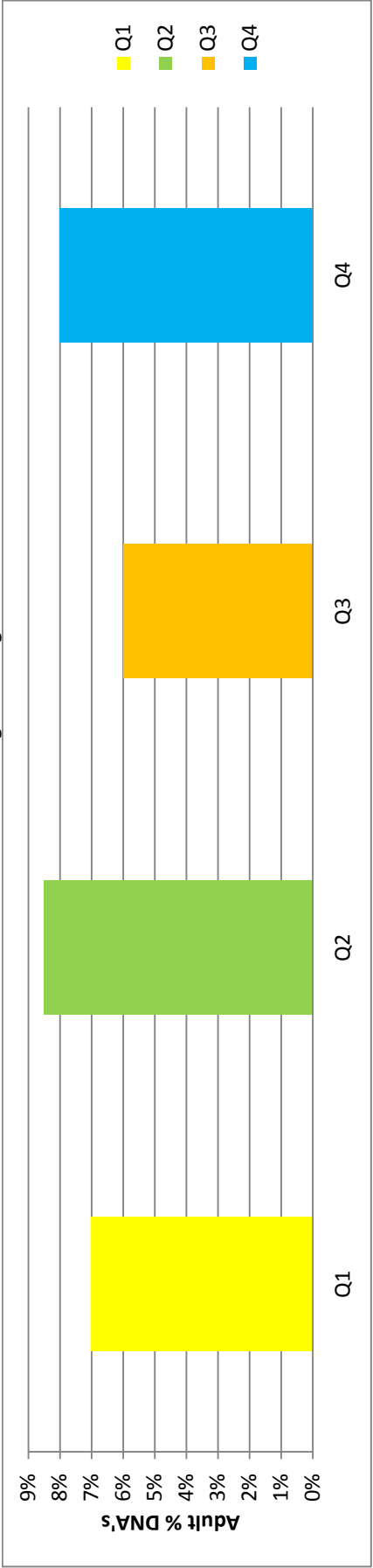
Section Two: Explanatory Notes

Quality Key Performance Indicators

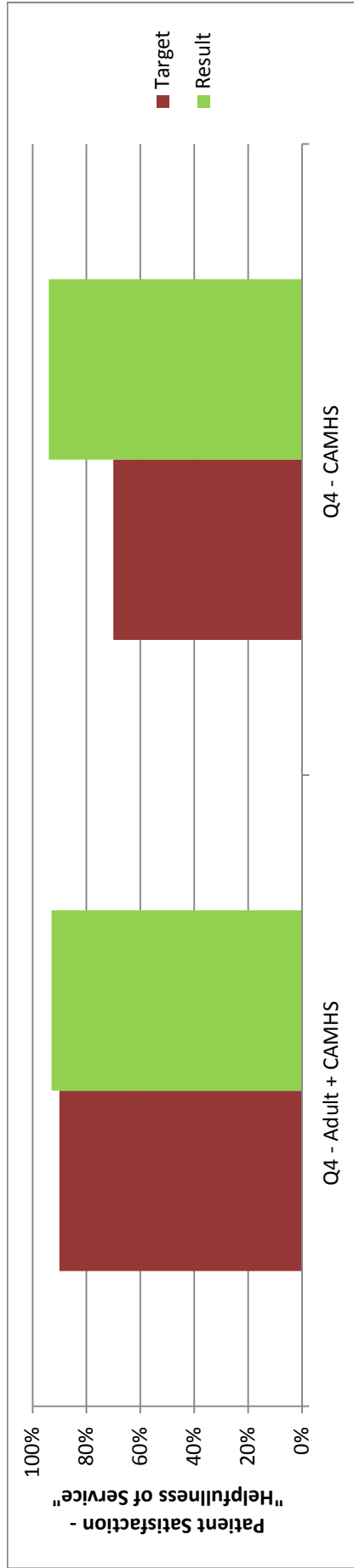
(i) **Waiting Times** - For Quarter 4, there were 11 waiting time breaches, where patients were required to wait eleven weeks or longer for their first appointment. Three of these breaches related to factors internal to the Trust and represented 0.3% of the total number of patients who were offered a first appointment in Quarter 4.



(ii) **Adult DNA Rates** - The Adult DNA rate for Quarter 4 is 8% and below the target of no greater than 10%.



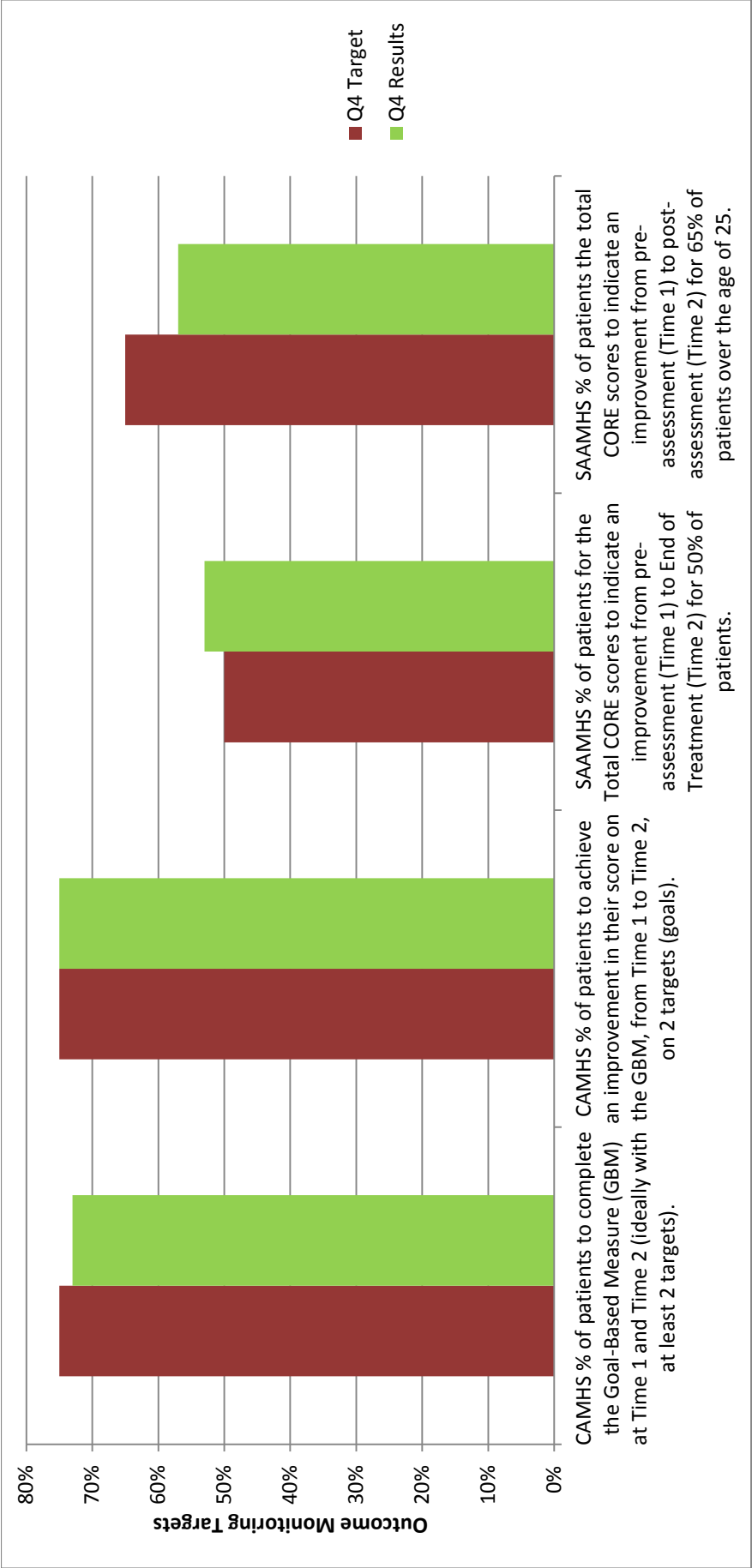
(iii) **Patient Satisfaction – Satisfaction with “Helpfulness of Service” (Experience of Service Questionnaire).**



(iv) **Complaints – Response to complaints within 25 days.**

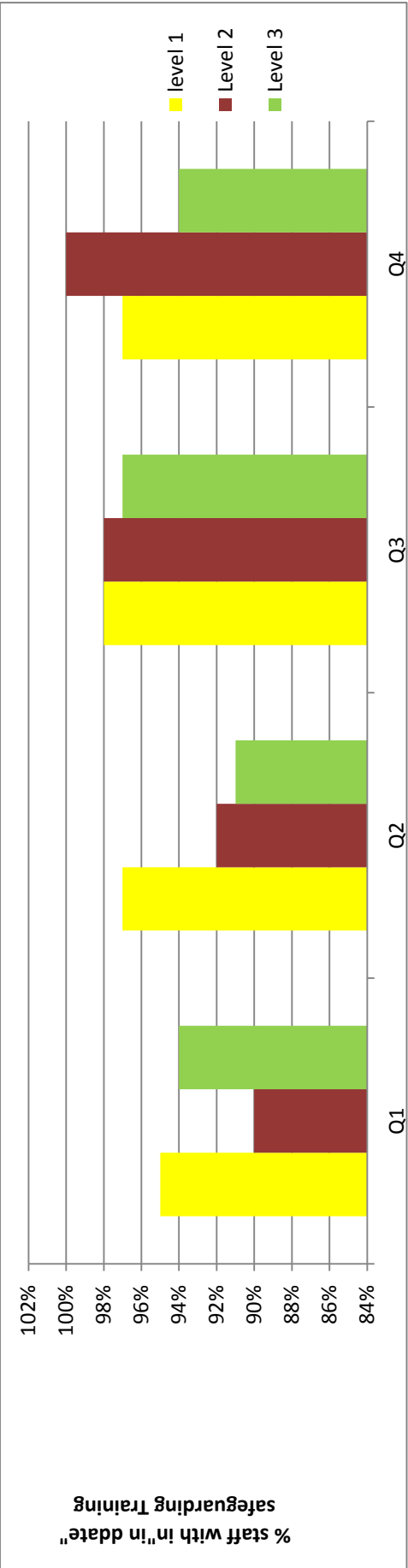
Target VIII - % response to complaints within 25 days. Target: > 95% green (80-95% = amber, <80% = red) - Monthly											
Quarter 1			Quarter 2			Quarter 3			Quarter 4		
RAG			RAG			RAG			RAG		
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
100% 0/0	100% 1/1	100% 0/0	33% 1/3	100% 0/0	100% 0/0	100% 1/1	100% 1/1	100% 1/1	50% 1/2	100% 0/0	n/a

(v) Outcome Monitoring - The data for the four Outcome Monitoring targets for Q4 are shown in comparison to the current target.

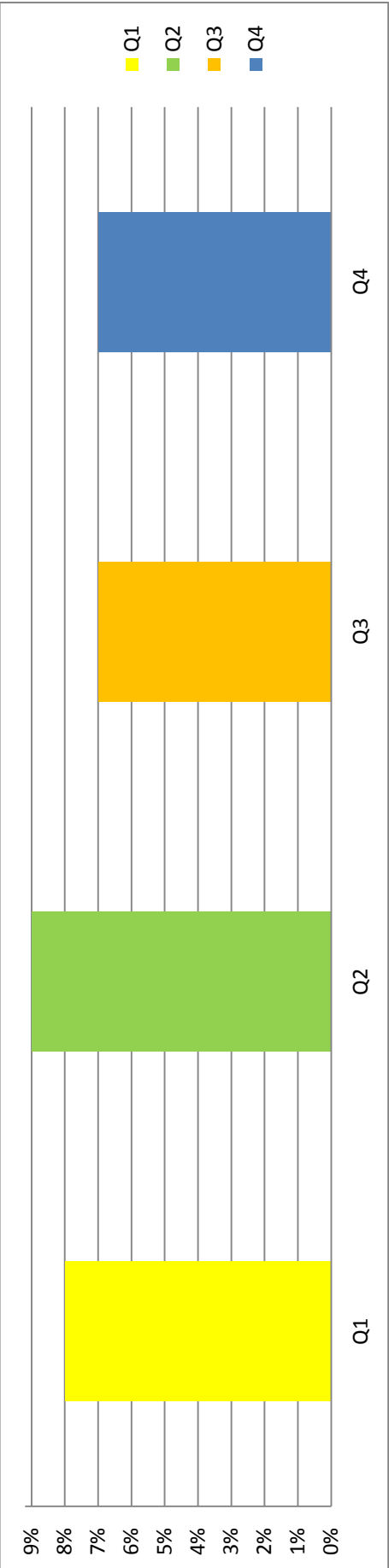


Service Developments

1. **Child Safeguarding Training** - The percentage of staff with 'in date' Child Safeguarding training does not include those members of staff who have just recently joined the Trust and not yet attended the training, nor those staff who are on sick leave or maternity leave. (The training for Safeguarding Level 3 was provided on Thursday 19th March).



2. **Trust-wide DNA Rates** - The DNA rate for Quarter 4 is 7% which below the target of no greater than 10%



## Section Three: Quality Priorities Progress

Quality Priorities											
Priority	Target	Priority Lead	Monitoring Processes	Evidence Required	Start Date	Achieve -ment Date	Progress	% Progress for 2014/15			
								Q1	Q2	Q3	Q4
(1)Outcome Monitoring	1. CAMHS (Child and Adolescent Mental Health Service): For 75% of patients (attending CAMHS who qualify for the CQUIN) to complete the Goal-Based Measure (GBM) at the Pre-Assessment stage (known as Time 1) and after six months or, if earlier, at the end of therapy/treatment (known as Time 2).	Caroline McKenna	OM tracking system  Monitoring of progress by the OM Lead  Quarterly progress report  Quarterly review by the CQSG Committee and Board of Directors	• OM analysis of the % return rate for Time 1 and Time 2.	1 April 2014	31/1/15	73% have returned a Time 1 & 2 Goal Based Measure. Aware below target but significant improvement from last quarter which saw 33% return rate.				
	2. CAMHS: 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).							N/A	N/A		
				• OM analysis of the % of patients who achieve an improvement in their score for at least two GBM targets.	1 April 2014	31/1/15	75% achieved an improvement in their Goal Based Measure score.	N/A	N/A		

	3. Adult Department: For the Total CORE scores to indicate an improvement from pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.	Michael Mercer		• OM analysis of the % of service users who achieve an improvement in their score from pre assessment to End of Treatment.	1 April 2014	31/3/15	53%. Achieved.		42%	43%	53%
(2) Access to Clinical Services and Health Care Information for Patients and Public	1. To ensure that information from the patient story is on the patient section of the website.	Sally Hodges	<ul style="list-style-type: none"> <li>Monitoring of progress by PPI Lead</li> <li>Quarterly progress report</li> <li>Quarterly review by the CQSG Committee and Board of Directors</li> </ul>	1. Link to the patient story on the relevant patient section of the website.	1 April 2014	31/3/15	1. The Patient story information (of service users who have given their consent) is to be added to the relevant sections of the website e.g. adult patient story to be added to the adult section, young person story to young person section.				
	2. To run a visual straw poll on awareness of the patient stories.			1. Visual straw poll results.			1. The VSP ran for a month to the question: Did you know you can come to our Board of Directors meeting and share your story? The results were: Y= 39, M= 30, N= 9 No respondents left their contact details in the comments box.				
	3. Based on the feedback from the visual straw poll, to revise the communications campaign to publicise patient stories if necessary.			3. Form the communications strategy around patients' stories.			1. Patient stories will continue to be advertised via the website and via trust information leaflets and the members newsletter. Updates on patient stories will also be included in the new PPI quarterly newsletter to be launched in Q1 of 2015/16.				

(3) Patient and Public Involvement	1. To run at least two staff trainings on having services users on panels.	Sally Hodges	<ul style="list-style-type: none"> <li>• Maintain minutes from the stakeholder quality meetings and patient forum</li> <li>• Monitoring of progress by PPI Lead</li> <li>• Quarterly progress report</li> <li>• Quarterly review by the CQSG Committee and Board of Directors</li> </ul>	1. Reports and action plans that come out of the training events.	1. April 2014	31/3/15	1. The 2 trainings have been completed.			
	2. To have at least three interviews with service users on the panel.			1. Panel staffing lists for the interviews and questionnaires completed by service users about their experience on the appointment process.			2. 11 interviews have taken place with service users on the panel.			
	3. To take a minimum of three real patient stories to the trust board in one of the following ways: a patient visiting the board, the board seeing a video or a transcript of the description of the journey.			1. NHS Board of Directors Minutes.			3. A patient story was shared at the board meeting in March in the form of a seven minute video of two adolescent service users from the North Camden Service interviewing one another about their experience.			

## Appendix One: CQUIN Targets

	Detail of indicator	Performance at Q4	Progress	Q1 RAG <sub>4</sub>	Q2 RAG <sub>4</sub>	Q3 RAG <sub>4</sub>	Q4 RAG <sub>4</sub>
Friends + Family Test	<b>Indicator 1a</b> – Implementation of Staff Friends + Family (FFT) Test by TPFT by 30 May 2014.	Achieved in Q1	Achieved. Implementation				
Friends + Family Test	<b>Indicator 1b</b> – Early Implementation of Service User FFT by 1 October 2014	Achieved	Achieved. This data is collected via the patient ESQ Experience of Service questionnaire.	N/A	N/A		
Friends + Family Test	<b>Indicator 1c</b> – Full implementation of Service User FFT by 1 January 2015.	Achieved	Achieved. This data is collected via the patient ESQ Experience of Service questionnaire.	N/A	N/A		
Physical Health	<b>Indicator 2</b> – Appointing clinical leader and training of Mental Health (MH) staff for Physical Health for People with MH Problems. (Q1 Appoint Trust Lead, End Q3 Develop and agree action plan to implement programme for ensuring staff are discussing and supporting service users and end Q4 Evidence all milestones set out in Action Plan have been achieved.)	Report in Q3	Achieved. The appointed leads meet regularly to continue planning for 2015/16. In October the clinical lead for Quit Smoking at the Whittington Hospital presented to the SAAMHS Clinical Governance team. At the end of January, there will be a smoking cessation presentation held within the Trust's Scientific Meeting.		N/A		
CAMHS Experience of Service (ESQ)	<b>Indicator 3a</b> – User Satisfaction (Target 75% satisfaction). Percentage of service users reporting satisfaction with the service as measured against CHI-ESQ.	97%	Achieved target.				
CAMHS ESQ	<b>Indicator 3b</b> – User Satisfaction with Explanation of Help (Target: 75% satisfaction). ESQ analysis 2012/13 identified a specific area for improvement in relation to the following statement "Satisfaction with explanation of help available".	83%	Achieved target.				
SAAMHS Outcome monitoring	<b>Indicator 4a</b> - 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%	Achieved target. 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 to the End of Treatment stage.				

4 RAG status for Q4. (Please note the Quality Standards and Reports Lead is not in a position to deliver these targets and only report on the progress. However, where every effort will be made to achieve the target by those responsible, it is not possible to provide assurance at this stage for the outcome at Q4).



SAAMHS Outcome monitoring – End of Treatment	<b>Indicator 4b</b> – For the total CORE scores to indicate an improvement from pre-assessment (Time 1) to post-assessment (Time 2) for 65% of patients over the age of 25.	57%	Target not achieved.				
SAAMHS	<b>Indicator 5a</b> – Smoking Cessation - Recording of smoking status for all new service users (aged 18 and over) who have received 2 appointments during each quarter in 2014-15.	81%	Target achieved. All patients within the cohort have been contacted but we are still waiting for some responses				
SAAMHS	<b>Indicator 5b</b> – Smoking Cessation - Provision of smoking cessation advice to all service users identified as smokers with advice on local stop smoking services. (Based on an audit of case notes of 25% of service users who have been identified as smokers in 5a.)	99%	Target achieved.				
CAMHS Outcome Monitoring + Clinical Effectiveness	<b>Indicator 6</b> - For at least 75% of patients (attending CAMHS who qualify for CQUINS) to achieve an improvement in their score on the Goal Based Measure from Time 1 pre assessment and Time 2 (6 month or end of therapy) on 2 targets, but only for patients who have attended at least 4 appointments and who completed GBM at Time 1.	75%	75% target achieved. This is an improvement since last quarter.	N/A	N/A		
CAMHS Length of Treatment	<b>Indicator 7</b> – All new cases whose first treatment attendance was 1 November 2012, or after, should not be in treatment for longer than a maximum of 2 years EXCEPT where longer treatment is specifically agreed.	2%	2% of the cases have stayed open for longer than 2 years. 100% of these have agreement from the senior clinical manager (24/24).	N/A	N/A		

4 RAG status for Q4. (Please note the Quality Standards and Reports Lead is not in a position to deliver these targets and only report on the progress. However, where every effort will be made to achieve the target by those responsible, it is not possible to provide assurance at this stage for the outcome at Q4).

## Appendix Two: Quality Indicator Performance Supporting Evidence

## 1. Waiting times

QUARTER 4							
	Adolescent	Adult	Camden CAMHS	Other CAMHS	Lifespan	Portman	TOTAL
Breaches Cause internal to Tavi	1	1	0	0	1	0	3
Breaches: Cause external to Tavi	2	0	3	2	1	0	8
Total number of breaches	3	1	3	2	2	0	11
Number of 'breaches' shown after data validation shown to be 'no breach'	0	6	4	2	13	0	25
Total number of patients offered a first appointment in the quarter	55	77	222	29	440	30	853
The percentage of patients that are breached in the quarter	5%	1%	1.4%	6.9%	2.5%	0%	1.29%
% of internal breaches	1.8%	1.3%	0.0%	0.0%	0.7%	0.0%	0.35%
% of external breaches	3.6%	0.0%	1.4%	6.9%	1.8%	0.0%	0.94%

## 2. DNA Rates

QUARTER 4							
	Adolescent	Adult	Camden CAMHS	Other CAMHS	Lifespan	Portman	Total
Target <10%							
Total 1st appointments attended	51	73	183	49	20	30	406
Total first appointments DNA's	5	5	16	3	1	5	35
Total first appointments	56	78	199	52	21	35	441
% 1st appointments DNA'd	8.9%	6.4%	8.0%	5.8%	4.8%	14%	8%
Total subsequent appointments attended	1134	2481	3510	1902	388	1125	10540
Total sub. appointments DNA'd	174	205	242	104	19	79	823
Total subsequent appointments	1308	2686	3752	2006	407	1204	11363
% DNA subsequent Appointments	13.3%	7.6%	6.4%	5.2%	4.7	7%	7%
Total Trust DNA	13%	8%	7%	5%	5%	7%	7%

3. **Patient Satisfaction** – See ESQ Report 2014-2015 Q4. (A hardcopy of this Report can be provided by the Quality Standards and Reports Lead).
4. **Patient Experience** - See Annual PPI Report. (A hardcopy of this Report can be provided by the Quality Standards and Reports Lead, if required.)
5. **Patient Information** - See patient leaflets on Trust Website. (In addition, a hardcopy of these leaflets can be provided by the Quality Standards and Reports Lead, if required.)
6. **Outcome monitoring-** Please refer to CQUINs Targets in Section Two and see 2014-15 CQUINs Outline (A hardcopy of this CQUINs Outline can be provided by Quality Standards and Reports Lead, if required.)
7. **Quality and Development of Staff** - Patient Development Plans (“PDPs”) are managed on an annual cycle with performance reported at end March each year, for implementation over the course of the next year. Updated figure for Q4 in table below.

Quality and Development of Staff - PDPs:		
Number of staff who require a PDP at 31.3.15	Number of staff with a PDP	% of staff with a PDP
482	470	97%

## 8. Safety (Children Safeguarding)

Level 1 Safeguarding Training/Adults at Risk Training				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	95%	97%	98%	97%
Narrative	In Q4...			
Total numbers requiring training: 489 Number of staff trained: 472 Number of staff NOT trained: 17 %: 97 <b>Rational (Reason for non-attendance):</b> 4 Mat/CB, 3 unable to attend Nov INSET Day and provided with exemptions from Director, 3 sick on Nov INSET Day and 7 new starters (4 had 2 day pre-planned conference FNP staff at the Trust Induction Feb 2015). All now have dates to attend the next events.				
Level 2 Safeguarding Training				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	90%	92%	98%	100%
Narrative	In Q4...			
Total numbers requiring training: 48 Number of staff trained: 48 Number of staff NOT trained: 0 %: 100				
Level 3 Safeguarding Training				
Quarter	Q1	Q2	Q3	Q4
% of staff whose training is 'in date'	94%	91%	97%	94%
Narrative	In Q4...			
Total numbers requiring training: 293 Number of staff trained: 276 Number of staff NOT trained: 17 %: 94 <b>Rational (Reason for non-attendance):</b> 2 returns from Mat Leave/Career Break, 3 Based in Leeds new starters, and 12 are new starters. All have dates to attend the next events.				

Justine McCarthy Woods  
 Quality Standards and Reports Lead  
 April 2015

# Board of Directors : April 2015

**Item : 11**

**Title : Draft Annual Quality Report 2015/16**

## **Purpose:**

The Board of Directors is asked to confirm whether this Draft Quality Report for 2014/15 is accepted both as adequate assurance and to provide feedback.

This report has been reviewed by the following Committees:

- Management Team on 16/4/2015

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

- Quality
- Patient / User Experience
- Safety

**For : Discussion**

**From : Quality Standards and Reports Lead**

# Draft Quality Report 2014/15

## 1. Introduction

The Board of Directors are asked to review and provide feedback on the Draft Quality Report 2014/15. This includes the data covering 2014/15, which has been validated by the Director of Quality and Patient Experience, who has reviewed the data validation forms for each data item. The remaining data will be added following validation and receipt of the signed data validation forms.

Feedback is invited by email or hardcopy to Justine McCarthy Woods, Quality Standards and Report Lead ([JMcCarthyWoods@tavi-port.nhs.uk](mailto:JMcCarthyWoods@tavi-port.nhs.uk)), by 5 May 2015.

Justine McCarthy Woods  
Quality Standards and Reports Lead

20 April 2015

# 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.

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

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

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

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

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

Demonstrating the effectiveness of our clinical services is one of our key priorities, with us continuing to raise the bar on our performance targets. So, we are very pleased that we have performed well and achieved most of our targets for clinical effectiveness this year. For our Child and Adolescent Mental Health Service (CAMHS), we reached our target, by achieving 75%, for an improvement from Time 1 and Time 2 for at least two of the goals (agreed by patients/service users in conjunction with clinicians). However, we just missed our other target for CAMHS by achieving 73% rather than 75% for the return

rate of forms for the Goal-Based Measure completed by patients/service users at both Time 1 and Time 2. We are also very pleased that we managed to exceed our (50%) target for our Adult Service, where the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 53% of patients.

We have been successful in achieving all of our targets for Improving Access to Information which this year has focused on patient stories. 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 services can be improved. In addition, as part of this initiative we have included the stories of those patients who consented on the website, so that members of the public might also have a better sense of patient journeys within our Trust.

We have also been successful in achieving all our targets for Patient and Public Involvement. Linked with the 'Access' indicator, the emphasis this year has been very much on hearing the patient's voice, whether this be at Board level, enabling the Board to hear patient's stories, but also about involving the patient/service user in interview panels for some of those staff posts which involve direct contact with patients.

### **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 2013-2014 evaluation and audit report:

100% of the parents, 100% of the children aged 8 and under and 75% of the children aged 9 – 11 said that overall the help received from TOPS was 'good'.

100% of parents, 100% of children aged 8 and under and 81% of children aged 9 – 11 said that their views and worries "were taken seriously".

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.
- 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 to win a 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 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 April.

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## 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
<b>Child and Adolescent Mental Health Service Outcome Monitoring Programme</b>			
For 75 % of patients to complete the Goal-Based Measure (GBM) at Time 1 and Time 2 (ideally with at least 2 targets).	Yellow	73%	
For 75% of patients to achieve an improvement in their score on the GBM, from Time 1 to Time 2, on 2 targets (goals).	Green	75%	
<b>Adult Outcome Monitoring Programme</b>			
For the Total CORE scores to indicate an improvement from Pre-assessment (Time 1) to End of Treatment (Time 2) for 50% of patients.	Green	53%	
<b>Access to Clinical Service and Health Care Information for Patients and Public</b>			
To ensure that information from the patient story is on the patient section of the website.	Green	Achieved	
To run a Visual Straw Poll on awareness of the patient stories.	Green	Achieved	
Based on the feedback from the Visual Straw Poll, to revise the communications campaign to publicise patient stories if necessary.	Green	Achieved	
<b>Patient and Public Involvement</b>			
To run at least two staff trainings on having services users on panels.	Green	Achieved	
To have at least three interviews with service users on the panel.	Green	Achieved	
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.	Green	Achieved	
<b>Patient Safety Indicators</b>			
NHS Litigation Authority Level	Green	Level 2 achieved Feb 2011	
Patient Safety Incidents		15	
Monitoring of Adult Safeguard Alerts		0	
Safeguarding of Children – Level 1 Training		97%	
Safeguarding of Children – Level 2 Training		100%	
Safeguarding of Children – Level 3 Training		94%	
<b>Clinical Effectiveness Indicators</b>			
Monitor number of staff with PDPs		97.5%	

Patient Experience Indicators		
Complaints received		14
Patient Satisfaction		
Percentage of patients that rated the overall help they had received as good:		
Quarter 1		93%
Quarter 2		92%
Quarter 3		91%
Quarter 4		93%
Did Not Attend Rate		
Trust Wide – First Attendances		7.8%
Trust Wide – Subsequent Appointments		7.7%
Waiting Time Breaches		
Trust Wide – Number of patients waiting for first appointment for 11 or more weeks		37
Internal Causes		14
External Causes		23
Trust Wide – Percentage of patients waiting for first appointment for 11 or more weeks		1.6%
Internal Causes		0.6%
External Causes		1.0%
Other Achievements		
IG Assessment Report overall score		96%
Maintaining a High Quality, Effective Workforce		
Attendance at Trust Wide Induction Days		90%
Completion of Local Induction		98%
Attendance at Mandatory INSET Training		98%

\*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).

## 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 already gained since 2012, with patients previously referred to CAMHS. The Goal-Based Measure enables us to know what the patient or service user wants to achieve (their goal or aim) and to focus on what is important to them.

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

As a result, we set the following targets (in the table below), which also represent the CQUIN (see Glossary) targets we had agreed with our commissioners for 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. Then, the patient is asked to complete this form again with their clinician after six months or, if earlier, at the end of therapy/treatment (known as Time 2).

1. Child and Adolescent Mental Health Service Outcome Monitoring Programme			
Targets for 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.

### 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 already gained since 2012, with patients previously referred to the Adult Service. We set the following targets, which also represent the CQUIN (see Glossary) target we had agreed with our commissioners for 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 would be 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 planned two training sessions for staff with an external trainer in order to prepare staff who are 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.

### Target 3

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

#### Measure Overview

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 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.

We are currently in the process of finalising our CQUINs targets with our commissioners, which will contribute to our choice of some of our quality priorities 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

As we are currently in the process of finalising our CQUINs targets with our commissioners, these targets need to be confirmed. (TBC)

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

##### Targets for 2015/16

1. (TBC)

2. (TBC)

#### Priority 2: Adult Outcome Monitoring Programme

As we are currently in the process of finalising our CQUINs targets with our commissioners, this target needs to be confirmed. (TBC)

## 2. Adult Outcome Monitoring Programme

### Target for 2015/16

1. (TBC)

## 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 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 need to improve our 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. We are committed 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 call 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

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 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 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 (TBC)

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 [insert number].

### 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 [provide a weblink] (TBC).

The total financial value for the 2014/15 CQUINs was £(TBC) and The Tavistock and Portman NHS Foundation Trust expects to receive £ (TBC). 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.

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 45, 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 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.

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



**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 36.

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## 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 2013-14, 100% families said it was certainly true that they "felt listened to" and that they were "treated well" and 92% said it was certainly true that it was "easy to talk" (8% said this was partly true).

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 this case the patient was 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. 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 2013/14. (TBC)

## 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.

### 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'.

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) 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.audit-commission.gov.uk/SiteCollectionDocuments/Events/2010/mental-health-benchmarking-club-presentations-april-2010.pdf>

## 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	37
Internal Causes	27	18	14
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%	1.6%
Internal Causes	1.4%	1.1%	0.6%
External Causes	4.5%	2.9%	1.0%
Unknown Causes	0.2%	N/A	N/A

- 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.
- 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, 37 (1.6%) 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 (1.0%) patients, and internal to the Trust, for 14 (0.6%) 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

### Appendix – Glossary of Key Data Items

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

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

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

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

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

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

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

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

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

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

**Did Not Attend (DNA) Rates** - The DNA rate is measured for the first appointment offered to a patient and then for all subsequent appointments. There is an 11% upper limit in place for the Trust, which is the quality standard outlined in our patient services contract.

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

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

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

**Goal Based Measure** - These are the goals identified by the child/young person/family/carers in conjunction with the clinician, where they enable the child/carer etc to compare how far they feel that they have moved towards

achieving a goal from the beginning (Time 1) to the End of Treatment (either at Time 2 at 6 months, or at a later point in time).

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

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

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

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

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

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

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

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

**In-Service Education and Training/Mandatory Training** - The Trust recognises that it has an obligation to ensure delivery of adequate and appropriate training to all staff groups, that will satisfy statutory requirements and requirements set out by the NHS bodies, in particular the NHS Litigation Authority and the Care Quality

Commission Standards for Better Health. It is a requirement for staff to attend this training once every 2 years.

**LGBT** - Refers to the 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, prior to their first appointment.

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

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

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

**Trust Membership** - As a foundation Trust we are accountable to the people we serve. Our membership is made up of our patients and their families, our students,



our staff and our local communities. Members have a say in how we do things, getting involved in a variety of ways and letting us know their views. Our members elect governors to represent their views at independent Boards where decisions about what we do and how we do it are made. This way we can respond to the needs of the people we serve.

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

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

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



## Board of Directors: April 2015

**Item :** 12

**Title :** Century Films - Tavistock Documentary

**Purpose:**

The purpose of this report is to update the Board of Directors on Century Film's progress and to seek agreement, in principle subject to a suitable access agreement, to move into the production phase.

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

- Patient / User Experience
- Communications

**For :** Noting

**From :**

Laure Thomas Director of Marketing and Communications  
Emma Heath – Communications Manager

## Century Film's proposal

### 1. Introduction

- 1.1 Channel 4 has agreed to commission a three or four part observational documentary series exploring the unique work we carry out here. Century Films has been commissioned to do this work and they are particularly interested in the work we do in CAMHS.
- 1.2 Over the past six months Century Films has spent time with our staff, getting to know the teams and their services and exploring the idea of a documentary series with them.
- 1.3 They have also met – always with the approval of the treating clinician - a number of patients, families and carers from these services. The meetings have provided an opportunity to hear, confidentially, about their experiences of living with mental health issues and receiving treatment.
- 1.4 These groups were also consulted about the idea of a potential Channel 4 documentary series being made and we've been told that feedback, overall, has been positive.
- 1.5 As the research phase draws to a close, subject to a thorough Access Agreement which will be presented to the management team and the Board of Directors in May, we are seeking approval to move into the production phase later this year.

### 2. Background

- 2.1 Liesel Evans, Executive Producer at Century Films, first approached us in 2012. Keen to explore the possibility of working together on a documentary about child and adolescent mental health services (CAMHS), detailed discussions with senior management commenced.
- 2.2 This dialogue largely concerned the practical and ethical issues of filming children young people and their families. Discussions culminated in us agreeing, in November 2014, to a period of confidential, no-obligation research.
- 2.3 Over the past six months a Century Films producer, Alice Mayhall, has met with staff from 14 different CAMHS. As the research phase progressed, Alice started to meet patient, families and carers.
- 2.4 The research phase is drawing to a close and Alice and Liesel are

developing and refining their proposals for the series. We have not yet identified, formally or finally, which services will be included. The series description is yet to be finalised also.

- 2.5 Whilst there are some valid reservations concerning our ethical and clinical responsibilities, we are confident we can reach an understanding for how we will protect the interests of those involved if we go ahead.
- 2.6 We have been discussing concerns internally as they arise and sharing them with Century Films during this period. We intend for all of these issues to be addressed in jointly agreed, robust protocols and a legally-binding access agreement.
- 2.7 This agreement will be presented to the Board of Directors following this. An outline of the headings and content intended to be included in this can be found in appendix 1. The access agreement will be developed in partnership with the CAMHS Director, Medical Director and the Communications Director. Once the final list of services that will be included is agreed, the cohort of staff this work directly impacts will also be involved in developing this agreement.

### **3. Development and next steps**

3.1 The emerging ideas include:

- A Channel 4 documentary consisting of a three or four part series.
- Exploration of 'mental health' through personal journeys and individuals narratives.
- An observational filming style, which include filming staff 'on the go'.
- Filming identified patients in clinic and in personal settings, including their own homes.

3.2 Following discussions with senior managers and their teams, Century Films are committed to and interested in filming the following five services.

#### **1. The Gender Identity Development Service (GIDS)**

Filming a variety of patients at different ages and stages of their treatment, we would showcase the ground-breaking work of our national specialist clinic. The emphasis would be on the patients and their families but also the complex nature of the work and how the multi-disciplinary team works together to care for them.

## **2. Gloucester House**

The focus here would be on the work of the staff at the school, who support children who have been excluded from everywhere else. Showcasing the combined clinical and educational offer and how this unique provision is helping young children to re-integrate.

## **3. Open Minded – South and North Teams**

Showing how Open Minded is supporting families across the borough of Camden, from Hampstead to Kilburn to Somers Town. The filming would show the range and complexity of the work done by the team in clinic and in the community.

## **4. Refugee Service**

This would focus on how families and young peoples' mental health can be affected by periods of upheaval and acute stress, and how the essential support and outreach work delivered here can support them.

## **5. Family Mental Health Service**

Exploring how therapy can impact on the complex dynamics of a family. With the experienced clinicians as our guides through the very detailed work, the focus would be on the changes that are made long term, both in the therapeutic space and out in the family home.

These are five services Century Films are committed to involving, above. Other services they remain interested in exploring further as part of the series include:

- **The Integrated Early Year's Service**
- **The Early Intervention Service.**
- **TOPS, and CAMHS in schools**
- **MALT**
- **Fostering, Adoption and Kinship Care**
- **Adolescent and Young Adult Service**
- **Barnet Young People's Drug and Alcohol Service**

## **4. Next steps**

4.1 During April and May the Access Agreement will be jointly developed with key identified stakeholders, including those this project would directly impact. The management team and the Board will sign this off, before we move into the production phase.

- 4.2 During May, a further one or two producers will join Alice Mayhall in the research phase. The researchers will work to identify the final shortlist of services to film. With agreement from us, staff, patients and their families will be approached during this period.
- 4.3 Once the Access Agreement has been finalised and agreed by the management team, it will go to the Board with a request for approval to move into the production phase.
- 4.4 A film Director will join the team to develop a filming schedule. Filming will commence, both on site at the Trust and in patients, families and carer's homes.

Laure Thomas Director of Marketing and Communications  
Emma Heath Communications Manager  
16 April 2015

## Appendix 1

### Outline summary of the Access Agreement

As well as setting out a series description, the Access Agreement will be a legal document, jointly developed, which commits both parties to the terms of agreement. It will include the following:

- Terms of agreement: series description (how many episodes in the series, the filming period, the Trust's commitment to assisying the producers to make the series, points of contact etc)
- Protocols for research and production(many already sent to you):
- Consent: for service users, families/ carers and staff
- Filming: practicalities and policies, health and safety, safeguarding, Ofcom guidelines.
- Data Protection: systems in place.
- Viewings: editorial control and Trust rights to view the programmes.
- Research: how to engage service users and staff, discussions about involvement with the series.
- Access: exclusivity, communication with staff about the series, addendums for each episode.
- Stakeholders & partners: agreement for how to manage partners and key stakeholders during the production phase.
- Press and Communication: press enquiries and releases.



## Board of Directors : April 2015

**Item :** 13

**Title :** Annual Complaints Report 2014-15: Patient Services

**Purpose:**

The purpose of this report is to provide a summary of the formal complaints received by the Trust in 2014-15 and to identify any lessons learned from these complaints.

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

This report has been reviewed by the following:

- Corporate Governance and Risk Workstream Committee
- Patient Safety Workstream Lead
- Management Committee, 16<sup>th</sup> April 2015.

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

- Patient / User Experience

**For :** Noting

**From :** CEO

## Annual Complaints Report

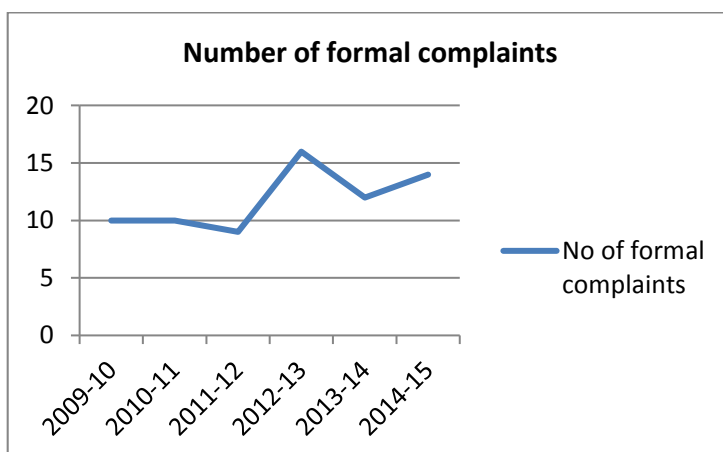
### 1. Introduction

The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations. As in previous years the number of formal complaints received by the Trust in 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.

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

### 2. Formal complaints received

Year	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
No of formal complaints	10	10	9	16	12	14



During 2014-15 the Trust received 14 formal complaints. These were all acknowledged by the Chief Executive, investigated under the Trust's complaints procedure and a detailed letter of response was sent by the Chief Executive to each complainant.

### 3. Time to respond to complaints

During 2014-15 of the 14 complaints received, 2 remained open at the end of the year (in time for a response), and 12 received formal responses, of which 9 (75%) were sent full responses within 25 days and 3 (25%) received full responses outside 25 days. 2 responses were delayed over the summer period due to the leave and consequent delays in collating responses and one was delayed in Jan due to sickness. The trust did not receive any negative feedback from the complainants as a result of these delays. The Trust is aware of the need for timely responses and is taking steps to ensure that there are systems in post to support the absence of our extremely experienced complaints manager.

### 4. Complaints by Service

During the year services were reconfigured so comparisons are shown by services rather than at a Directorate Level for 2013-14 and 2014-15.

Service	Number of complaints	
	2013-14	2014-15
Adult services	5	7
Portman service	2	2
Adolescent service	0	1
GIDS service	2	0
CAMHS (excluding GIDS and adolescent)	3	4
<b>TOTAL</b>	<b>12</b>	<b>14</b>

### 5. Complaints Upheld

Upheld?	2012-13	2013-14	2014-15
Upheld in full	0	0	0
Upheld in part	5	2	3
Not upheld	11	9	9
Under investigation at time of report	0	0	2
<b>Total complaints</b>	<b>16</b>	<b>12</b>	<b>14</b>

## 6. Topics of Complaints

In 2014-15 as in the previous year all complaints related to aspects of clinical care. The trust did not receive any complaints about environment or facilities

The following table provides a summary of topic of complaints, all related to clinical care.

Topics of complaints received
Long wait for treatment
Non-involvement in an SI investigation (brother of the patient)
Criticism of handling of a child safeguarding matter
Balance between confidentiality and disclosure
Termination of therapy process (2 separate complaints about this, in different services)
Alleged breach of confidentiality (re letter to a GP)
Parent claiming that their child had been misdiagnosed
Alleged errors in the clinical record
Case closed due to non-attendance
Treatment was 'overwhelming'
Failure to inform one parent of young person's attendance (young person with other parent and did not want second parent to be informed)
Parent unhappy about health and social services plans to support teenage child
Unhappy with assessment process, believes was hypnotised during session

## 7. Lessons learned

Complaints are always considered as opportunities for lessons to be learned, whether or not the complaint is upheld.

As can be shown by the list above there are very few themes that can be drawn from the wide range of concerns expressed in letters from complainants.

In all cases the clinical teams seek to learn lessons from the complaints that are received, which whilst being low in number often generate large files of records of dialogue with patients, often over months or even years; meetings with patients and considerable careful clinical consideration as to the best way in which each individual complainant can be helped.

A number of specific actions have been taken during the year in direct response to complaints and these are shown 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

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

If a patient is dissatisfied with a response to a complaint that they have received from an NHS Trust they have the right to refer their complaint to H M Ombudsman who will review the concern and may take one of three options:

- Refer the matter back to the trust for further investigation
- Under an investigation itself (if the complaint involves clinical matter the Ombudsman's office is required to seek expert opinion)
- Take no action

During the year no patients referred a complaint to H M Ombudsman compared to 7 in 2013-14

During the year one case from March 2012 was finally resolved. In this case the Trust did not accept the findings of the Ombudsman appointed expert and unusually the Ombudsman's office commissioned a second

expert opinion this time from a suitably experienced psychotherapist who did find that the clinical decisions taken by the Trust were right in the circumstances. This matter has now been resolved and the case closed.

## **9. Next steps**

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. This is shown at Appendix 1.

Complaints management will continue to be promoted at induction and INSET and in other settings as appropriate during the year.

Some changes are proposed in the course of the year in the handling of work on complaints within the Trust. This is linked to the appointment of a new Clinical Governance and Quality Manager reporting to Louise Lyon as Director of Quality and Patient Experience. A further update on these arrangements will be provided to Directors in due course.

Summary prepared by  
Jane Chapman, Governance and Risk Adviser  
on behalf of Chief Executive Officer

April 2015

## Appendix 1 Guidelines for staff issued March 2015

### Guidance for staff: Responding to Complaints and Concerns

The Care Quality Commission (CQC) requires all Trust staff to be able to support any patient who wishes to raise a query, complaint or concern. These guidance notes have been prepared to support this process.

Any patient who attends the Trust is able to raise any concerns they may have directly with their clinician. Some will wish to raise a concern or a complaint outside the therapeutic relationship.

All staff should be sensitive to the wishes of patients who may have queries and concerns, and should be able to guide patients on their options which include:

- raising queries or concerns via PALS (our Patient Advice and Liaison Service)
- raising concerns informally with their clinician
- raising concerns informally with a member of the administrative and/or management team
- making a formal complaint (normally by letter or e-mail)

### How can you help a patient who has a concern or a complaint?

- If a patient tells you they want to complain, then explain that they have a number of options available to them in order to try and best resolve their concern or complaint. For example, you can advise a patient that they can: speak to their clinician; talk to PALS, or make a formal complaint to our Chief Executive.
- For more information about how we handle patient concerns and complaints here, please see our 'Comments and suggestions, Concerns and complaints' leaflet by downloading it from our website by [clicking here](#).

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

- If a patient chooses to raise their concern/complaint directly with you, do not give an undertaking that you can deal with it. Depending on the nature of the concern you may have to refer it to e.g. your team leader, directorate manager or our complaints manager.
- If the concern is about care or treatment that you have given, and something has gone wrong, then it is okay to say 'sorry' (this is not the same as accepting responsibility). In this situation you should refer the matter to your line manager or the complaints manager so that a detailed investigation and explanation can be prepared.

### Learning from complaints and feedback

Fortunately, we receive very few formal complaints (around 12 per year), but each one of these complainants consider that something has not gone well for them, and they may then enter into lengthy correspondence with the organisation. It is important that we take every opportunity to learn lessons from these complaints.

From 1 April 2015, on a quarterly basis, a short summary of lessons learnt will be included in the Quality Newsletter which is circulated via an 'all-user' email. You can also read the latest edition of the newsletter by visiting the CQC Intranet pages.

Note: in order to protect the confidentiality of individuals, care will be taken to 'disguise' any facts that could lead to identification of complainants. Team managers and governance leads are encouraged to use these summaries to prompt local discussion and, if appropriate, local quality improvement in services.

For further advice on handling complaints speak to your team leader, directorate manager or the Trust's Complaints Manager, Lotte Higginson (available Tuesday to Thursday) on x2335 or via email: [LHigginson@tavi-port.nhs.uk](mailto:LHigginson@tavi-port.nhs.uk).

### Further information

If you have a question about our up-and-coming CQC inspection, please contact the CQC team by emailing: [CQCHelp@tavi-port.nhs.uk](mailto:CQCHelp@tavi-port.nhs.uk).





## Board of Directors : April 2015

**Item :** 14

**Title :** Annual Whistleblowing Report

### **Summary:**

The Trust Secretary now keeps a register of all incidents of Whistleblowing, and reports on these annually to the Board. This is the first report on Whistleblowing to come to the Board.

We have had no incidents of Whistleblowing in 2014/15, and no concerns that escalated to the formal stage of the procedure.

Concerns that are raised at a lower, informal, level with managers are not currently recorded centrally. Keeping lower level concerns informal is good practice, and is recommended in the policy, but it has been acknowledged in the CQC Programme Board and in other places that more work needs to be done on gathering these concerns centrally so that learning from them can be shared throughout the Trust rather than just within teams.

Louise Lyon, the Director of Quality and Patient Experience, is working on a practical method of gathering and addressing the concerns raised.

This report has been reviewed by the following Committees:

- Management Team, 16<sup>th</sup> April 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

## Board of Directors : April 2014

**Item :** 15

**Title :** Corporate Governance: Use of Trust Seal, Governor Elections, Annual Review of External Networks

**Purpose:**

This report includes:

- Details of a use of the Trust seal in December, for approval.
- Details of Governor elections to be held this year, for noting.
- The list of external contacts, for review and approval.

This report has been reviewed by the following Committees:

- Management Committee, 16<sup>th</sup> April 2015

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

**For :** Approval

**From :** Gervase Campbell, Trust Secretary

## Corporate Governance Report – Use of Trust Seal, and Annual Review of External Networks

### 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 14<sup>th</sup> April 2015 the Trust sealed an agreement with Sweett (UK) Ltd for the supply and installation of the modular building at the Tavistock Centre. 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 Board are asked to approve this use of the Trust Seal.

### 2. Governor Elections 2015

- 2.1 The current terms of office of our public and staff Governor come to an end on the 31<sup>st</sup> October this year, so we will be holding elections to find new Governors to take office from the 1<sup>st</sup> November.
- 2.2 Most of our elected Governors are on their first terms and so are eligible to stand for re-election to a second term. We very much hope many of them will decide to stand again as we value not only the contribution they have made, but also the benefits of some continuity within the Council. The only elected governors who are on their second term and so cannot stand for re-election are Mary Burd and Sara Godfrey.
- 2.3 Following discussions with Electoral Reform Services, who run our elections, we have settled on a timetable for the elections which we hope will avoid the worst of the summer hiatus, whilst still allowing sufficient time for inductions before November.

<b>ELECTION STAGE</b>	<b>OPTION 1</b>
Trust to send nomination material and data to ERS	Friday, 19 Jun 2015
Notice of Election / nomination open	Friday, 3 Jul 2015
Nominations deadline	Friday, 31 Jul 2015
Summary of valid nominated candidates	Monday, 3 Aug 2015

published	
Final date for candidate withdrawal	Wednesday, 5 Aug 2015
Electoral data to be provided by Trust	Monday, 10 Aug 2015
Notice of Poll published	Friday, 28 Aug 2015
Voting packs despatched	Monday, 31 Aug 2015
Close of election	Wednesday, 23 Sep 2015
Declaration of results	<b>Thursday, 24 Sep 2015</b>

- 2.4 We have begun work on a plan for engagement with our membership in advance of the elections. The first advance information has already gone out with the Members' Newsletter.

### 3. Annual Review of External Networks

- 3.1 The Board of Directors is responsible for ensuring that the Trust co-operates with other NHS bodies, Local Authorities and other relevant organisations with an interest in the local health economy. Monitor requires that the Board ensure effective mechanisms are in place, and review the effectiveness of these annually.
- 3.2 The Management Team have reviewed this list, the Trust's relationship with each of the listed parties, and highlighted the main contact for each party. The Trust has reviewed the mechanisms that are in place to cooperate with relevant third party bodies, and has ensured that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority.
- 3.3 The Board are asked to approve this review of external contacts.

## **Annual Review of External Trust Links, 2015**

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## Annual Review of External Trust Links, 2015

Party <sup>1</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
Monitor	<p>Monitor is the independent regulator of NHS foundation trusts.</p> <p>Monitor's role as a regulator is to ensure that FTs are well led, that their leaders are focused on the quality of care patients get, and that they are financially strong</p> <p>Monitor look at whether FTs are meeting the required quality standards, as judged by the CQC, and at the Trust's financial strength</p> <p>Monitor regulates FTs to ensure they comply with the Terms of Monitor's licence. <a href="http://www.monitor-nhsft.gov.uk/">http://www.monitor-nhsft.gov.uk/</a></p>	<p>The Trust must submit an Annual Plan and regular reports to Monitor. The frequency of reports is related to the Trust's risk ratings.</p> <p>Where Monitor feels the Trust is failing in an area, it requires the Trust to develop an action plan and monitors progress against that plan.</p> <p>The Trust must submit Annual Reports and Annual Accounts to Monitor (and Parliament) each year</p>	<p>The Trust has an annual planning process, which is led by the Chief Executive and the Director of Finance. The development of the Plan involves senior Trust staff, Non-Executive Directors, and the Board of Governors</p> <p>The Trust submits regular declarations on finance, governance, &amp; quality. These submissions inform Monitor's risk ratings</p> <p>The Directorate of Finance is responsible for the production of the Annual Accounts. The Trust Secretary's office is responsible for the production of the Annual Report, in consultation with senior Trust staff.</p>	<p><b><u>Paul Jenkins, Chief Executive</u></b></p> <p>Angela Greatley, Trust Chair</p> <p>Simon Young, Director of Finance</p> <p>Gervase Campbell, Trust Secretary</p>
Care Quality Commission	<p>The CQC is the independent regulator of healthcare and adult social care in England.</p> <p>It monitors providers'</p>	<p>All care providers in England must be registered with the CQC. In order to be registered, each provider must show they meet essential standards of</p>	<p>The Trust completed registration, and is currently fully registered</p> <p>The Trust has a nominated CQC</p>	<p><b><u>Louise Lyon, Director of Quality and Patient Experience</u></b></p>

<sup>1</sup> This list is partially informed by Appendix A to Monitor's Compliance Framework 2013/14 (published March 2011)

\* Lead contact appears in bold and underlined

Party <sup>1</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
	<p>compliance with Essential Standards as set out in the Health and Social Care Act 2008 (Regulated Activities)</p> <p>Regulations 2009 on an on-going basis</p> <p>It has a range of enforcement powers available to it to address failure to maintain compliance with these requirements up to removing registration to practice</p>	<p>quality and safety in all of their regulated services</p> <p>The Trust must cooperate with any request for information and inspections that the CQC may choose to conduct</p> <p>The Trust must inform the CQC of any significant changes to practice and through relevant agencies (e.g. NPSA) of any significant adverse events</p>	<p>contact who will approach the Trust directly with any concerns and/or requests for information</p>	<p>(Nominated Manager registered with CQC)</p> <p>Paul Jenkins, Chief Executive Officer</p> <p>Gervase Campbell, Trust Secretary</p>
Quality Assurance Agency for Higher Education (QAA)	The independent body entrusted with monitoring, and advising on, standards and quality in UK higher education.	<p>The Trust must cooperate with inspections by the QAA.</p> <p>The Trust consults the UK Quality Code for Higher Education (the Quality Code) in setting standards.</p>	The Trust cooperates with inspections and follows the recommendations of the QAA.	<p><u>Mr Louis Taussig, Head of Academic Governance and Quality Assurance</u></p> <p>Mr Brian Rock, Director of E&amp;T/Dean.</p>
Health Education England (HEE)	The NHS body, established as a Special Health Authority in 2012, responsible for the education, training and personal development of every member of NHS staff.	<p>Provide information as requested. Ensure funding is spent effectively and correctly. Comply with all guidance and best practice.</p>	Through contact with relevant LETBs.	<u>Mr Brian Rock, Director of Education and Training/ Dean.</u>
Regulators of individual health professionals	Currently there are nine regulators of individual health professionals, covering a range of professions. Each has the power to demand the release of information where it relates to a hearing about the fitness to practice of a health professional. Some regulators also have powers in relation to the accreditation of courses, education, or training for health professionals wishing to register			
General Medical Council	The GMC registers doctors to practise medicine in the UK.	All doctors must be registered with the GMC to practice	HR maintains a system of checking registrations at	<u>Rob Senior, Medical Director</u>



Party <sup>1</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
	<p>Their purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine</p> <p><a href="http://www.gmc-uk.org/">http://www.gmc-uk.org/</a></p>	<p>medicine in the UK</p> <p>The Trust is required to respond to any requests for information made by the GMC under their investigation of complaints and/or disciplinary procedures</p>	<p>employment and annually thereafter, and is fully compliant with revalidation requirements.</p>	<p>Dr Jessica Yakeley, Associate Medical Director (Lead on Revalidation Process)</p>
<ul style="list-style-type: none"> <li>Health and Care Professions Council</li> </ul>	<p>The HCPC currently regulates 15 health professions, including Social Workers and Practitioner Psychologists, which covers educational psychologist, counselling psychologists and clinical psychologists.</p>	<p>All professionals covered by the HCPC must be registered with the HCPC to practice in the UK</p>	<p>HR maintains a system of checking registrations at employment and annually thereafter</p>	<p><u>Bernadette Wren,</u> <u>Trust-wide Head of Psychology Discipline</u></p> <p><u>Gill Rusbridger,</u> <u>Trust-wide Head of Social Work Discipline</u></p>
<ul style="list-style-type: none"> <li>Nursing and Midwifery Council</li> </ul>	<p>The NMC registers all nurses and midwives and ensure that they are properly qualified and competent to work in the UK, and sets the standards of education, training, and conduct for nurses and midwives</p> <p><a href="http://www.nmc-uk.org/">http://www.nmc-uk.org/</a></p>	<p>All nurses must be registered with the NMC to practice as nurses in the UK</p> <p>The Trust is required to respond to any requests for information made by the NMC under their investigation of complaints and/or disciplinary procedures</p>	<p>HR maintains a system of checking registrations at employment and annually thereafter</p>	<p><u>Lis Jones, Nurse Director and Head of Nursing.</u></p>
Charities Commission	<p>The Charities Commission is a statutory regulator and registrar for charities in England and Wales</p> <p><a href="http://www.charity-commission.gov.uk/">http://www.charity-commission.gov.uk/</a></p>	<p>Submission of annual returns, Annual report and Accounts</p> <p>Response to any other enquiries</p>		<p><u>Simon Young,</u> <u>Director of Finance</u></p>
Equality and Human Rights Commission	<p>The Equalities and Human Rights Commission is an independent</p>	<p>The Trust has no formal link with the Equality and Human</p>	<p>The Website and Helpline are used on an ad hoc basis for</p>	<p><u>Chair of Equalities Committee</u></p>

Party <sup>1</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
	statutory body established to promote and monitor human rights, and to protect, enforce and promote equality across the nine "protected" grounds.	Rights Commission and is not required to do so	information and/or advice	
Environment Agency	The Environment Agency is the leading public body for protecting and improving the environment in England and Wales. It grants licences for waste management services, including clinical waste	The Trust must ensure that any waste it produces is handled safely and in accordance with the law according to the Duty of Care legislation	The Trust receives certification to verify safe and legal disposal of all electrical and electronic equipment under WEEE regulations	<u>Pat Key, Director of Corporate Governance &amp; Facilities</u>
Health Protection Agency	The HPA is a statutory body set up to identify and respond to hazards and emergencies; anticipate and prepare for emerging and future threats; provide specialist health protection services; and support others in their health protection roles	A nominated member of staff and a Director must be available for alerts. Up to date contact details must be kept with the HPA  Security alerts and other reports must share information with staff	Nominated staff to react and cascade alerts  Health and Safety Manager and Director of Corporate Governance & Facilities receive security alerts and other reports (e.g. extreme weather)	<u>Pat Key, Director of Corporate Governance and Facilities</u>  Lisa Tucker, Health & Safety Manager
Fire Authorities	Fire Authorities are responsible for fire fighting and fire safety, and may require NHS Foundation Trusts to make changes to buildings or operations to prevent fires	Trust is required to ensure risk assessments are carried out regularly on all buildings. All staff must be appropriate trained on fire safety. The Trust must cooperate with any request for information and/or spot check visit that the Fire Authorities may choose to conduct	Risk Assessments for all buildings the Trust owns (updated if changes to fabric or usage of building)  Fire training; INSET; and local induction with Manager  Annual Fire warden training and evacuations	<u>Pat Key, Director of Corporate Governance &amp; Facilities</u>  Lisa Tucker, Health & Safety Manager Dave King, Fire Safety Consultant
Health and Safety Executive	The Health and Safety Executive is responsible for the regulation of almost all the risks to health	Ensure Building Regulations and training for staff is delivered	Annual Estates Risk Assessments. & Lone Worker Risk Assessments. Mandatory Health & Safety	<u>Pat Key, Director of Corporate</u>

Party <sup>1</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
	and safety arising from work activity <a href="http://www.hse.gov.uk/">http://www.hse.gov.uk/</a>	Ensure Institute of Health & Safety qualified staff on site	<p>training for specific staff groups; Manual Handling training; Conflict resolution training</p> <p>Incident reporting.</p> <p>Risk and method statements and health and safety statements are supplied by contractors prior to projects starting</p> <p>HSE is given notification of projects where construction work where required.</p> <p>All contractors are given a site and orientation induction from the Support Services Manager. All contractors who attended site must be signed in. A permit to work system operates with in the Trust</p>	<p><b>Governance &amp; Facilities</b></p> <p>Lisa Tucker, Health &amp; Safety Manager (IOSH)</p>
Information Commissioner	<p>The Information Commissioner's Office is the UK's independent authority set up to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals.</p> <p>To ensure organisations meet their information rights obligations they may issue monetary penalties, enforcement notices, issue</p>	<p>The Trust must register annually with the ICO.</p> <p>The Trust must have policies and procedures to ensure compliance.</p> <p>The Trust must respond promptly and appropriately to any enquiries, investigations or requests for information from the ICO.</p> <p>All public authorities are also</p>	<p>We register annually.</p> <p>Information Governance assessment is submitted to the DH online in March every year.</p> <p>Embraces all aspects of Confidentiality, Freedom of Information, Data Protection Act, Human Rights Act (privacy clause), health records, data security, Information Governance Management.</p>	<p><b>Simon Young, Senior Information Risk Owner</b></p> <p>Caroline McKenna, Caldicott Guardian</p> <p>Lotte Higginson, Access to Health Records Officer</p> <p>Tom Rose, FOI Officer</p> <p>Pat Key, Director of</p>

Party <sup>1</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with statutory enforcement powers over NHS foundation trusts</b>				
	decision notices and other actions including criminal prosecutions. <a href="http://www.ico.gov.uk/">http://www.ico.gov.uk/</a>	obliged to provide public access to official information.	Such enquiries are infrequent, but are dealt with appropriately.	CGF Jonathan McKee, Governance Manager
Public Accounts Committee	The Public Accounts Committee is a Parliamentary Committee with the power to call any Accounting Officer of a public body (including NHS Foundation Trusts) before it.	Accounting Officer required to provide information to Public Accounts Committee if called upon.	No direct contact to date.	<u>Paul Jenkins Chief Executive Officer</u> Simon Young, Director of Finance
Parliament	Requests for information	The Trust is required to respond to legitimate requests for information in relation to Parliamentary questions relating to the services we offer.	The Chief Executive would sign off on all communication. No direct contact to date.	<u>Paul Jenkins, Chief Executive</u>
Police	The Police have powers to investigate any crime in the United Kingdom and to arrest any persons suspected of illegal activities.	The Police have legitimate powers of entry and investigation of anyone suspected of criminal activity. Should the Police carry out an investigation, the Trust is required to share information as agreed under Memorandums of Understanding and to co-operate with enquiries.	There are Memorandums of Understanding between the Police and the National Health Service.	<u>Paul Jenkins, Chief Executive</u> <u>Jonathan McKee, Governance Manager</u>

Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with a statutory role but no enforcement powers over NHS foundation trusts</b>				
Department of Health	<p>The DoH is a Government department, headed by the Secretary of State for Health which sets NHS policy and regulatory requirements for the delivery of health and social care.</p> <p>The DoH also commissions national frameworks for care delivery that must be reflected in trust plans and policies (e.g. mental health agendas). <a href="http://www.dh.gov.uk/">http://www.dh.gov.uk/</a></p>	<p>No direct cooperation is required, but the Trust shall ensure the Trust is up-to-date with any new requirements set by the relevant agency or regulator, and maintain evidence of compliance.</p> <p>To operate within the statutory framework (via Monitor) as an authorised NHS organisation.</p>	<p>These would usually be set out in contracts with the commissioners</p> <p>Information Governance Toolkit used to report compliance with IG standards.</p>	<p><b>Pat Key, Director of Corporate Governance &amp; Facilities</b>(for emergency planning)</p> <p>Jane Chapman, Governance &amp; Risk Advisor</p> <p>Jonathan McKee, Governance Manager</p> <p>Lisa Tucker, Emergency Planning Liaison Officer</p>
Commissioners	<p>Commissioners specify in detail the delivery and performance requirements of NHS Foundation Trusts, and the responsibilities of each party through legally binding contracts.</p> <p>NHS FTs are required to meet their obligations to commissioners under their contracts. Any disputes about contract performance should be resolved in discussion between commissioners and Trusts, or through their dispute resolution</p>	<p>The provision of clinical services in line with contractual agreements.</p> <p>The provision of patient level activity data and Trust performance-related data as required by the contract and CQUIN agreements.</p>	<p>Quarterly / six-monthly Commissioner meetings which review activity against contract.</p> <p>Monthly patient-level data reports to all Commissioners with whom the Trust has a contract.</p> <p>A systemised linking of informal contacts between the Trust Clinical Leads / Associate Director of Business Development / Director of Service Development &amp; Strategy</p>	<p><b>Julia Smith, Commercial Director</b></p>

Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with a statutory role but no enforcement powers over NHS foundation trusts</b>				
	procedures.		and Commissioners.	
Parliamentary and Health Service Ombudsman	The Parliamentary and Health Service Ombudsman investigates complaints made by or on behalf of people who consider that the trust has failed to address their concerns via the NHS complaints procedure. <a href="http://www.ombudsman.org.uk/">http://www.ombudsman.org.uk/</a>	Respond to any requests from PHSO for records and/or other information in relation to internal investigation of complaints.  Respond to any formal letter of conclusion from PHSO following a complaints investigation.	Arrangements set out in the Trust's Complaints Policy and managed by the Complaints Officer.	<b><u>Paul Jenkins, Chief Executive Officer</u></b>  Lotte Higginson, Complaints Officer  Pat Key, Director of CGF
HM Coroner	Investigates all "unnatural" deaths that occur in his geographical jurisdiction.  Has the power order people to attend his court.	To report any patient who dies whilst in therapy and to co-operate fully with any inquiry that HM Coroner chooses to undertake.	Direct reporting and/or response to requests from Coroners' Office.	<b><u>Rob Senior, Medical Director</u></b>  Jane Chapman, Governance & Risk Lead
Cooperation and Competition Panel	The CCP investigates potential breaches of the Principles and Rules of Cooperation and Competition, and makes independent recommendations on how such breaches may be resolved. <a href="http://www.ccp-panel.org.uk/">http://www.ccp-panel.org.uk/</a>	The Trust is required to cooperate with the CCP in relation to proposed transactions.  The Trust is subject to scrutiny on any mergers or acquisitions.	Trust will send relevant documentation as required.	<b><u>Paul Jenkins, Chief Executive</u></b>
Health and Social Care Information Centre	The HSCIC is the national provider of information, data and IT systems for health and social care.	The Trust is required to report information as specified by schedule 6 of its authorisation.	Response to information requests.	<b><u>Toby Avery</u></b> Director of IMT
Overview and Scrutiny Committees of Local Authorities	The Overview and Scrutiny Committees of Local Authorities inquire into all "matters of local	The Trust is required to send its Quality Report to the OSC for comment.	OSC feedback is built into the Quality Report timetable.	<b><u>Paul Jenkins Chief Executive Officer</u></b>



Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with a statutory role but no enforcement powers over NHS foundation trusts</b>				
	<p>concern", including the NHS, e.g. health inequalities and access to services in the NHS.</p> <p>NHS Foundation Trusts must consult before making any material changes to service offerings that will result in a change to mandatory services, and must provide any information requested.</p>	<p>The Trust is invited to visit the OSC to report on various matters, e.g. ethnic diversity on the Boards of Governors and Directors, or the work of the Trust.</p>	<p>The Trust sends relevant documentation and will often send a staff member to attend a meeting of the OSC.</p>	
Healthwatch England, Local Healthwatch, Healthwatch Camden	<p>Healthwatch is the independent consumer champion that gathers and represents the public's views on health and social care services in England, replacing LINKs in 2012.</p>	<p>Trust is required to send the Quality Report to Healthwatch for feedback to be included in the final version.</p>	<p>Trust sends Quality Report each year.</p>	<p><u><b>Sally Hodges, PPI Lead</b></u> Justine McCarthy Woods, Quality Lead</p>
Ofsted	<p><b>Ofsted Education</b></p> <p>Ofsted is the inspectorate for children and learners in England.</p> <p>It is Ofsted's job to contribute to the provision of better education and care through effective inspection and regulation.</p> <p><a href="http://www.ofsted.gov.uk/">http://www.ofsted.gov.uk/</a></p>	<p>Gloucester House is required to meet Ofsted requirements in order to retain a DCSF number and independent school status.</p> <p>The requirements are mandatory compliance requirements and Gloucester House needs to be able to provide evidence in relation to these.</p> <p>Many of the requirements are in relation to the building, safeguarding etc. and the relevant directorates need to be aware of these.</p>	<p>Head Teacher and other school staff need to be aware of requirements and have available evidence to support compliance.</p> <p>Staff must cooperate with inspection procedures.</p> <p>The Unit Director, the school administrator, the Trust Chair, the Director of CYAF, and the Directorates of Corporate Governance &amp; Facilities and Human Resources need to be aware of requirements and ensure the Head Teacher has evidence to support compliance</p>	<p><u><b>Nell Nicholson, Head Teacher, Gloucester House</b></u> Rita Harris, Director of CYAF</p>

Party <sup>2</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with a statutory role but no enforcement powers over NHS foundation trusts</b>				
		<p>The Head Teacher is responsible for ensuring standards of teaching and learning are adequate.</p> <p>Inspections are carried out approximately every two years and the Head Teacher is given one or two days' notice of inspection.</p>	<p>measures.</p> <p>The building has to be kept in a good state of repair in respect of this.</p> <p>The Trust Chair is the named person as the proprietor of Gloucester House.</p>	
	<b>Ofsted Safeguarding Children</b> Trust is required to co-operate when partner organisations providing care to children are being reviewed by Ofsted / CQC.	To provide information as requested.	<p>Direct request received from inspector or inspected organisation.</p> <p>Would be led by Medical Director and Trust-wide Safeguarding Lead.</p>	<u><b>Rob Senior, Medical Director</b></u> Sonia Appleby, Trust Safeguarding Lead



Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>4</sup></b>				
Formally-appointed committees, working groups and forums advising the Department of Health on topics across health and social care	There are about 40 groups which advise the Department of Health on a range of topics across health and social care. Of these, about half may work with NHS Foundation Trusts from time to time, and include the NHS-wide Clearing Service, the National Specialist Commissioning Advisory Group, and the Specialist Advisory Committee on Antimicrobial Resistance.	Feedback on formal consultations.  Input into policy fora.	The Trust inputs via the NHS Confederation, the Foundation Trust Network, and the Mental Health Network on formal responses to consultations.  Individual Trust staff, e.g. the Trust Chair or the CEO, participate in more specific for a convened on policy (e.g. Children's IAPT).	<u>Paul Jenkins, Chief Executive Officer</u>
British Psychoanalytic Council	The confederation of senior psychoanalytic organisations which accredits and regulates psychoanalytic professional and training organisations and validates their training.	BPC registers registrants of member organisations, sets standards of CPD requirement, sets professional and ethical standards and deals with complaints for all of its allied organisations.	The Trust has representatives on various committees and groups.	<u>Brian Rock, Director of Education and Training/ Dean.</u>  Jo Stubley Adult Psychoanalytic Psychotherapist
Confidential Enquiries	Confidential enquiries research the way patients are treated, to identify ways of improving the quality of care.  The two relevant to the Trust are the National Confidential	Trust is required to respond to requests for identification of patients who falls into either of these enquiries and may be asked to undertake reviews of cases.	Trust will send information as required on receipt of letter from the Director of the Enquiry.	<u>Rob Senior, Medical Director</u>  Jane Chapman, Governance and Risk Advisor

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

\* Lead contact appears in bold and underlined

<sup>4</sup>These parties have no statutory powers over NHS Foundation Trusts. However, Monitor expects that NHS Foundation Trusts will generally cooperate with such bodies, and a failure to cooperate may, under certain circumstances, constitute a breach of the Authorisation and grounds for intervention

Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>4</sup></b>				
	Inquiry into Suicide and Homicide by People with Mental Illness, and the Centre for Maternal and Child Health Inquiries.			
National Patient Safety Agency	<p>The NPSA coordinates the reporting of, and learnings from, mistakes and problems that affect patient safety.</p> <p>It also incorporates the National Clinical Assessment Service, which provides a support service where there are concerns over the performance of an individual doctor or dentist.</p>	<p>The Trust is required to advise the NPSA of all incidents involving patients.</p> <p>The Trust is required to respond to any relevant alert issued via the NPSA.</p>	<p>Nominated staff report all patient incidents via NPSA external web link on a quarterly basis incident and be recognised link for NPSA.</p> <p>All alerts issues via the CAS system are reviewed and any relevant alerts (e.g. estates) are brought to the attention of appropriate staff for action.</p>	<p><b><u>Pat Key, Director of Corporate Governance and Facilities</u></b></p> <p>Jane Chapman, Governance and Risk Adviser</p>
NHS Business Services Authority	<p>The NHS Business Services Authority is responsible for policy and operational matters relating to prevention, detection, and investigation of fraud and corruption in the NHS.</p> <p><a href="http://www.nhsbsa.nhs.uk/">http://www.nhsbsa.nhs.uk/</a></p>	<p>Compliance with counter-fraud guidance.</p> <p>Compliance with security management guidance.</p> <p>NHS Pensions Agency.</p> <p>Provision of information from payroll.</p> <p>Prescriptions pricing authority.</p> <p>Procedures for security of prescriptions (few).</p> <p>Paying invoices.</p>	<p>Annual return submitted by the Trust and assessed by NHS Protect (the new name for this part of the NHS BSA, previously CFSMS), leading to a rating.</p> <p>Monthly and annual transfers of information on pension contributions.</p> <p>Medicines Management Procedure, approved October 2010.</p>	<p><b><u>Simon Young, Director of Finance</u></b></p> <p><b><u>Simon Young, Director of Finance</u></b></p> <p><b><u>Rob Senior, Medical Director</u></b></p> <p>Simon Young, Director of Finance</p>
NHS Litigation	The NHSLA is responsible for	The Trust is required to register	The Trust is a member of the	<b><u>Pat Key, Director of</u></b>

Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>4</sup></b>				
Authority	<p>handling negligence claims made against NHS bodies in England.</p> <p>It helps to manage clinical risks (via the Clinical Negligence Scheme for Trusts) and non-clinical risks (via the Risk Pooling Scheme for Trusts) and manages claims and litigation for both.</p> <p><a href="http://www.nhs.uk/home.htm">http://www.nhs.uk/home.htm</a></p>	<p>all claims for compensation brought as clinical negligence, employer liability, or public liability with the NHS, and then respond to all request during the management of each claim.</p> <p>The Trust is required to be assessed by the NHS on a fixed schedule against standards for risk management.</p>	<p>NHSLA schemes – CNST, PES and LTPS.</p> <p>The Trust's Governance and Risk Adviser ensures that claims are managed in line with NHSLA requirements.</p> <p>The Trust has been assessed as required at Level 1 (Feb 2009) and at Level 2 (Feb 2011).</p>	<p><u>Corporate Governance and Facilities</u></p> <p>Jane Chapman Governance and Risk Adviser</p>
National Treatment Agency for Substance Misuse	The NTA is a special health authority within the NHS, established by the Government in 2001 to improve the availability, capacity, and effectiveness of treatment for drug misuse in England.	Monthly reports to National Drug Treatment Monitoring Service, which is a part of NTA.	Monthly deadlines agreed with Commissioners.	<u>Sally Hodges,</u> <u>Associate Clinical Director, CYAF</u>
Association of Medical Royal Colleges	Royal colleges aim to ensure high quality care for patients by improving standards and influencing policy and practice in modern healthcare. They set standards for clinical practice, conduct examinations, define and monitor education and training programmes for their members, support clinicians in their practice of medicine, and advise the Government, public and the profession on healthcare issues.			
Royal College of Psychiatrists	<p>The Royal College of Psychiatrists is the professional body for psychiatrists in the UK.</p> <p>It aims to set standards and promote excellence in psychiatry and mental healthcare; lead, represent, and support psychiatrists; and work with service users, carers and their</p>	<p>Respond to requests for information.</p> <p>Ensure good standing of psychiatrists with college for CPD.</p> <p>Contribute to College Committees as requested.</p>	Appraisal system for individual psychiatrists.	<u>Rob Senior, Medical Director</u>

Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>4</sup></b>				
	organisations.			
British Psychological Society	<p>The BPS is the representative body for psychology and psychologists in the UK.</p> <p>It is responsible for the development, promotion, and application of pure and applied psychology.</p>	All staff using the title <i>Chartered Psychologist</i> must register with the BPS. It is illegal to use the title <i>Chartered</i> without registration. Chartered status is regarded as involving a higher threshold of professional scrutiny, and is therefore considered good practice.	All Trust appointments are for psychologists who are Chartered or at least eligible for Chartered status at the time of application for employment.	<u><b>Bernadette Wren,</b></u> <u><b>Trust-wide Head of Psychology Discipline</b></u>
Association of Family Therapy	The AFT is an alliance of professionals working therapeutically with children, adults, and those important in their lives, in health, social care, education, and third sector services. The AFT formally accredits professional training courses.	AFT sets standards for supervision etc. that the Trust must comply with.	The Trust has representatives on various bodies.	<u><b>Karen Partridge,</b></u> <u><b>Trust-wide Head of Systemic Psychotherapy Discipline</b></u>
Universities, post-graduate deaneries and the Postgraduate Medical Education and Training Board	<p>NHS foundation trusts may offer professional education or training in conjunction with universities or other professional bodies.</p> <p>The accreditation process for such education or training may include a requirement for inspection and monitoring of provision.</p> <p>For NHS Foundation Trusts with</p>	<p>To deliver undergraduate and postgraduate medical education, in the Trust, we must ensure that GMC/PMETB standards for our teaching and training are met, the London Deanery's strategic direction is supported, and that the educational contract between the Trust and the London Deanery/NHS London is fulfilled. We are required to complete an annual report for the London Deanery</p>	<p>The Director of Medical Education (DME) is responsible for ensuring the delivery of medical teaching and training in line with these requirements. The DME is aided in her work by the Medical Education Board, consisting of the PGME administrator, the Training Programme Directors, Librarian, and Trainee rep. The Board meets regularly throughout the year to promote the</p>	<u><b>Jessica Yakeley,</b></u> <u><b>Associate Medical Director</b></u>

Party <sup>3</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with no statutory role but a legitimate interest<sup>4</sup></b>				
	cross-border activities in Wales, the list also includes the Welsh Assembly, local health boards, Health Commission Wales, and Healthcare Inspectorate Wales.	in line with the requirements of the Learning Development Agreement and Quality Management Manual. In addition, our trainers and trainees are required to complete an annual survey administered by the GMC/PMETB of the quality of training provided by the Trust. The London Deanery carries out an annual inspection of the quality of medical training provided by the Trust, taking into account the results of these reports.	development and quality of education provision. The DME also consults regularly with the wider consultant group of clinical and educational trainers, and ensures that they are fully trained in line with the London Deanery's Faculty Development Framework.	
Trades' Unions	Trades' unions protect the interests of their members. The Trust's staff are members of the British Medical Association, Unison, Royal College of Nursing, MiP, and Unite.	The Trust is required to include trades' union representatives in discussions about restructuring changes that affect staff and to include them in discussions about banding and grading of new posts. All staff have a right to a union representative at any formal meetings and the Trust is required to ensure that union representatives receive copies of any formal papers in advance of any meetings.	The Trust works in close partnership with Staff Side colleagues both through the formal JSCC and regular bi-weekly meetings between the HR Director and Staff Side Chair. This approach allows many issues to be dealt with at an informal level therefore facilitating progress on management issues for the Trust.	<b>Susan Thomas,</b> <b><u>Director of Human Resources</u></b>

Party <sup>5</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with representation on the Trust's Council of Governors</b>				
Camden CCG	Camden CCG to appoint one member to the Council	As for all Governors, keep representatives informed of developments.	Camden CCG to nominate: Dr Thomas Das is the current nominee.	<u><b>Angela Greatley, Trust Chair</b></u> Paul Jenkins, Chief Executive Gervase Campbell, Trust Secretary
Local Authorities – Camden	At least one member of the Council must be appointed by one or more qualifying local authorities. A qualifying local authority is a local authority for an area which includes the whole or part of an area specified in the constitution as the area for a public constituency <sup>6</sup> .	As for all Governors, keep representatives informed of developments.	The London Borough of Camden agreed to represent Local Authorities. Cllr Claire-Louise Leyland (Con) is the incumbent.	<u><b>Angela Greatley, Trust Chair</b></u> Paul Jenkins, Chief Executive Gervase Campbell, Trust Secretary
Non-Statutory Sector – Voluntary Action Camden	An organisation specified in the constitution as a partnership organisation may appoint a member of the board <sup>7</sup> .	As for all Governors, keep representatives informed of developments.	Voluntary Action Camden agreed to represent the non-statutory sector. Ms Sue Dowd is the incumbent.	<u><b>Angela Greatley, Trust Chair</b></u> Paul Jenkins, Chief Executive Gervase Campbell, Trust Secretary
University of Essex	An organisation specified in the constitution as a partnership	As for all Governors, keep representatives informed of	Prof Jo Jackson is the incumbent	<u><b>Angela Greatley, Trust Chair</b></u>

<sup>5</sup> This list is partially informed by Appendix A to Monitor's Compliance Framework 2011/12 (published March 2011)

\* Lead contact appears in bold and underlined

<sup>6</sup>National Health Service Act 2006, Schedule 7, paragraph 9(4) and (5)

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

Party <sup>5</sup>	Description	Scope of cooperation required	Mechanism for cooperation	Contacts*
<b>Bodies with representation on the Trust's Council of Governors</b>				
	organisation may appoint a member of the board <sup>8</sup> .	developments.		Paul Jenkins, Chief Executive Gervase Campbell, Trust Secretary
University of East London	An organisation specified in the constitution as a partnership organisation may appoint a member of the board <sup>9</sup> .	As for all Governors, keep representatives informed of developments.	Prof John Joughin is the incumbent	<u>Angela Greatley, Trust Chair</u> Paul Jenkins, Chief Executive Gervase Campbell, Trust Secretary

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

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





BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 28<sup>th</sup> April 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.10
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.11
7.	Finance & Performance Report Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.13
8.	Training and Education Report Mr Brian Rock, Director of Education & Training; Dean	To approve	Enc.	p.25
9.	Quarter 4 Governance Statement Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.30
10.	Quarter 4 Quality Report Dr Justine McCarthy Woods, Quality Lead	To note	Enc.	p.35

11.	<b>Draft Annual Quality Report</b> Dr Justine McCarthy Woods, Quality Lead	To discuss	Enc.	p.52
12.	<b>Century Films Documentary Update</b> Mr Paul Jenkins, Chief Executive	To discuss	Enc.	p.113
13.	<b>Complaints Report</b> Mr Paul Jenkins, Chief Executive	To note	Enc.	p.119
14.	<b>Whistleblowing Report</b> Mr Gervase Campbell, Trust Secretary	To note	Enc.	p.126
15.	<b>Corporate Governance – External Contacts Review and Use of Trust Seal</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.128
CONCLUSION				
16.	<b>Any Other Business</b>		Verbal	-
17.	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"><li>Wednesday 20th May 2015: Extra-ordinary meeting of the Council of Governors, afternoon, Lecture Theatre</li><li>Tuesday 26<sup>th</sup> May 2015: Board of Directors Meeting, 2.00pm – 5.00pm, Board Room, Tavistock Centre</li><li>Tuesday 9<sup>th</sup> June 2015: Directors' Conference 12.00am – 5.00pm, Lecture Theatre</li></ul>		Verbal	-