

## Board of Directors Part One

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

2.00pm–4.30pm  
Tuesday 28<sup>th</sup> June 2016

Lecture Theatre,  
Tavistock Centre,  
120 Belsize Lane,  
London, NW3 5BA



## BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 28<sup>th</sup> June 2016, 14.00 – 16.30  
Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

### AGENDA

PRELIMINARIES				
1.	<b>Chair's Opening Remarks</b> Mr Paul Burstow, Trust Chair		Verbal	-
2.	<b>Apologies for absence and declarations of interest</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
3.	<b>Minutes of the previous meeting</b> Mr Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	<b>Outstanding Actions</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
4.	<b>Matters arising</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	<b>Student Story – Clinical Psychoanalytic Portfolio</b>	To discuss	Verbal	-
6.	<b>Service Line Report – Clinical Psychoanalytic Portfolio</b> Ms Anne Hurley, Portfolio Lead	To discuss	Enc.	p.10
7.	<b>Trust Chair's and NEDs' Reports</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
8.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To note	Enc.	p.20
9.	<b>CQC Action Plan</b> Ms Louise Lyon, Director of Quality & Patient Experience	To note	Enc.	p.23
10.	<b>Board and CEO Objectives</b> Mr Paul Burstow, Trust Chair	To approve	Enc.	p.29
11.	<b>Finance and Performance Report</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.42
12.	<b>Training and Education Report</b> Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.50
13.	<b>Annual Safeguarding Report</b> Dr Rob Senior, Medical Director	To note	Enc.	p.55
14.	<b>Statement of Support for Tobacco Control</b> Ms Louise Lyon, Director of Q&PE	To approve	Enc.	p.66

15.	<b>Terms of Reference for Management Team and Audit Committee</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.70
16.	<b>Scheme of Declaration of Powers</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.86
17.	<b>Second Self-Certification to Monitor</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.96
<b>CLOSE</b>				
18.	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"> <li>Thursday 30<sup>th</sup> June 2016: Council of Governors' Meeting, 2.00 – 5.00pm, Lecture Theatre</li> <li>Tuesday 12<sup>th</sup> July 2016: Leadership Group, 12.00-5.00pm, Lecture Theatre</li> <li>Thursday 14<sup>th</sup> July 2016, 10am – 5.00pm and Friday 15<sup>th</sup> July 2016, 9.00am – 12.00pm: Board Away Day, Danubius Hotel</li> <li>Tuesday 26<sup>th</sup> July 2016: Board Meeting, 2.00- 5.00pm, Board Room</li> </ul>		Verbal	-

## Board of Directors Meeting Minutes (Part One)

### Tuesday 24<sup>th</sup> May 2016, 2.00 – 4.45pm

Present:			
Prof. Paul Burstow Trust Chair	Prof. Dinesh Bhugra NED	Ms Jane Gizbert NED	Mr David Holt NED
Dr Sally Hodges CYAF Director	Mr Paul Jenkins Chief Executive	Ms Lis Jones Nurse Director	Ms Louise Lyon Director of Q&PE and A&FS
Ms Edna Murphy NED	Mr Brian Rock Director of E&T/ Dean	Dr Rob Senior Medical Director	Mr Simon Young Deputy CEO & Director of Finance
Attendees:			
Dr Julian Stern, Director of Adult and Forensic Services	Mr Gervase Campbell Trust Secretary (minutes)		
Apologies:			
Dr Ian McPherson NED & Vice Chair of Trust			

#### Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to be made to the minutes	GC	Immd.

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

Mr Burstow opened the meeting.

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

Apologies as above. No interests specific to the meeting.

#### 3. Minutes of the Previous Meeting

**AP1** The minutes were approved subject to minor amendments

#### 4. Matters Arising

Action points from previous meetings:

AP1 – (minutes) – completed

AP2 – (appraisal rates) – Mr Campbell confirmed that the discrepancy was due to the date each data set represented, and the figure in the HR report was correct for the full year - completed

AP3 – (complaints comparison) – Amanda Hawke had circulated details - completed.

#### 5. Service User Story – Camden CAMHS

Dr Wiener introduced Ms K, a young service user with Camden CAMHS, and discussed her experience with her. Ms K had started attending the Trust 5 years ago, following attending 5 or 6 hospitals between the ages of 12 and 16. Her first impression of the Tavistock Centre was that it was a scary and unwelcoming building, and she hadn't wanted to come inside. The waiting rooms had been dull and boring then, but were brighter and more friendly now. She'd also been

unsure of her clinician on first meeting him. It had taken some time to build up trust in him and feel that he understood her, and it was being visited at hospital and at home that had made her feel that he did care and wanted to help.

Ms K had first been admitted to hospital at 12, not sectioned but still restrained, and she had hated it and been homesick, isolated, and not treated well. Her later experience in Surrey after being sectioned had been better, she had found supportive staff who were actively trying to help, and had made good friends.

At the Trust she had seen two clinicians, and most of her therapy had been Cognitive Behavioural Therapy (CBT). She felt she had good support from the Trust; there was always someone she could go to if she needed help, including a crisis plan. Ms K found that CBT was helpful, she was learning strategies to replace self-harm or arguing with family, a middle path. The mindfulness and self-soothing practices helped with this.

Dr Hodges noted her response to the building, and asked if there was anything she would have liked to have been different. Ms K didn't think there was, she added that she had always found the staff to be friendly and welcoming even when she first started and didn't trust them. Mr Holt asked about the home visits, and Ms K explained that she had found them easier, and said she thought they would be helpful as a first experience for other new patients, as they were less overwhelming. Ms Jones asked what advice she would give to someone else coming for the first time, and Ms K explained she would say that it was normal to be nervous or scared at the beginning, but it would get better, and that the staff really were here to help and would give the support you needed to get better. Dr Stern asked whether she thought the clinicians were ever too friendly, to the detriment of doing their jobs, Ms K thought this wasn't the case, and it would be helpful if therapists were more relaxed at first until a rapport had been built.

Prof. Burstow thanked Ms K for attending and bringing her experience to life for the Directors.

The Board **noted** the report.

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

Mr Holt followed up on the point Ms K had made about home visits. Dr Wiener explained that in her case it had been a necessity, but more generally they were included as a part of the repertoire of responses when someone did not attend an appointment and screening showed they were at higher risk.

Dr Wiener introduced his report, highlighting that areas of concern included data, where Carenotes implementation had caused difficulties that were still not fully resolved. An easy system that everyone could use was essential if outcome data was going to be used to improve services. Ms Gizbert asked whether there had been a loss of credibility with commissioners, and Dr Wiener explained that the service had not been able to give them all the data they required for 8 months in a row, which had damaged the reputation and relationship that had been built up over a long period. Mr Burstow enquired if the service was receiving the support they needed to recover from IMT, and Dr Wiener felt that a

lot more work was required to get a system that worked for clinicians. Mr Jenkins agreed that they should have been more upfront about the difficulties the transition to Carenotes was likely to encounter and the impact this would have on services already under pressure. He commented that they now needed to target effort to the integration of the system with clinicians so that it helped them in their work, and they were working to achieve this as quickly as they could.

Mr Holt noted the high workload evident in the activity table on page 15, and asked about the effects of coping with the system and the increased activity at the same time. Dr Wiener commented that it didn't help, and added that they had worked hard on stabilising the volume of work and had some success. He added that the percentage of referrals not accepted was just 1.3%, which was incredibly low. They were looking for alternative pathways that could be offered, which feedback showed patients would prefer, and they felt 8-12% would be a better target for the future. Dr Senior commented that commissioners were under pressure too, so additional funding was unlikely, and so the best approach was in developing new models such as THRIVE. Dr Weiner noted that staff were busy and felt pressured, but their caseload was being monitored and they were dedicated. Dr Hodges noted that there didn't seem to be any sickness incidents related to burnout, and that the CQC had received positive feedback from staff they spoke to.

Prof. Burstow asked if there were impediments to the development of THRIVE other than data issues. Dr Wiener commented that the redesign was having a good effect, and Dr Hodges added that there was still something of a cultural issue, and it was easy to underestimate how long a change programme took to embed. Mr Jenkins agreed, commenting that a conceptual model could be developed relatively quickly, but changing practice at scale was a slower process. He added that THRIVE was important because it helped manage the difficult position they were in with increasing pressure and no new resources, so they would continue to drive forward with it.

Mr Rock asked about the impact of accommodating trainee placements within the service, and what support would be helpful. Dr Weiner commented that a large proportion of their work was done by trainees, up to 45% in North Camden, and so a lot of training and supervision was taking place, but he hadn't heard of any problems or that trainees were not being supported. He noted that there was a tension with part time posts split between clinical and training roles, as in some cases they meant that clinicians were only in teams one day a week, when ideally they would be present for at least three.

Mr Jenkins thanked Dr Wiener for his effective leadership in Camden CAMHS. Prof. Burstow commented on the inspiringly low turn-away figure, which spoke to why staff were feeling overwhelmed, and thanked Dr Wiener for his candour in the report, which was important for assurance. He gave his thanks to all the staff.

The Board **noted** the reports.

## **7. Trust Chair and NEDs' Reports**

Prof. Burstow summarised the service visits he had made, including to the Early Intervention Service. Mr Campbell reported that a list of services for the joint NED-Governor visits had been drawn up and circulated.

The Board **noted** the report.

## **8. Annual Report and Accounts, Quality Report, and Letter of Representation**

### **8a - Annual Report**

The board discussed the Annual Report. Mr Holt suggested that an explanation of the exit packages be provided on page 63 to confirm that they were not made to senior managers, and were entitlements due under their Terms and Conditions.

The Board **approved** the annual report with the suggested addition.

### **8b - Financial Statement**

Mr Young tabled a list of late amendments to the Financial Statement, noting that there had been delays in completing the audit this year. The late changes were not large but affected a number of pages. One was that, in the Statement of Comprehensive Income, the surplus had reduced to £237k primarily due to the reclassification of some of the relocation project costs as revenue after discussion with the auditors. The second was a reduction in the Revaluation figure down to £5,528k.

There had also been changed or clarified wording in the Notes:

Note 5.1 – the impairments figure had changed due to the reclassification of the relocation project costs which had led to expenditure previously capitalised being taken out of assets and written off.

Note 21.1 – the trade receivables from NHS bodies of £4,820k was due to NHS England requiring us to bill them in advance because of their systems, and so was included as a technicality, and is shown in Note 28 as deferred income.

Mr Holt commented that the Audit Committee had met the previous week and considered the accounts, and had been fully satisfied, especially on the large items of income recognition, asset valuation, and debts. On valuation, where there had been a large change, the auditor's expert team had reviewed the outcome and it also tallied with his experience. He commented that it partly appeared a large change due to the long time since the last appraisal was done.

The Board **approved** the tabled Financial Statements.

### **8c – Quality Report**

Ms Shipman tabled a number of amendments to the Quality Report, and explained them in detail. The Board discussed these and noted that the change in DNA data meant that there had been an overall increase in the rate rather than a decrease, and so the associated text would need to be amended to reflect this. It



was agreed that this would be done and the revised text approved by the Chair and CEO. The Board discussed the importance of DNA rates more widely.

Prof. Burstow asked about an executive summary, and Ms Shipman explained that the format they had to work to called for an introduction instead, but that they were at liberty to do a more readable version of the Quality Report for sharing later.

Mr Holt noted that the Auditors had qualified their opinion, a 'limitation on limited assurance', on one of the quality priorities and asked for the background and whether it tied into the data robustness problems. Ms Shipman explained that there was concern over the waiting time data, principally on how timely the data entry was done, and validation of the data. The team was relatively new, and this had been a wakeup call, but they now had validation of the data and would put together a plan for closer review and better assurance on it. Ms Shipman noted that it was not unusual for Trusts to receive a qualification of this sort, but acknowledged there could be an impact on the reputation of the Trust.

Mr Holt commented that the internal audit rating was also down a notch this year, and the Trust had not passed the IG toolkit, which taken together were indicators of stress in the system that was not critical but needed to be addressed. Mr Jenkins added that there was a particular point about data brought into focus by Carenotes, and it needed work to address which would not be straightforward. They would review the whole system of data validation as well as each component of the process, including clinical practice. In the management team they would clarify who could provide assurance for the whole process overall and clarify responsibilities.

The Board **approved** the Quality Report, subject to the amendments discussed.

#### **8d – Letter of Assurance**

Mr Young tabled the final version of the letter and explained the differences from the circulated version were the removal of paragraph 26, and the addition of appendix 1 giving details and an explanation of the, non-material, incorrect allocation of revenue. Mr Holt suggested that paragraph 24 needed a qualification because they had received amber/red reports, so should end: "other than those identified".

The Board **approved** the letter with the discussed changes.

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

Mr Jenkins introduced his report by noting the powerful coverage of GIDS on the Today programme, which was a good example of the profile raising work the Trust needed to be doing more of. Mr Holt asked whether it was possible to put the programme on the website, and Mr Jenkins confirmed that this was possible with the new website.

Mr Jenkins gave an update on the open meeting he and Prof. Burstow had held with Black and Minority Ethnic staff, which had been well attended and had

raised a number of issues to address. He had been struck by some of the improvements made in the Trust, but the feedback was that many processes were not perceived as equitable. This was especially true in training and education, and it could be that positive discrimination could be used successfully there. The Workforce Race Equality Standard report would be published shortly with data from all Trusts in the country, and whilst we were not the worst there was work to be done and this issue would return to the Board regularly.

Mr Jenkins gave an update on Carenotes optimisation, noting a lot of work had been done and there was good cooperation between IT and clinical teams. The goal was to complete the work by September or October, and the key to this was a shared understanding of what works best for the Trust and for clinical staff. Sadly Mr Avery had decided to leave the Trust, and he would be missed because of the significant impact he had made in his time here. They would ensure robust arrangements were in place to take the work forward. Prof. Burstow noted the risk regarding funding confirmation, p.236, where project management had previously been allocated to the capital budget, but this was being questioned by the auditors. Mr Jenkins confirmed that they had been able to identify funding for the current year from contract agreements.

The board **noted** the report.

#### **10. Finance and Performance Report**

Mr Young highlighted the movement changes from the opening budget, page 241, noting the increase in the GIDS contract but also partially offsetting that a higher dividend from the revaluation of the Trust's land and buildings, and also at present a reduction caused by classification of some of the Relocation Project costs as revenue rather than capital. The classification of the project costs would be discussed with the auditors, and if resolved the budget gap had been bridged with a small contingency reserve. The Management Team would be agreeing additional allocations for the year based on the underspend in month 1 and the projected surplus.

Mr Holt commented that he would find a graphical representation of income and expenditure against targets helpful for discussions of priorities and when surpluses could be released. Mr Burstow added that this could complement the 3/5 year forward view. Mr Young discussed the details of this and agreed to put together something useful.

The Board **noted** the report.

#### **11. Education and Training Report**

Mr Rock presented the report, noting the work on Visiting Lecturers would come to the Board in July.

Prof. Burstow asked for more details on the increase in applications, para. 6.2.1. Mr Rock explained that they had received 350 completed applications, and were receiving approximately 25 a week. More activity was being devoted to engagement and promotion, and they were actively interviewing and selecting earlier in the cycle than in previous years. Some courses were in a good position,

but others needed more work, and there was an open evening and webinar on the 9<sup>th</sup> June. Ms Murphy added that there were definitely more applications than at this point last year, and this was a tribute to the marketing work, and the rapid processing of applications that the reorganisation had enabled.

Ms Lyon asked how the student numbers on courses were mapping to the aims of the National Contract. Mr Rock confirmed there was general alignment but with some bulges and one gap of concern. He added that their initial aim was for visibility and presence, rather than income growth, to protect the contract and create a pipeline to courses in new areas.

Dr Hodges asked whether the good student numbers had affected staff engagement with the changes made over the past year. Mr Rock confirmed that they had, with staff seeing the benefits and feeling increased confidence. The creation of the separate student reception area had also had a very positive effect by creating a much better environment to work in and less disruption. Implementation of the new SIMS would still cause difficulty, and there were concerns about resources and staffing numbers, but overall there was increasing confidence.

The Board **noted** the report.

## 12. CQSG Report

Dr Senior highlighted that the Information Governance Toolkit issue which was an area that needed prompt attention. He noted that they would be holding a special meeting on the 7<sup>th</sup> June to review the action plan for the CQC.

The Board **noted** the report.

## 13. CQSG Annual Report and Terms of Reference

Dr Senior presented the committee's annual report and ToR, which had considered the CQC and the need to integrate a quality programme into the CQSG structure. Prof. Burstow commented that it was appropriate to take the opportunity to look at how the infrastructure supported the work of the board and ensure that all areas are covered and captured in the assurance given. Mr Holt added that it was important to also ensure that areas were divided between Audit and CQSG so that there were no gaps and no duplication of effort. Mr Young reminded the board that the committee existed to provide assurance, and not to do the management work, which fell to the directors. Prof. Burstow commented that it all came together in the need to do a periodic review of all governance, and a review of the committee could be included in that.

The Board discussed the ToR and agreed the membership should refer to '2 Governor members' rather than 'up to 2..', and that the reference to monitoring implementation of the strategic plan should be removed from section 9.4 as this was part of the role of the Strategic and Commercial Committee.

The Board **noted** the report and **approved** the Terms of Reference with the discussed amendments.

#### **14. CQC Report Update and Timings**

Ms Lyon noted that the final report was due to be published by the CQC on the 27<sup>th</sup> May, and as they had discussed over lunch, the Trust's action plan focussed on the three 'must do' areas and needed to be submitted by the 7<sup>th</sup> June. The action plan would be taken to a special meeting of the CQSG committee before being submitted, and then brought to the Board for information at the June meeting.

The Quality Summit would be held on the 7<sup>th</sup> July and was an opportunity for a real discussion with all stakeholders of the changes needed in the coming year.

The Board **noted** the report.

#### **15. Corporate Governance Self-Certification for NHS Improvement**

Mr Young explained that the management team had reviewed the statements, and he recommended them for approval.

The Board **approved** the self-certification.

#### **16. Any Other Business**

The Board noted its future meetings.

Part one of the meeting closed at 4.45pm

Action Point No.	Originating Meeting	Action Required	Director / Manager	Due Date	Progress Update / Comment
2	Feb-16	Monthly Optimisation Updates, and Quarterly IMT reports, to come to the Board	Toby Avery	April 2016	First update came in May, Quarterly report due in July. Completed.
3	Mar-16	3 to 5 year financial view to be drawn up	Simon Young	July 2016	Scheduled for Board Away Day.



## Board of Directors : June 2016

**Item :** 6

**Title :** Service Line Report – Clinical Psychoanalytic Portfolio

**Purpose:**

The purpose of this report is to provide the Board of Directors with an update of progress on the Psychoanalytic Clinical Portfolio within the Directorate of Education and Training (DET).

This report has been reviewed by the following Committees:

- Management Team, June 2016

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

- Quality
- Patient / User Experience
- Risk
- Finance

**For :** Noting

**From :** Anne Hurley, Portfolio Manager, Psychoanalytic Clinical Programmes

# Service Line Report

## Department of Education and Training

### Clinical Psychoanalytic Portfolio

#### Executive Summary

## 1. Introduction

- 1.1 The re-structuring of the Department of Education and Training in 2015 included the establishment of six Portfolio Manager posts in order to give a greater degree of operational coherence and strategic management to our comprehensive training programme. Each Portfolio Manager falls within the remit of one of two Associate Deans, and functions to oversee, lead and develop a portfolio of linked courses.
- 1.2 In keeping with the aforementioned structural change and following on from the previous introduction of a separate service line for Education and Training, this is the second Service Line report focusing on a particular portfolio.
- 1.3 The Psychoanalytic Clinical Portfolio is the largest of the six portfolios and delivers ten long courses which are accredited by a professional body and /or lead to an academic award. Three of the courses are delivered in Leeds and Manchester. The portfolio also delivers a range of CPD courses. The staffing consists of one portfolio manager, eight course leads, one link tutor, seven other members of staff, and a range of other staff who give a small proportion of their time to education and training. The portfolio also makes use of over 50 visiting lecturers, seminar leaders and clinical supervisors.

## 2. Areas of Risk and/or Concern

- 2.1 Many of the courses within the portfolio have a close connection with HEE priorities. While this is implicit in course brochures and website information, the link could be more explicitly highlighted in some of our publicity material. Our annual review of course publicity is addressing this.
- 2.2 Areas of risk within the portfolio primarily centre on reduced availability of funding for training in the public sector. Employers necessarily are privileging mandatory training and IAPT and there has been less possibility of releasing staff for additional continuing professional development. Students embarking on adult psychotherapy training in particular are increasingly self-funded, which is challenging in the current economic climate. The high cost of living (and particularly housing costs) in the South East has had consequences for our overall student recruitment across our adult courses. While our entry level courses continue to be in popular demand, progression to our 4 year intensive adult psychoanalytic psychotherapy has seen some decline in recent years. However, the trend seems to have changed this year as we have an increased number of applicants.



- 2.3 Moreover we are operating in a competitive market. Balancing the need to achieve increased recruitment with a cost effective fees structure, paying regard to these market forces, is a continuing challenge.
- 2.4 There remains a high degree of financial investment by HEE in our doctoral level training of child and adolescent psychotherapists. However, the Department of Health Workforce Development Team is currently consulting on reforming healthcare education funding. This specifically does not include child and adolescent psychotherapy training but the central structures for funding healthcare training are in a process of change. The accommodation of small specialist trainings like child psychotherapy within an architecture which is being re-shaped brings some uncertainty about the future funding and commissioning arrangements for child psychotherapy training.

### 3. Proposed Action Plan

- 3.1 Work is underway to ensure that HEE priorities are more explicit in our course publicity across the portfolio. Our annual update of website information is presently being used as an opportunity to revise course information with regard to this. All new course developments and new CPD events are now more closely informed by HEE priorities.
- 3.2 A close alliance has been made with the Lead for the Commercial Engagement Development Unit (CEDU) who is tasked with proactive work with employers about the benefits of our training approach. Some of the benefits of intensive lengthy trainings for the sustainability of the workforce in the NHS which is increasingly operating in challenging circumstances under fire and under-resourced are now being promoted. Employers who are concerned about staff recruitment and retention in challenging stressful mental health settings are interested in our trainings which produce resilient staff who can endure working with people experiencing high levels of emotional distress and disturbance over time. Additionally, we are more aware of making our training offer more relevant, accessible and affordable to self-funding students. Therefore we are reviewing all courses within the portfolio and increasingly looking to offer aspects of our courses as stand-alone modules that particularly fit with current NHS preoccupations and priorities.
- 3.3 There has been close liaison between the M80 Course Lead, the Head of the Child Psychotherapy Discipline and the Professional Body, the Association of Child Psychotherapists about responding to the consultation document on reforming healthcare education funding. Paul Jenkins, our Chief Executive together with Brian Rock, Director for Education & Training/Dean are also coordinating strategic discussions about our response to the possible implications of the Education Funding Reforms consultation for changes in structure for the commissioning and funding of child psychotherapy training.

## Main Report

### 4. Overview of the Portfolio

#### 4.1 Core identity and purpose

The Psychoanalytic Clinical Portfolio comprises psychoanalytic and psychodynamic psychotherapy trainings across the lifecycle. The Portfolio incorporates clinical training in child and adolescent psychotherapy, including a specially tailored programme for child and adolescent psychiatrists, as well as our key training programmes in psychotherapy with adults and couples. Two programmes have alternative sites of delivery in Leeds and Manchester. All programmes within the Portfolio lead to membership of a professional body (The Association of Child Psychotherapists or The British Psychoanalytic Council) and/or an academic award from the University of Essex or the University of East London. The Tavistock Society of Psychotherapists (TSP) functions as the Member Institution of the British Psychoanalytic Council (BPC). The Portfolio also includes a wide range of short CPD courses.

The main programmes in the Portfolio are:

- Professional Doctorate/ Professional Masters in Child and Adolescent Psychoanalytic Psychotherapy (M80)
- Psychodynamic Psychotherapy for Child and Adolescent Psychiatrists (M14)
- Interdisciplinary Training in Adult Psychotherapy (M1)
- Intercultural Psychodynamic Psychotherapy (D59I)
- Psychodynamic Psychotherapy with Couples (D59C)
- MA/PGDip Foundation in Psychodynamic Psychotherapy (D58)
- MA/PGDip Foundation Course in Psychodynamic Psychotherapy (D58Leeds)
- Foundation Course in Psychodynamic Psychotherapy (D58 Manchester)

The Portfolio Manager for the Psychoanalytic Clinical Portfolio came into post in October 2015 and has five sessions per week in this role. The portfolio represents well established, national and internationally respected psychoanalytic clinical trainings across the adult department and the children, young adults and families department. This provides interesting cross-departmental opportunities for discussion, joint working and development.

Both child and adult psychotherapy training are the more advanced clinical psychoanalytic programmes and have close links with other courses in the Applied Psychoanalytic Portfolio. The latter provide prerequisite foundation and pre-clinical opportunities for study within the Psychoanalytic Clinical Portfolio. There is a clear progression route or escalator across both portfolios from entry- level certificate courses, through to advanced professional training in psychoanalytic psychotherapy.

Some students from the more advanced child and adult psychotherapy programmes (i.e. M80, M16, D59I, D59C), who are already qualified and experienced mental health professionals, contribute clinical work to teams

across the Trust on placement. Others have clinical placements within a number of other NHS Trusts. There are close monitoring structures in place in relation to all placements.

Two courses within the portfolio have university accreditation. The MA/PGDip Foundation in Psychodynamic Psychotherapy (D58) which is delivered at the Tavistock Centre and in Leeds has always been validated by the University of Essex. The Professional Doctorate/ Professional Masters in Child and Adolescent Psychoanalytic Psychotherapy (M80) is going through a period of transition with our new university partner. Year one students are now registered with the University of Essex while other cohorts of students remain registered with the University of East London as the teach-out arrangement allows for the completion of the programme of study for which they have enrolled within a set timescale. Relating to two university partners with their own distinctive structures, processes and academic regulations in this interim period, which is likely to endure for a number of years, presents time consuming additional pressures for the course team.

The portfolio team is working closely within new DET structures around such issues as recruitment, marketing and course administration. There is now one main course administrator for the portfolio with some additional input from a course administrator dedicated to courses in our National Centres. This represents a considerable change and there is anxiety about the impact of reduced administrative time on the quality of our course delivery and the student experience. However, continuing work on developing standard operating procedures for administrators is expected to streamline work more effectively. In addition a new Student Information Management System is to be implemented in the near future and it is hoped that this will assist in more accurately tracking student data.

The QAA visited in April 2016, at a time of transition in DET with changing university partners and when new structures, processes and procedures were in the process of being embedded. This followed on from the CQC visit in January. While it is positive that we are so well regulated, the QAA visit generated understandable anxiety and additional work among the course teams. Course Leads of the two university accredited programmes within my portfolio which were part of this investigative process worked hard to prepare for this visit. The QAA team showed a keen and searching interest in all aspects of our training endeavour. While we are expecting some favourable feedback, there are likely to be some areas highlighted for improvement.

## 4.2 Overall vision and strategy

The portfolio's vision and strategy is in accordance with the DET strategic objectives:

(a) Increase intake of Year 1 student numbers to 900 for 2017/2018

Recruitment to courses within the portfolio has been greatly helped by dedicated recruitment advisors who now look after all recruitment matters up to the point of students accepting a place on a course. These new roles have been a major asset in promoting our courses, proactively following up course enquiries, organising shortlisting and interviewing processes and so forth. We have set ambitious targets for recruitment to courses within the portfolio. We have participated in two Trust Open Events to promote our courses so far this year as well as convening course specific open events. These have been well attended and we are planning involvement in an open day one Saturday in July. These efforts are proving successful and we are likely to meet or in some cases exceed our targets for recruitment. This success does bring challenges also, especially in terms of available rooms for increased student numbers and identifying sufficient teaching staff to act as tutors and supervisors for our trainees. We are reviewing resources within the portfolio and are confident that we can match available resources to recruitment requirements.

- (b) Increase the national reach of our training and education offer through greater regional presence

Our D58L and D59L programme in Leeds and our D58M programme in Manchester has a small cohort of students and this is slowly increasing. We have a link tutor in place for Leeds and Manchester and we are in the process of appointing a new Course Lead in Leeds to further promote our training offer in the North. This post will also include some development work in Leeds. There is close collaboration with the Northern School of Child and Adolescent Psychotherapy (NSCAP) in Leeds which is a major NHS centre of mental health learning and practice, where these adult programmes are delivered. We are also developing a D59M course in Manchester as there are sufficient numbers graduating from the D58M that are interested in progressing to more advanced training.

Our M80 programme attracts trainees from many regions across the UK. It has contracts with education commissioners not only in London but also in the East of England, the South West, and Thames Valley, East Midlands, Kent, Surrey and Sussex.

We are also continuing to build our links with international colleagues from all over the world who express interest in acquiring more knowledge of psychoanalytic ideas. They look to the Tavistock as the psychoanalytic hub and request attendance at our seminars during visits to the UK. We have a long and continuing tradition of devising bespoke programmes based on our existing adult and child psychotherapy courses. We have attracted visiting students from as far afield as Taiwan, China and Bangladesh. This has proved a helpful strategy over time in terms of attracting attendance at our conferences and short courses. In some instances it has initiated long lasting relationships with the Tavistock, for

example we have three students from Taiwan currently enrolled on our 4 year M80 course on a self-funded basis.

- (c) Broaden our portfolio of training to reach a wider section of the workforce and respond to emerging issues in health and social care

The length and intensity of some programmes within the portfolio make it difficult for some employers to release staff for entire programmes. We are increasingly making individual modules of programmes available to reach a wider section of the workforce. Similarly we are developing short CPD courses that are less time intensive and more affordable. We are also mindful of tailoring our courses to be relevant to the modern NHS. Offering courses that grow expertise in shorter length treatments and CPD in specialist interest areas are good examples of this. These also accord with HEE priorities around developing psychological therapies and reflective practice.

#### 4.3 Progress to date and current position

In the current academic year 2015/16 there is a total of 304 students enrolled on courses within the portfolio across all year groups. The duration of each course is between 2 and 4 years long.

Our recruitment to the next academic year 2016/17 which is still ongoing looks favourable. The table below gives a more detailed status report on recruitment figures comparing the number of our June 2016 applications with applications received the same time last year. So far this year we have received a total of 143 applications to courses within the portfolio as compared to 106 applications at the same time last year. D59I, M1 and M80, our lengthier more intensive psychoanalytic programmes are performing particularly well on recruitment this year. BD58, our blended learning version of D58, which investment in technology advanced learning (TEL) has allowed us to develop in recent years, and which includes online lectures as well as direct seminars, is also a popular course.

Status Report on Recruitment		
Psychoanalytic Clinical courses	Number of Applications June 2016	Number of Applications June 2015
M1	13	8
D59I	29	7
D59C	5	3
D58	34	40
D58M	1	1
D58L	1	5
BD58	15	3
M80	37	38
M14	3	1
STPP	5	0
<b>TOTALS</b>	<b>143</b>	<b>106</b>

## **5. Portfolio Developments**

- 5.1 Since the establishment of the portfolio in July 2015, the following development have taken place:

### **Successful M80 Re-accreditation Visit by ACP**

All training schools which provide clinical training for Child and Adolescent Psychotherapists in the UK have to be accredited by the training council of the Association of Child Psychotherapists. A re-accreditation process happens every four years and in February 2016, the re-accreditation team visited the Tavistock over a three- day period. The team was involved in a comprehensive programme of inquiry: meeting with the M80 Course Lead and senior DET colleagues, attending some teaching seminars, being introduced to our TEL resources, meeting with trainees and service supervisors and gathering feedback about all aspects of our programme. We have been given initial feedback which is very positive. The M80 programme was re-accredited with no conditions and a number of commendations. The latter included a commendation on the commitment and enthusiasm of the hardworking teaching team, and the quality of trainees who impressed the panel with their willingness to learn, often overcoming challenges such as long distance travel. One of the recommendations made was for the M80 management team to request resources from the Trust to support development and implementation of a comprehensive equality and diversity strategy and action plan. The course team is actively considering ACP recommendations.

### **Positive Annual Report by HEE Quality and Regulation Team**

The Quality and Regulation Team (London and the South East) measures how Education Providers ensure the next generation of healthcare professionals have the right skills to deliver world-class patient care. The Quality and Contract Performance Management (QCPM) measures Education Providers against an agreed set of contract performance indicators (CPIs). The most recent annual report concerning our Child Psychotherapy programme, received in April 2016, but pertaining to 2014/2015 awarded green ratings to all qualitative and quantitative CPIs, giving us a score of 100%. The annual report noted this excellent achievement, acknowledged this result having been consistent for the past few years and specified that "this level of performance does not happen through luck or without hard work".

### **Review of M1**

There is a plan to review M1 which is being led by Associate Dean Elisa Reyes-Simpson. This has been prompted by the need to ensure M1 is relevant and sustainable in the modern NHS context. M1 was originally conceived as a public sector course for people in a position to contribute to the NHS once qualified. The pattern of attracting young qualified mental health



professionals to do this training has changed over the years. This is in part connected with workplace pressures, which make it difficult for employers to release staff for training and limits around employer investment in training, and in part perhaps M1 is perceived to be going against the trend of short-term treatments that are now most commonly offered in the NHS. Intensive treatments can be a cost effective preventative measure and an alternative to serial short episodes of treatment. While a small cohort of students at a relatively early stage of a NHS career continues to apply to do M1, and our intake this next academic year is quite strong, we are aiming to continue to increase the uptake of NHS professionals who have an NHS career in development.

M1 plays a key role in contributing to the training of psychiatrists and this influential training continues to resonate over subsequent long careers. Consultant psychiatrists employed across a number of different NHS Trusts who have done M1 are positively inclined towards and often powerful advocates of Tavistock training and clinical services.

A wide-ranging review of M1 is now timely which will consider its course content, curriculum and mode of delivery, mindful of the contemporary NHS context, and its operational functioning across DET and the Adult and Forensic Services within the Trust.

### **The Role of the Tavistock Society of Psychotherapists (TSP)**

The Tavistock Society of Psychotherapists (TSP) is the professional body for psychotherapists who have trained at the Tavistock and Portman NHS Foundation Trust. It has an important function for many of the training programmes within the portfolio as it is a Member Institution of the British Psychoanalytic Council (BPC). Graduates of our adult and child psychoanalytic trainings get membership of the BPC by virtue of being members of the TSP. The TSP organises a number of CPD events for its membership. It also has had a role in processing applications for Equivalence from individuals who have completed psychoanalytic psychotherapy trainings elsewhere and are seeking to become members of the BPC. This sometimes involves 'top-up' training to be provided by programmes within the portfolio to achieve Equivalence.

When the Chair of the TSP recently stepped down it was an opportunity to revisit discussions about the place of the TSP within the Trust. A financial review is imperative to explore whether membership fees can cover the structural and functional requirements of the TSP. We also want to ensure that Trust provision, especially in relation to M1, is able to meet requirements stipulated by the BPC. The last M1 re-accreditation report by the BPC in 2013 highlighted what it saw as some structural flaws, for example the need for the TSP to have a more formal and written constitution. This has been written, but will need to be reviewed in light of the outcome of the overall review. It seems timely for the role, functions, structures and financial underpinning of the TSP to be reviewed in full. To this end Associate Director Elisa Reyes-Simpson is currently undertaking a review of TSP functioning, which will be reported on later this year.

## CPD Developments

The portfolio runs a range of CPD courses, primarily for professionally qualified mental health professionals. We have recently developed three short CPD courses deriving from expertise in couples psychotherapy. These encompass themes to do with assisted reproduction, and couples in crisis and safeguarding issues for young children in the midst of couple conflicts. We are also in the process of developing CPD courses on groups. All these developments align well with HEE priorities.

## 6. Financial Situation

The table below lists the courses within the portfolio and includes student numbers in year one and associated income for the year 2015/16.

Course Code	Anne Hurley			D58, D59C, L and i increases 6.25%, M1 6.5%										
Portfolio	Psychoanalytical Clinical													
Course Code	Enrolment 2012/13	Enrolment 2013/14	Enrolment 2015/16	Enrolment Target 2015/16	Enrolment Target 2016/17	Income 2015/16	Contribution 2015/16	Closest Competitor	Competitor Price	TPFT Price 15/16	Average Market Price	Suggested 16/17 Course Price	Course Duration /YR	% Difference on Last Year Price
M80*	20	16	21	20	18	£ 546,596	£106,659	Note - out	NA	£ 8,291	NA	£5799:49	4	No change
D58/BD58	23	24	34	25	35/15	£ 301,645	£ 193,212	WPF	£ 3,997	£ 4,000	£ 3,507	£ 4,250	3	6.25%
M1	4	2	6	4	8	£ 87,860	£ 27,663	Institute c	£ 600	£ 4,600		£ 4,899	4	6.50%
D58M	7	8	7	8	10	£ 46,800	£ 19,490	No competitors		£ 4,000	£ 2,424	£ 4,250	3	6.25%
D58L	7	8	7	8	10	£ 49,500	£ 10,069	No competitors		£ 4,000	£ 2,424	£ 4,250	3	6.25%
D59C	0	0	7	0	10	£ 20,116	-£ 1,834	The Tavist	£ 4,495	£ 4,000	4248	£ 4,250	2	6.25%
D59L	0	0	17	8	20	£ 25,800	£ 8,269	Refugee T	£ 2,860	£ 4,000	3539	£ 4,250	2	6.25%
D59i	0	0	13	10	15	£ 119,852	£ 76,582	Institute of Psychiati		£ 4,000		£ 4,250	2	6.25%
Grand Tot	61	58	112	83	141	£1,198,169	£ 333,451							

Anne Hurley  
Portfolio Manager Psychoanalytic Clinical Programmes  
June 2016



## Board of Directors: June 2016

**Item :** 8

**Title :** Chief Executive's Report (Part 1)

**Summary:**

This report provides a summary of key issues affecting the Trust.

**For :** Discussion

**From :** Chief Executive

## Chief Executive's Report

### 1. CQC

- 1.1 The report of the Trust's Inspection by CQC was published on 27<sup>th</sup> May. The Trust was given an overall rating of "good" with the same rating for all domains except safety where the Trust was given a rating of "requires improvement". This related to issues about the recording of risk and a specific point about arrangements at the waiting room in the Portman. An action plan has been developed to address the recommendations made by CQC and our responses to their 3 recommendations for actions we must take have been submitted to them on 7<sup>th</sup> June. The action plan is due to be considered by the Board of Directors later in the agenda.
- 1.2 Specific reports for our children's' services, GID Service and specialist psychological therapies for adults also rated those services as "good".
- 1.3 The result is one which the Trust and its staff can be immensely proud of. In general the report provides a great endorsement of the quality and effectiveness of the Trust's clinical work. The report highlighted a wide number of areas of good practice across the Trust and in particular stressed the caring qualities of teams and individual teams.
- 1.4 The report and our "good" rating provide an excellent basis from which to build our future aspirations to further develop our strategy for clinical quality.

### 2. North Central London STP

- 2.1 Together with other members of the Management Team, a major priority in the last month has been providing input to both the mental health work stream of the North Central London STP and the wider plan.
- 2.2 During the last month I have taken over a SRO for the Mental Health workstream.
- 2.3 An initial submission of the plan to national bodies is scheduled for 30<sup>th</sup> June.

### **3. Perinatal Mental Health**

- 3.1 As part of the deliverables for the National Training Contract in 2016/7 the Trust has been asked to take a key role around the development of training for perinatal mental health. This includes the development by September 2016 of a national set of training and education competencies.
- 3.2 As part of this work a workshop for key national stakeholders, including the two national associate clinical leads was held on 25<sup>th</sup> May.

### **4. NHS Confederation Conference**

- 4.1 With Paul Burstow and Brian Rock I attended the annual NHS Confederation Conference.
- 4.2 Keynote presentations from Jim Mackey and Simon Stevens both presented a clear but sombre view of the challenges for the NHS in the next couple of years to restore financial balance, deliver key objectives and land the STP process around new models of care.
- 4.3 It was encouraging to see ongoing and more publicly visible references to mental health including a commitment to publishing shortly an implementation plan for the recommendations of the Mental Health Taskforce.

### **5. Media coverage**

- 5.1 The Trust has continued to attract a good level of media coverage. This included a very positive article about our Camden TAP service in the HSJ and the appearance of Dr Andy Wiener, Associate Director for our Camden CAMHS service on the Today Programme on 17<sup>th</sup> June.

### **6. Louis Taussig**

- 6.1 This month has seen the retirement of Louis Taussig, the Trust's Head of Academic Governance and Quality Assurance. Louis has provided a crucial input over 15 years to the Trust's work on the quality of our education and training work, including, recently, leading the Trust's preparation for the visit by QAA.

Paul Jenkins  
Chief Executive  
20<sup>th</sup> June 2016



## Board of Directors: June 2016

**Item:** 9

**Title:** Care Quality Commission Report 2016: Update on our response to CQC

**Purpose:**

The purpose of this report is to inform the Board of the steps taken in response to the publication of the Care Quality Commission in May.

The overall rating for the Trust was 'Good'. We received a Requires Improvement rating on Safety in one area. An action plan to address the areas requiring improvement was drawn up and submitted to CQC within the required timescale. The action plan is made available to the Board within this report.

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

- Quality

**For:** Noting

**From:** Louise Lyon, Director of Quality and Patient Experience

## Care Quality Commission Report 2016

1. Our Care Quality Commission Report was published on 27<sup>th</sup> May 2016. Our overall rating was 'Good'. We were rated Good across all services and all Key Lines of Enquiry apart from Safety, for which we were rated 'Requires Improvement' in the Specialist Psychological Therapy Services.
- 1.1 We received 'Requires Improvement' in the Safety domain because the CQC reported that we were not meeting regulation 12 HSCA (RA) Regulations 2014, as set out in the table below.

Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment
	How the regulation was not being met:
	<p>Care and treatment was not always provided in a safe way.</p> <ol style="list-style-type: none"> <li>1. The trust had not ensured that all patients had a comprehensive risk assessment and a risk management plan demonstrating how risks would be managed.</li> <li>2. The trust had not ensured that adults had a separate waiting area from adolescents and children at the Portman Clinic. Potential risks to adolescents and children were not sufficiently mitigated.</li> <li>3. Individual plans to mitigate risks to patients in a crisis were not always in place or were not stored where they could be found easily in a crisis.</li> </ol>

- 1.2 An action plan was prepared to address the three areas in which the regulation was not being met. This was presented to the Executive Management Team on 31<sup>st</sup> May 2016 and to an Extraordinary Meeting of the Clinical Quality, Safety and Governance Committee on 7<sup>th</sup> June 2016. With minor amendments the Action Plan was submitted to CQC as required on 7<sup>th</sup> June 2016 (see the Appendix).
- 1.3 Implementation of the CQC Action Plan will be monitored by both the Executive Management Team and the Clinical Quality Safety and Governance Committee. Action is already in hand in all three areas and we therefore anticipate that any risk to patients is very low.

Once actions are completed, we are advised to inform the CQC that we are thereby meeting the regulations.

2. In addition to the three areas in which improvement is required, the CQC listed areas in which we 'should' improve. Areas for improvement are set out in the Overall Report and in the three service specific reports. This is a longer list of points to address, varying in compass and complexity.
- 2.1 An action plan to address all of these points has been drafted and reviewed by the Executive Management Team and at the Extraordinary Meeting of the Clinical Quality, Safety and Governance Committee. Many of the areas of improvement are already being addressed through, for example, the CareNotes optimisation plans, CQUIN and KPIs. Others will require the development of a larger scale project, such as addressing the recommendation that we should develop and embed an integrated approach to quality improvement. Some details of the action plan remain to be finalised. Overall, no major difficulties are anticipated in achieving the improvements within the timescales set out in the action plan.

The CQC are holding a Quality Summit on 7<sup>th</sup> July 2016 at the Tavistock Centre. Details were given in a previous report to the Board. In brief, the CQC will present their report and we are then invited to present our plans to address areas for improvement and development. As the invited participants will include commissioners, service users, representatives of professional bodies and other stakeholders, this will be an opportunity to engage in discussion about the ways in which we may build on our achievement of a 'Good' rating to further enhance our clinical services.

**Louise Lyon**  
**Director of Quality and Patient Experience**

16<sup>th</sup> June 2016

Appendix

CQC Action Plan

No.	CQC Requirements	Success criteria	Actions	Timescale	Lead	Update
1	The trust must ensure that all patients, have a comprehensive risk assessment completed and a risk management plan detailing how risks are being managed or mitigated. These must be kept up to date.	<ol style="list-style-type: none"> <li>1. Improved timely risk assessment documentation on Carenotes</li> <li>2. Increased team awareness of risk assessment form completion</li> <li>3. Improved clinicians' awareness and assessment of suicide and self-harm.</li> <li>4. Improved clinicians' awareness and assessment of domestic violence and abuse</li> <li>5. Improved clinicians' awareness and assessment of digital risks for patients and service users</li> </ol>	<ol style="list-style-type: none"> <li>1. Review Carenotes forms for risk assessment to confirm information capture fields</li> <li>2. Undertake a baseline case note audit by team to determine whether risk assessments have been recorded on Carenotes.</li> <li>3. In depth examination of a sub-sample of patient records to review in more detail the quality of risk assessments</li> <li>4. Rolling programme of mandatory clinical risk assessment, management and review training for clinical staff and trainees to be established (6 monthly)</li> <li>5. Trust re audit of completion of risk assessment and review forms on Carenotes to include as part of bi-annual Trust casenotes audit</li> <li>6. Include risk assessment form completion data on Team level dashboards</li> </ol>	<p>30 June 2016</p> <p>31 July 2016</p> <p>31 July 2016</p> <p>31 July 2016</p> <p>31 January 2017</p> <p>30 November 2016</p>	<p><b>Medical Director</b> Supported by: Associate Medical Director (Trust Lead for Patient Safety and Clinical Risk)</p>	<p>Clinical Risk training delivered Sept 2015. Required 3-yearly.</p>



No.	CQC Requirements	Success criteria	Actions	Timescale	Lead	Update
2	The trust must ensure that children and young people have a separate waiting area from adults at the Portman clinic in order to maintain their safety.	Separate waiting areas for adults and for children and young people provided	New waiting room on the ground floor of the Portman clinic next to Admin manager office. The existing protocol will remain in place to ensure that children and young people are always accompanied by a responsible adult. Arrangements will be kept under regular review.	31 August 2016	<b>Director of Adult and Forensic Services</b> <u>Supported by:</u> Estates Projects Team	Work has already begun.
3	The trust must ensure that patients have personalised crisis plans that reflect their individual circumstances and ensure these are up to date. These must be kept where they can be found quickly by all staff.	Crisis Plan section on Carenotes assessment form implemented.  Evidence that patients have discussed the crisis plan and been given a copy.  Evidence that the patients GP and other referrers where appropriate, receive details of the crisis plan.	1. For all patients <18 years and >18 years assessment forms on Carenotes add a new section called "Crisis Plan", with following fields: "Crisis plan required" Yes/No If 'yes' then the following fields to be completed: "Have you discussed the crisis plan with the patient?" "Have you given a copy of the crisis plan to the patient?" "Have you sent a copy of the crisis plan to the GP/Referrer?"	30 September 2016	<b>Director of Adult and Forensic Services (AF) /Director Children, Young Adults and Families (CYAF)</b> <u>Supported by:</u> Informatics Manager and Associate Medical Director (Clinical Effectiveness)	

No.	CQC Requirements	Success criteria	Actions	Timescale	Lead	Update
			<ol style="list-style-type: none"> <li>2. Set up a crisis plan proforma on the Carenotes system for staff to use</li> <li>3. Deliver training and pilot with early adopter teams in AF and CYAF directorates</li> <li>4. Roll out training to all Trust teams</li> <li>5. Add use of crisis plans to team dashboards for regular monitoring of compliance</li> <li>6. Undertake audit of Trust compliance with crisis plans (target &gt;95%)</li> </ol>	<p>30 September 2016</p> <p>30 October 2016</p> <p>31 December 2016</p> <p>30 November 2016</p> <p>28 February 2017</p>		

## Board of Directors : June 2016

**Item :** 10

**Title :** Board and Chief Executive's Objectives for 2016/7

**Purpose:**

This paper covers draft objectives for the Board of Directors and Chief Executive for the period July 2016 to June 2017.

The Objectives are presented for approval.

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

*(delete where not applicable)*

- Strategy
- Performance
- Quality
- Enablers
- Governance

**For :** Discussion and agreement

**From :** Paul Burstow Chair  
Paul Jenkins Chief Executive

## Board and CE Objectives 2016/7

### 1. Introduction

- 1.1 This paper covers draft sets of objectives for the period of July 2016 to June 2017 for the Board of Directors (**Annex A**) and Chief Executive (**Annex B**). In previous years the Chief Executive's objectives (while linked to Board objectives) have been agreed separately but our view was that, this year, with a greater focus in the organisation on the delivery of our organisational strategy and medium term plan they were best agreed at the same time.

### 2. Key messages

- 2.1 Both set of objectives draw heavily on the medium term plan which the Board of Directors agreed at its meeting in November 2015.
- 2.2 There are some important additional points which reflect changes in the external environment since then. These include:
- The emergence of the STP process as the major driver for delivery of the 5 Year Forward View.
  - The clearer picture we now have of drivers for the development of the National Training Contract.
  - The outcomes of inspections by CQC and QAA.
- 2.3 The objectives reflect the wide range of challenges which the Trust continues to face and its ambitions to promote its distinctive psychosocial model of mental health as central to new models of care and to the training and education of health and care practitioners.
- 2.4 The draft Chief Executive objectives draw from the Board of Director objectives.

### 3. Monitoring

- 3.1 It is proposed that the Board should undertake a formal 6 monthly review of progress against its objectives, aligned to the proposed review of the Medium Term strategy in October 2016 and April 2017 Board of Directors meetings.

- 3.2 The Chief Executive will undertake to highlight progress against his objectives through his monthly report to the Board, linked to the review dates set out against each objective.

#### **4. Recommendations**

- 4.1 The Board of Directors is invited to consider and agree the proposed draft objectives for the Board of Directors and Chief Executive.

Paul Burstow & Paul Jenkins  
Chair & Chief Executive  
June 2016

## **Annex A - Board of Directors Objectives – 2016/7 - draft**

### **A Strategy**

#### **A1.**

Ensure Trust plays an active role in development and implementation of the mental health and wider strategy for North Central London as part of the Sustainability and Transformation Plan and identifies wider opportunities to support the transformation agenda in other parts of London and England.

#### **A2.**

Review and update Trust Medium Term Strategy and Board Assurance Framework.

#### **A3.**

Ensure the Trust meets the strategic opportunity to broaden the range and reach of its work in education, training and workforce transformation.

#### **A4.**

Ensure the Trust continues to contribute to and lead the development of evidence based new models of care through its work on i-Thrive, FDAC, FNP, and primary care mental health.

#### **A5.**

Promote and support Directorates and Teams in horizon scanning for opportunities to apply the Trust's psychoanalytical and psychosocial approaches to create new local and national service offerings and apply research and practice lessons to improve current service lines.

#### **A.6**

Oversee an expansion in the Trust's role in research including delivery of existing programmes and securing at least one new major research grant.

## **B Performance**

### **B.1**

Use dashboards to offer challenge and drive improvements in operational performance.

### **B.2**

Agree an updated medium term financial and sustainability strategy including plans for growth in clinical services and training and education and options for organisational partnerships.

### **B.3**

Oversee the delivery of the financial control total for 2016/7 and ensure all required financial duties are delivered.

### **B.4**

Maintain a financial sustainability risk rating of 3 or above (or equivalent under the new Provider Oversight Model due to be introduced).

### **B.5**

Oversee delivery of targets for training and education including targets set for the National Training Contract and targets for student recruitment.

### **B.6**

Oversee the significant further expansion of the GID service and review of the service model, to meet rising demand and manage waiting times within the increased funding available.

### **B.7**

Oversee work to improve the Trust's performance against its agreed Equalities objectives including action on the Workforce Race Equality Standard.

## **C Quality**

### **C.1**

Lead a quality engagement programme on how the Trust might move from “good” to “outstanding”.

### **C.2**

Finalise the Trust’s clinical quality strategy including supporting the adoption of a range of quality improvement methodologies.

### **C.3**

Oversee delivery of action plans for recommendations made by CQC and QAA.

### **C.4**

Drive developments in the Trust’s use of data for quality improvement including an increase in the collection and use of outcome monitoring data.

### **C.5**

Encourage the maintenance and development of existing services and strengthen relationships with commissioners.

### **C.6**

Oversee the further development of patient, carer and student engagement and their involvement in the development of the Trust’s work.



## **Enablers**

### **D.1**

Shape and agree a strategy for developing the Trust's national and international presence.

### **D.2**

Agree a Public Affairs strategy for the Trust and oversee work to raise the Trust's profile including follow through to Century Films project and the launch of an alumni programme.

### **D.3**

Oversee development/implementation of the Trust's IM&T strategy.

### **D.4**

Oversee development of the Trust's workforce and people strategy including a specific focus on staff wellbeing.

### **D.5**

Oversee the next stages of work on relocation leading to the production of a Full Business Case with a focus on creating an environment which meets the future needs of patients, carers, students and staff and enables the Trust's mission, values and ambitions.

## **Governance**

### **E.1**

Carry out a Governance review. Including reviewing the modus operandi of Board Committees, their nomenclature and function.



## Tavistock and Portman NHS Foundation Trust Chief Executive Objectives July 2016- June 2017

Area	Aim	Objective	Review Date
Strategy	Ensure the Trust plays an active role in the development and implementation of the NCL STP.	As SRO for the Mental Health Programme in the STP oversee development of robust plans for the transformation of mental health services and champion the wider contribution of mental health to the delivery of the STP.	April 2017
		Identify, with colleagues, the opportunities to promote the Trust's expertise as part of the wider development of STP plans in London and other parts of the country.	
		Provide leadership for the Trust's work on the development of evidence based new models of care such as Thrive, FDAC, FNP and primary care mental health.  Secure sustainable new models of funding for FDAC.	
Strategy	Give leadership to the programme to transform the Trust's training and education work in the light of changes to the National Training Contract.	Agree with HEE a strategic plan for the development of the National Training Contract over the next 2 years.  Ensure delivery of key milestones for the National Training Contract in 2016/7 including those relating to perinatal mental health.	April 2017

Area	Aim	Objective	Review Date
<b>Strategy</b>	Ensure Trust strategy and risk management frameworks remain up to date and effective	<p>Agree with the Board of Directors an updated Trust Medium Term Strategy and Board Assurance Framework</p> <p>Agree an updated medium term financial and sustainability strategy.</p>	October 2016/April 2017
<b>Strategy</b>	Oversee an expansion in the Trust's role in research	Ensure delivery of existing programmes and securing at least one new major research grant.	April 2017

Area	Aim	Objectives	Review Date
Performance	Ensure Trust maintains strong operational and financial performance	<p>Use dashboards and other approaches to strengthen the performance culture within the organisation.</p> <p>Deliver financial control total for 2016/7 and other required financial duties.</p> <p>Ensure the Trust maintains a financial sustainability risk rating (or equivalent under the new Provider Oversight Model) of 3 or above.</p> <p>Ensure delivery of targets for student recruitment.</p> <p>Oversee significant further expansion of GID service to meet rising demand and manage waiting times within the increased funding available.</p> <p>Drive improvements in the Trust's performance against its agreed Equalities objectives including progress on performance against the Workforce Race Equality Standard.</p>	April 2017

Area	Aim	Objective	Review Date
Quality	Champion the quality of the Trust's activities and our aspiration to move from "good" to "outstanding".	<p>Oversee engagement around and finalisation of the Trust's clinical quality strategy including the adoption of a range of quality improvement methodologies</p> <p>Ensure delivery of action plans to address recommendations made by CQC and QAA.</p> <p>Drive developments in the Trust's use of data for quality improvement including an increase in the collection and use of outcome monitoring data.</p> <p>Encourage the maintenance and development of existing services and support the development of strong relationships with commissioners.</p> <p>Ensure the further development of patient, carers and student engagement and their involvement in the development of the Trust's work.</p>	<p>October 2016</p> <p>April 2017</p>

Area	Aim	Objective	Review Date
Enablers	Ensure the Trust has the necessary plans and capacity to deliver its strategic objectives.	Ensure the development of a strategy for developing the Trust's national and international presence.	April 2017
		Support development of the Trust's Public Affairs strategy including follow through of the Century Films project and the launch of an alumni programme.	
		Ensure the development and implementation of the Trust IM&T strategy.	
		Ensure development of the Trust's workforce and people strategy including a specific focus on staff wellbeing.	
		Oversee the next stages of work on relocation leading to the production of a Full Business Case with a focus on creating an environment which meets the future needs of patients, carers, students and staff and enables the Trust's mission, values and ambitions.	
		Deliver successful changes in Executive team including appointment of new Deputy Chief Executive and Director of Nursing.	

Area	Aim	Objective	Review Date
Governance	Support effective Governance in the organisation.	Support a Governance review including reviewing the modus operandi of Board Committees, their nomenclature and function.  Ensure ongoing effective support to the Board of Directors and Council of Governors in the carrying out of their duties.	June 2017



## Board of Directors : June 2016

**Item :** 11

**Title :** Finance and Performance Report

**Summary:**

After the second month of the new year, a surplus of £579k is reported before restructuring costs, £347k above the revised planned surplus of £232k.

We aim to have a surplus of £800k by the end of the year after the control total was revised due to additional funding.

Analysis by service line is not provided this month.

The cash balance at 31 May was £4,582k.

**For :** Information.

**From :** Simon Young, Director of Finance

## 1. **External Assessments: NHS Improvement**

- 1.1 NHS Improvement's assessment on Quarter 4 is awaited. It is expected that our Financial Sustainability Risk Rating (FSRR) will remain at 4, and the rating for governance remain green.
- 1.2 A revised 2016/17 Plan will be submitted to NHS Improvement on 29 June. The Plan should lead to an FSRR of 4. The two changes from the original plan are:
  - 1.2.1 The Trust will receive an allocation of £500k from the "targeted element" of the Sustainability and Transformation Fund.
  - 1.2.2 The Trust's control total – i.e. our required surplus – is increased by £500k to £800k. There is therefore no funding available for additional expenditure.
- 1.3 These two changes were notified to Board members before they were agreed.
- 1.4 The return for May was submitted on 15 June with an FSRR of 4.
- 1.5 NHS Improvement have announced that the present Risk Assessment Framework, which includes the FSRR, will be replaced during 2016/17 by a new Provider Oversight Model which will apply both to Trusts and Foundation Trusts. Details are not yet available.

## 2. **Finance**

- 2.1 **Income and Expenditure 2016/17** (Appendices A and B)
  - 2.1.1 The budget has been revised to reflect the changes outlined in 1.2 above. The additional £500k income is included in line 1 on Appendices A and B, clinical income; 2/12 of it has been included in the month 2 cumulative figures, budget and actual.
  - 2.1.2 After May the trust is reporting a surplus of £496k before restructuring costs, £347k above the revised budget. Income is £46k below budget, and expenditure £381k below budget.
  - 2.1.3 The income shortfall to date of £46k is mainly due to Training and Consultancy:
    - 2.1.3.1 Training is £48k below plan due to LCPPD income deferred to reflect activity in a later period.
    - 2.1.3.2 Consultancy Income is £35k below target mainly due to TC Income £36k below budget. This has been offset by an expenditure under spend.
    - 2.1.3.3 Clinical Income is £29k above budget, Adult and Forensic Services income is £10k under budget due to a shortfall on NPA income which is offset by a GIDU over performance payment from 2015/16.

- 2.1.4 The favourable position of £381k on the expenditure budget was due mainly to the under spends of £129k in GIDU, £95k in Portfolios and £75k in Primary Care due to vacancies and lower than expected non pay costs.
- 2.1.5 There are currently 578 WTE funded posts in May and 544 were occupied which included 43.5 bank and agency staff. Additional posts will be added as the increased funding for GIDS is phased in later in the year.
- 2.1.6 Contingency reserve was reduced to £22k due to a number of non-recurrent projects being funded.
- 2.1.7 Though the surplus is ahead of plan after two months, some of this may be due to phasing of costs; and income for the remainder of the year is not all secured. A forecast for the year will be included in next month's report; and is not currently expected to be significantly different from the revised plan.
- 2.1.8 The FSRR calculation excludes restructuring costs. However, it is currently expected that achievement of the control total will be measured *after* restructuring costs. We will therefore comment mainly on the surplus after restructuring costs in future reports.

## 2.2 Cash Flow

- 2.2.1 The actual cash balance at 31 May was £4,582k this is a decrease of £488k on last month but is above Plan. The decreased balance was mainly due to the quarterly payment in advance from Health Education England. The balance is above Plan due to lower than planned capital expenditure in addition to the higher than planned surplus.

## 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 May we achieved 93% (by number) for all invoices. The cumulative total for the year was 93% by number and 94% by value. In line with previous Board discussions, this is considered satisfactory; Finance will continue to work with colleagues to avoid delays as far as possible, but no additional action is planned.

## 2.4 Capital Expenditure

- 2.4.1 The capital budget for the year is £2,480k in total which includes £1,100k for the Relocation Project up to Full Business Case.
- 2.4.2 Up to 31 May, expenditure on capital projects was £92k. This included £65k on IM&T and £27k on the Relocation project. The expenditure for the year is forecast to be on budget.

2.4.3 The Relocation project cumulative capital costs up to 31 March 2016 were £575k but this was reduced to £112k on the advice of our external auditors with the balance being charged to revenue. (These figures exclude £76k for the portacabin extension, which has been capitalised as a separate asset).

Capital Projects 2016/17	Budget 2016/17	Actual YTD May 2016	Forecast 2016/17	Spend 2014/15	Spend 2015/16	Total Project	
						Spend to date	Budget to date
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Estates General	190		190			-	190
Relocation Project up to OBC	-	-	-		50	50	50
Relocation Project up to FBC	1,100	27	1,100		62	89	1,162
<b>Total Estates</b>	<b>1,290</b>	<b>27</b>	<b>1,290</b>	<b>-</b>	<b>112</b>	<b>139</b>	<b>1,402</b>
IM&T Infrastructure	300	65	300			65	300
IM&T Project Posts	125		125			-	125
IM&T Developments	390		390			-	390
IDCR	50		50	389	268	657	707
Student Info. Mgmt System	325		325			-	325
<b>Total IT</b>	<b>1,190</b>	<b>65</b>	<b>1,190</b>	<b>389</b>	<b>268</b>	<b>722</b>	<b>1,847</b>
<b>Total Capital Programme</b>	<b>2,480</b>	<b>92</b>	<b>2,480</b>	<b>389</b>	<b>380</b>	<b>861</b>	<b>3,249</b>

### 3. Patient Services

#### 3.1 Activity and Income

- 3.1.1 All the major contracts have now been agreed. Total contracted income for the year is expected to be in line with budget. Part of the budgeted income for the year is dependent on meeting our CQUIN<sup>1</sup> targets agreed with commissioners and achievement is reviewed on a quarterly basis.
- 3.1.2 After two months the income budget for named patient agreements (NPAs) is £13k below plan.
- 3.1.3 Day Unit income budget was increased by £215k to £1,054k in 2016/17 and is on target after May.

### 4. Consultancy

- 4.1 TC income was £108k at the end of May, compared to the phased budget of £144k. The expenditure budget was under spent by £53k. Our forecast for the year assumes at present that the budget is achieved.
- 4.2 Departmental consultancy is also £1k below budget after two months.

<sup>1</sup> Commissioning for Quality and Innovation

## 5. Training

- 5.1 Training income is £48k below budget after May, with the shortfall mainly on LCPPD income due to a deferral and CP Trainees due to lower numbers than expected. Education and training expenditure was £137k below budget spread across the service.
- 5.2 The key area of uncertainty is, as always, fee income from students and sponsors for the academic year starting in October. Recruitment to date is reviewed each month by the Training and Education Programme Board

Carl Doherty  
Deputy Director of Finance  
21 June 2016



THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST								
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2016-17								
All figures £000			May-16			CUMULATIVE		
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	OPENING BUDGET	REVISED BUDGET
<b>INCOME</b>								
1 CENTRAL CLINICAL INCOME	762	743	(19)	1,389	1,385	(4)	7,397	8,036
2 CYAF CLINICAL INCOME	502	514	12	973	998	24	5,490	5,527
3 AFS CLINICAL INCOME	615	623	7	1,252	1,241	(10)	4,127	4,947
4 GENDER IDENTITY	415	414	(1)	830	848	19	3,487	4,978
5 HEALTH EDUCATION ENGLAND TRAINING CONTRACT	605	605	0	1,209	1,209	0	7,254	7,254
6 CHILD PSYCHOTHERAPY TRAINEES	150	170	20	349	340	(9)	2,391	2,342
7 JUNIOR MEDICAL STAFF	70	71	1	140	146	6	838	838
8 POSTGRADUATE MED & DENT'L EDUC	7	2	(5)	15	4	(11)	88	88
9 PORTFOLIO FEE INCOME	411	467	55	823	864	41	6,072	5,859
10 DET TRAINING FEES & ACADEMIC INCOME	52	8	(44)	104	27	(77)	823	1,036
11 FAMILY NURSE PARTNERSHIP	257	247	(10)	514	514	0	3,274	3,086
12 TC INCOME	72	65	(7)	144	108	(36)	863	863
13 CONSULTANCY INCOME CYAF	4	6	2	8	11	3	48	48
14 CONSULTANCY INCOME AFS	16	18	2	32	31	(2)	193	193
15 R&D	4	4	0	9	9	0	53	153
16 OTHER INCOME	27	34	7	78	86	8	571	536
<b>TOTAL INCOME</b>	<b>3,970</b>	<b>3,989</b>	<b>19</b>	<b>7,869</b>	<b>7,823</b>	<b>(46)</b>	<b>42,967</b>	<b>45,783</b>
<b>EXPENDITURE</b>								
17 COMPLEX NEEDS	135	136	(1)	270	253	16	1,618	1,618
18 PRIMARY CARE	434	404	30	863	788	75	1,885	2,658
19 PORTMAN CLINIC	120	108	11	239	224	16	1,380	1,378
20 GENDER IDENTITY	265	190	75	529	400	129	2,795	4,027
21 DEV PSYCHOTHERAPY UNIT	10	11	(1)	21	19	2	124	124
22 NON CAMDEN CAMHS	482	510	(28)	933	967	(34)	5,273	5,329
23 CAMDEN CAMHS	403	386	18	804	780	24	4,803	4,822
24 CHILD & FAMILY GENERAL	62	66	(4)	120	128	(8)	699	720
25 FAMILY NURSE PARTNERSHIP	204	192	12	406	387	19	2,893	2,706
26 JUNIOR MEDICAL STAFF	83	68	15	166	137	29	993	993
27 NHS LONDON FUNDED CP TRAINEES	148	179	(31)	346	353	(7)	2,370	2,321
28 TAVISTOCK SESSIONAL CP TRAINEES	2	1	0	3	2	1	18	18
29 FLEXIBLE TRAINEE DOCTORS & PGMDE	20	25	(5)	40	54	(14)	242	242
30 EDUCATION & TRAINING	259	251	8	515	504	12	3,598	3,907
31 VISITING LECTURER FEES	168	147	21	253	250	3	1,229	1,215
32 CYAF EDUCATION & TRAINING	0	(1)	1	(0)	(0)	(0)	(0)	0
33 ADULT EDUCATION & TRAINING	(0)	(0)	(0)	0	(0)	1	(0)	(1)
32 PORTFOLIOS	211	155	55	424	329	95	2,797	2,547
33 TC	63	28	34	120	67	53	687	687
34 R&D	13	14	(1)	26	29	(3)	155	293
35 ESTATES DEPT	158	186	(27)	329	353	(24)	2,045	1,972
36 FINANCE, ICT & INFORMATICS	218	217	1	431	422	9	2,562	2,623
37 TRUST BOARD, CEO, DIRECTOR, GOVERNS & PPI	123	122	1	246	244	2	1,458	1,472
38 COMMERCIAL DIRECTORATE	39	37	1	77	76	1	464	504
39 HUMAN RESOURCES	68	72	(4)	121	135	(14)	642	642
40 CLINICAL GOVERNANCE	37	42	(5)	103	107	(4)	789	637
41 CEA CONTRIBUTION	10	8	2	20	18	2	117	117
42 DEPRECIATION & AMORTISATION	63	61	2	133	122	11	850	815
43 PRODUCTIVITY SAVINGS	0	0	0	0	0	0	(441)	0
44 CENTRAL RESERVES	2	0	2	4	0	4	150	22
<b>TOTAL EXPENDITURE</b>	<b>3,795</b>	<b>3,615</b>	<b>180</b>	<b>7,541</b>	<b>7,149</b>	<b>392</b>	<b>42,195</b>	<b>44,411</b>
<b>OPERATING SURPLUS/(DEFICIT)</b>	<b>175</b>	<b>374</b>	<b>199</b>	<b>328</b>	<b>674</b>	<b>346</b>	<b>772</b>	<b>1,372</b>
45 INTEREST RECEIVABLE	1	1	1	1	2	1	8	8
46 DIVIDEND ON PDC	(57)	(57)	0	(97)	(97)	0	(480)	(580)
<b>SURPLUS/(DEFICIT)</b>	<b>119</b>	<b>319</b>	<b>200</b>	<b>232</b>	<b>579</b>	<b>347</b>	<b>300</b>	<b>800</b>
47 RESTRUCTURING COSTS	0	57	(57)	0	61	(61)	0	0
<b>SURPLUS/(DEFICIT) AFTER RESTRUCTURING</b>	<b>119</b>	<b>262</b>	<b>143</b>	<b>232</b>	<b>518</b>	<b>286</b>	<b>300</b>	<b>800</b>





## Board of Directors : June 2016

**Item :** 12

**Title :** Department of Education and Training Board Report

**Purpose:**

To update on issues in the Education & Training Service Line.

To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 13<sup>th</sup> June 2016.

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

*(delete where not applicable)*

- Quality
- Risk
- Finance
- Communications

**For :** Noting

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

## **Department of Education and Training Board Report**

### **1. Introduction**

- 1.1 The Training and Education Programme Management Board met on 13<sup>th</sup> June 2016 and discussed the issues presented in this report.

### **2. Visiting Lecturers Review**

- 2.1 Brian Rock provided a brief update on the review of Visiting Lecturers outlining the steps that would be taken to progress the review at this stage.
- 2.2 It was agreed that the proposal would return to the September programme board for discussion before coming back to the Board.

### **3. Education Funding Reforms**

- 3.1 Catrin Bradley, Head of the Child Psychotherapy Programme attended for this item.
- 3.2 The programme board discussed what had been happening in this area. At this stage the possible implications for the funding of Child & Adolescent Psychotherapy training remain unclear and there are differing views and suggestions as to what the outcome of the review of funding may be.
- 3.3 An internal review group has been set up to consider the Trust's options and how this training may be delivered in the future should the funding be reduced. It was agreed that the potential of degree apprenticeships as a model for this would be discussed by the group.
- 3.4 The programme board agreed that the Trust should make a formal response to the review that would, firstly, set out the case for the role played by the profession in delivering to the needs of children and families, and, secondly, emphasise that any training programme needed to be funded to support diversity in the workforce. It would also make clear that we would want to be involved in taking this training forward.

### **4. QAA Review**

- 4.1 Elisa Reyes-Simpson updated the programme board on the outcome of the QAA Review. She confirmed that the draft report had been received and that the Trust needed to address any issues of accuracy. Once this is complete the final report will be sent on 18<sup>th</sup> July.

- 4.2 The outcome of the review is positive with a number of commendations and areas of good practice highlighted. In addition there were some recommendations which need to be implemented.

## **5. Recruitment Update**

- 5.1 Laure Thomas provided an update on student recruitment highlights of which were;
  - 5.1.1 756 applications started with 445 complete
  - 5.1.2 194 offers made of which 154 have been accepted
  - 5.1.3 We continue to receive applications at a rate of around 30 a week
  - 5.1.4 It was acknowledged that recruitment to target is not steady across all courses with the Psychoanalytic Clinical portfolio doing particularly well
- 5.2 Marketing events continue with course specific open evenings well attended and 70 signed up for the Saturday open day in July.
- 5.3 Those with incomplete applications are being followed up and a number of conversion events including the open day, webinars and taster sessions being planned.
- 5.4 An even more up to date recruitment position is reflected in Appendix 1 with a comparison to the same point in the last financial year.

## **6. National Contract and Strategy**

- 6.1 Paul Jenkins advised the programme board that a task and finish group had been set up with himself and Brian as well as colleagues from Health Education England to progress the work in relation to the national contract. There is also an internal Trust group working on this.
- 6.2 The group discussed the implications of changes to the national contract in particular financially and in relation to how we develop and promote our courses. It was made clear that we must be shown to be embracing change and working to find new ways of working.
- 6.3 Karen Tanner updated the group on the various strands of work underway with current and potential regional partners including Birmingham, Bristol, Pen Green, Corby and Stroud.
- 6.4 It was agreed that there would be more done to promote our regional offer in next year's prospectus, however it should be noted that our national centres and partners are being given more prominence on the new website, which will be launched in July.

## **7. SIMS Project Update**

- 7.1 BR updated the programme board on the work of the SIMS project
- 7.2 There have been improvements in the relationship with the team at TRIBAL with some changes to their staffing. The work to agree a contract is well underway.
- 7.3 The programme board were made aware of the strain the development of the software and delays in roll out was placing on staff across the directorate and advised that steps were being taken to accommodate this particularly in relation to course administration.

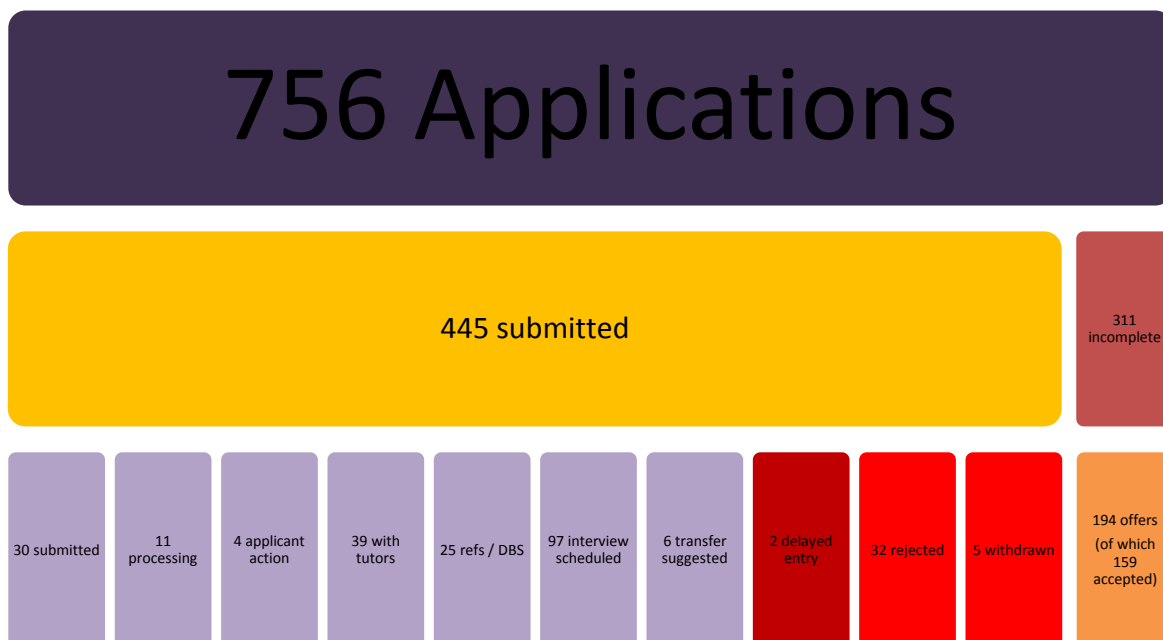
**Brian Rock**

**Director of Education and Training/Dean of Postgraduate Studies**

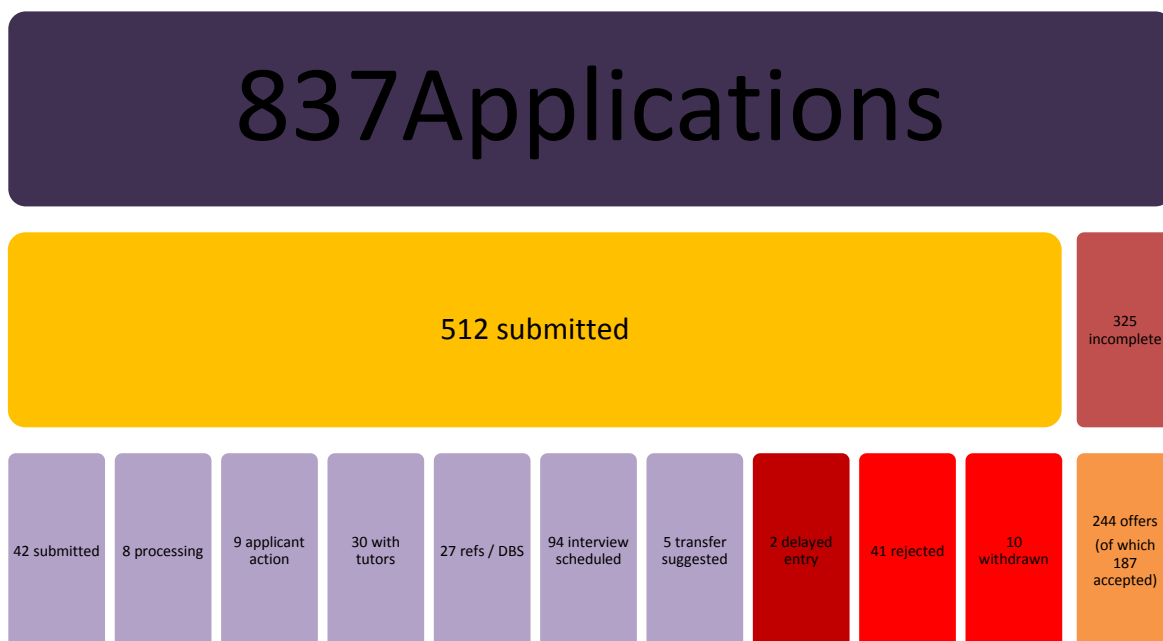
**15<sup>th</sup> June 2016**

## Appendix 1: Recruitment comparator as at 19 June 2016

The numbers as at 6<sup>th</sup> June 2016 (presented to TEPMB 13 June 2016:



The numbers as at 19<sup>th</sup> June 2016:



This means in the last 13 days:

- 67 applications were submitted
- 81 applications were started
- 50 offers were made
- 28 offers were accepted



## Board of Directors : June 2016

**Item :** 13

**Title :** Annual Safeguarding Report 2016

**Purpose:**

This paper provides an update for the Board of Directors about safeguarding of children, young people and adults at risk in the Tavistock & Portman NHS Foundation Trust in the context of local and national developments.

This report includes information about both safeguarding children and adults at risk.

This report has been reviewed by the Management Team.

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

- Patient / User Experience
- Risk
- Quality

**For :** Discussion and noting

**From:** Rob Senior, Medical Director, Sarah Helps, safeguarding adults at risk lead, and Sonia Appleby, named professional for child protection.

## **SAFEGUARDING CHILDRENS' REPORT**

### **1. Introduction**

Safeguarding children within the Trust is a central component of patient safety, it encompasses the need for multi-agency and multi-professional networks to respond to safeguarding and child protection concerns in both the delivery and the commissioning of services.

### **2. Legislative Changes**

In the last year, there have been three changes in the law impacting on the work of safeguarding children which are described later in this paper:

(a) the Counter-Terrorism and Security Act 2015;

(b) s.74 & 76 of the Serious Crime Act 2015.

### **3. External Monitoring**

Safeguarding Children within the Trust is currently externally monitored by Camden Safeguarding Children Board, (CSCB); Camden Commissioners (local authority and health); Camden Designated Professionals, the Health and Social Care Information Centre (HSCIC). Our regulators, the CQC and Ofsted continue to prioritise safeguarding of children in their inspections of Local Authorities, Schools and Health and Care providers.

### **4. Delivery of Services and Some Challenges**

Camden children's services, including CAMHS, are currently being restructured to create a focus on early help and building resilience within service users and the workforce. The change programme is transformational in scale within a significant shift in being able to deliver 'joined up', evidence-based interventions.

The tide of change is echoed across all services indicative of the need to manage complex and challenging cases in the wake of raised statutory thresholds.

Some staff have reported to safeguarding leads the pressure and impact of the work, which can be distressing and even traumatic.

### **5. Assurance**

Following the publication of the Lampard Report, co-authored by Kate Lampard and Ed Marsden, Commissioners required the Trust to be compliant with eleven recommendations. The report was submitted in Q2 2015/2016 and will be followed up during the safeguarding work programme for this year.



Safeguarding practice regarding those patients subject to child protection plans (CPPs) are scrutinised by the Designated Nurse. In addition, both the Named Doctor and Named Professional receive external supervision provided by the Designated Professionals

Safeguarding children audits have been challenging to complete largely due to problems associated with the migration to CareNotes.

The children safeguarding lead now attends the Patient Safety work stream.

In Quarter 3, a Safeguarding Supervision Forum was instigated for team managers to attend on a termly basis to discuss their work specific to the supervision and management of safeguarding children.

A safeguarding supervision pro forma will be used via CareNotes to evidence supervision regarding all Looked After Children (LAC); CPP and Children in Need (CIN) cases.

Finally, the safeguarding work plan is monitored through the Safeguarding Children and Adults Committee with oversight from the Patient Safety Committee.

## **6. CQC Inspection**

There were no specific recommendations following the recent CQC inspection regarding the management of those children who are identified as being vulnerable: LAC; CPP and CIN.

The requirement for the Portman Clinic to provide a separate waiting area for under 18s attending forensic services was seen as a safeguarding issue.

## **7. CareNotes**

CareNotes reports are a continuing challenge requiring careful scrutiny of the data in respect of safeguarding children to ensure 'fields' are opened and closed and checked for accuracy. The safeguarding team is working directly with the Quality Team to refine the output of data reports.

## **8. Mandatory Reporting**

Following the publication of the Rotherham Inquiry Report, (2013); the Government has been consulting regarding the efficacy of mandatory reporting. At the time of writing this report, there is not a definitive position.

However, by dint of the Serious Crime Act 2015 (s.74), which came into force in October 2015, all regulated health and social care professionals must report to the police if an under 18 discloses that they have been subject to FGM or a FGM procedure is observed. Of note, health and social care

professionals, who fail to report, will have their 'fitness to practice' called into question with their registration body

The construct of mandatory reporting and the sanctions for non-compliance is worrying for staff particularly in circumstances of historical abuse; whether the perpetrator has been disclosed and in circumstances where the child or young person is not a patient. The Safeguarding Procedures will be updated to clarify the processes to manage historical abuse.

**9. Child Sexual Exploitation**

The CSCB working programme includes maintaining a focus on child sexual exploitation (CSE) and associated intra-familial sexual abuse (CSA).

**10. PREVENT**

The Counter-Terrorism and Security Act 2015 which came into force on 1<sup>st</sup> July 2015, places a duty on specified authorities to 'have due regard' to the need to prevent people from being drawn into terrorism. Section 26 deems the Trust is required, known as a Prevent Duty, to inform local authorities of persons who are known or suspected of being vulnerable to radicalisation. PREVENT training figures for Q4, 2015/16 are set out in the following Adult section of this report.

**11. Domestic Abuse**

The Serious Crime Act s.76 came into force on 29<sup>th</sup> December 2015 making controlling and coercive behaviour a criminal offence.

Prior to this financial year, the Trust workforce received basic information about domestic abuse, however, the publication of NICE guidance 2016 regarding domestic abuse has enabled a training template to increase knowledge, skills and competencies.

**12. CQUIN 2016/2017**

There are quarterly expectations to deliver domestic abuse training within the safeguarding children framework.

**13. Safeguarding Children Training**

To improve the efficient delivery of resources for staff requiring Level 2 safeguarding training, these clinicians will be subsumed into Level 3 trainings.

## Safeguarding Children Training Rates for 2015/2016:

**Level 1 Safeguarding Children Training**

Quarter 1 2015/2016	Total Staff requiring Level 1  505	Number of staff in date with appropriate training 468	Rate  93%
Quarter 2 2015/2016	533	506	94%
Quarter 3 2015/2016	548	500	91%
Quarter 4 2015/2016	546	496	91%

**Level 2 Safeguarding Children Training**

Quarter 1 2015/2016	Total Staff requiring Level 1  45	Number of staff in date with appropriate training 44	Rate  98%
Quarter 2 2015/2016	44	43	98%
Quarter 3 2015/2016	39	38	97%
Quarter 4 2015/2016	36	33	92%

**Level 3 Safeguarding Children Training**

Quarter 1 2015/2016	Total Staff requiring Level 1  308	Number of staff in date with appropriate training 272	Rate  94%
Quarter 2 2015/2016	305	284	93%
Quarter 3 2015/2016	317	285	90%
Quarter 4 2015/2016	326	295	90%

**14. Numbers of children subject to CPPs 2015/2016**

Camden & other services <18 n= 84

*Of the above 84 cases, some were identified wherein the CPP event may have predated the referral to our services.*

**15. Number of Looked After Children 2015/2016**

LAC n= 44

**16. Number of Children known to Trust and Children's Social Care**

n= 142

**17. Allocation of Work**

All cases of CPP, LAC and CIN are allocated to a named HCP.

**18. Safeguarding Alerts**

In the last year, the safeguarding team has embedded centrally recording safeguarding alerts via the Safeguarding Alerts Form (SAF).

The following is a quarterly analysis of the alerts received:

<b>Children Safeguarding Alerts</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
Section 17 referrals	3	2	7*	5
Section 47 referrals	8	5	12**	9
Escalated Cases	3		5	6
Facilitated service user to self-report	3			
Child subject to extant CPP but s.47 instigated		1		
Adult referred to the police following allegations of historical childhood sexual abuse (perpetrator known)		1		
Trust staff member mentioned via social media regarding an on-going case of satanic abuse		1		
<b>Total Safeguarding</b>	<b>17</b>	<b>10</b>	<b>24</b>	<b>20</b>

<b>Alerts</b>				
<b>Additional information</b>				
*Child already subject to a CIN Plan			1	
** Child already subject to a CP Plan			1	
FGM disclosure via the Community Paediatrician under s.17			1	
Escalated cases			5 including 1 s.47 referral	6 (1 case referred to LADO; 1 case referred to the GP regarding suicide risk; 1 case regarding the professional conduct of a CPC Chair; 1 case should have been referred to the LADO by a 3 <sup>rd</sup> party; 1 case escalated to Lambeth and one case escalated to Bucks CSC.
Domestic Violence Disclosure			1	1
Consultations	-	-	-	41
Missing Child/ren				1

It is thought likely that there are far more cases of domestic abuse within the Trust (undisclosed or unrecognized), and it is envisaged with increased skills and competencies training, there will be improved reporting.

Similarly, it is planned that monthly reports by Quarter 2, will indicate segmented areas of risk and abuse.

**Sonia Appleby, named professional for safeguarding children**

**Rob Senior, named doctor**

## **SAFEGUARDING ADULTS AT RISK**

### **1. Introduction**

- 1.1 The national context for adult safeguarding continues to grow. Safeguarding is now seen as encompassing a wider brief than ever before and adult safeguarding concerns now have a similar level of importance as those regarding children. This is particularly the case in light of the abuses that adults, especially vulnerable adults, have been revealed to suffer in recent years.
- 1.2 Dr Sarah Helps (0.05 wte) have been in the role of adult safeguarding lead since the start of 2015. She attended the NHS Executive training course for adult safeguarding leads, to enable her to develop an overview of the work and the role. She has maintained her professional development in the area of safeguarding, most recently by attending training regarding the complex interweave between adult mental health difficulties, and self-neglect. She regularly attends Camden Adult Safeguarding Board meetings.

### **2. Work involving our patients**

#### **2.1 Adult safeguarding consultations and alerts**

Staff are increasingly seeking consultation on adult safeguarding matters. Currently Dr Helps provides about two consultations a month. The number of adult safeguarding alerts to the local authority has continued to slowly increase. Of note, these alerts often highlight complex boundary discussions about whether the issues relate to adult safeguarding or to adult mental health.

### **3. Work to support staff**

#### **3.1 Trust developments in recording adult safeguarding issues**

The new adult safeguarding policy was launched in January 2016, to take account of the changes within the Care Act.

As part of this a new form has been added to Care Notes to enable capture of data regarding adult safeguarding alerts, in a way that can be easily gathered for the purposes of internal and external reporting.

#### **3.2 We continue to deliver Level 1 training at INSET and Induction.**

There is now a mandatory responsibility to train all staff with professional and organisational responsibility for safeguarding adults to a higher level. Bespoke training has been piloted with three teams / staff groups to date. Work with HR is required to identify the number of staff who require level 2 and 3 adult safeguarding training and to set out a framework and associated costs for the delivering of this training.

In line with CQUINs, work is also required to develop staff training in relation to domestic violence and abuse. This will happen in conjunction with the children's safeguarding lead.

As part of the preparation to deliver further training, a snapshot audit of staff's knowledge and competence was completed. The results (see appendix 1) have highlighted a general confidence in relation to adult safeguarding issues and need for further training on sharing information across agencies, how to respond in an acute situation, regular reminders about where to find information on policies and procedures and how to work collaboratively with a patient if they decline support to keep themselves safe when safeguarding risk has been identified.

### 3.3 MCA and DoLs

MCA and DoLs training continues to be offered to all staff led by Dr Caroline McKenna.

A recent re-audit of Care Notes data indicated that staff are more regularly completing the initial assessment forms to indicate whether or not a patient has the capacity to consent to their own treatment.

Of note, no patients have to date been identified as lacking capacity to consent to their own treatment. Given our clinical population, we would not expect a high number of patients to fall into this category, but it is surprising that no patients have been identified or even that no detailed assessments of capacity have been required. Further work is therefore needed to ensure that staff are sufficiently able to identify patients where further exploration of their capacity is required.

### 3.4 PREVENT

From Q1 2016, two levels of training have been added to the Trust's mandatory training programme; Basic Prevent awareness training for all staff at INSET and Inductions and a Workshop to Raise Awareness of Prevent (WRAP) rolled out to all staff currently receiving level 2 & 3 safeguarding training. Training figures are reported quarterly to NHS England and our local Prevent commissioners.

**Below are the Q4, 2015/16 Prevent training figures**

Total number of staff who require Basic Prevent Training (BPT)	Total number of staff who are up to date with Basic Prevent Training (BPT)	Number of staff who received Basic Prevent Training (BPT) this quarter	Total number of staff who require a Workshop to Raise Awareness of Prevent (WRAP)	Number of Staff who attended WRAP this quarter	Total number of staff who have attended WRAP to date
505	365	30	50	0	2

#### **4. Priorities for 2016-2017**

Based on the Adult Safeguarding self-audit (a voluntary audit, results of which are compiled by the local adult safeguarding board), the following targets have been set for 2016-2017:

- Development of recording and monitoring of supervision regarding adult safeguarding
- Further audit: are we accurately assessing, monitoring and recording mental capacity?
- Involve service-users in discussions about adult safeguarding policy and procedures
- Ensure board have up to date information on SARs/ DHRs
- Develop easy-read materials regarding adult safeguarding

**Dr Sarah Helps, adult safeguarding lead**

**Dr Rob Senior, Medical Director**



## Appendix 1: Safeguarding Questionnaire Results

	Clinical Staff			Non-Clinical Staff		
	No	Somewhat	Yes	No	Somewhat	Yes
<b>Do you understand your role in safeguarding adults</b>	0	5	19	1	4	18
<b>Can you recognise an adult potentially in need of safeguarding and take some action?</b>	0	5	19	5	11	8
<b>Do you understand the trust procedures for making a safeguarding alert?</b>	1	8	15	1	10	11
<b>Do you feel confident in knowing where to find policy, procedures and legislation that supports safeguarding adult's activity?</b>	0	14	10	3	4	16
<b>Can you develop a conversation with patients about how you can help to keep them safe?</b>	0	2	22			
<b>Do you understand when to use emergency systems e.g. the police, to safeguard adults?</b>	1	8	15			
<b>Do you know how to maintain accurate, complete and up to date clinical records regarding safeguarding concerns?</b>	0	5	19			
<b>Are you clear about what to do if you are worried about an adult at risk?</b>	0	7	17			
<b>Do you know how and when to share information with other agencies if you have concerns?</b>	1	12	11			
<b>Do you know what to do if a person declines an offer to make a safeguarding alert on their behalf?</b>	5	11	8			
<b>Total</b>	8	72	155			



## Board of Directors: June 2016

**Item :** 14

**Title :** NHS Statement of Support for Tobacco Control

**Purpose:**

This report outlines the background to the NHS Statement of Support for Tobacco control and proposes that the Trust makes a public commitment of support through signing the Statement.

The ways in which we are currently fulfilling the conditions of the Statement are briefly described.

The Board are asked to approve signing of the Statement.

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

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

**For :** Approval

**From :** Timothy Quinn, Physical Health Specialist Nurse

## NHS Statement of Support for Tobacco Control

### 1. Introduction

- 1.1 The Statement of Support for Tobacco Control is about making a broad (and public) commitment to tobacco control and then using it as a lever to promote smoking cessation. There are no solid obligations or extra costs to the Trust.
- 1.2 In support of the NHS Statement of Support on Tobacco Control we commit to:
- Continue to actively support work at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
  - Work with our partners and local communities to address the causes and impacts of tobacco use, according to NICE guidance;
  - Play our role in tackling smoking through appropriate interventions such as 'Make Every Contact Count';
  - Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition.

### 2. Background

- 2.1 The Smokefree Action Coalition is an alliance of over 250 organisations including medical royal colleges, the British Medical Association, the Trading Standards Institute, the Chartered Institute of Environmental Health, the Faculty of Public Health, the Association of Directors of Public Health and ASH.

The Coalition has engaged with Government on a wide range of tobacco control issues, including the introduction of standardised ("plain") packaging for tobacco products. CCGs and NHS trusts can be a voice for the health of local people on the national platform. More information is available through Emily James at ASH, which provides the secretariat for the SFAC.

- 2.2 Smoking is the single greatest cause of premature death and disease in our communities.

In England alone, more than 80,000 people die from smoking-related diseases each year. This is more than the next six causes of premature death put together, including obesity, alcohol and illegal drugs.

Smoking accounts for one third of all deaths from respiratory disease, over one quarter of all deaths from cancer and about one seventh of all deaths from heart disease. An average smoker can expect to lose 10 years of life as a result of their habit.

Health interventions are also less successful for smokers than non-smokers. If hospitalised, smokers are more likely to require longer stays and need intensive care after surgery. They also have an increased risk of emergency readmission after discharge. This has an inevitable cost to society and to the NHS.

2.3 The Tavistock and Portman NHS Foundation Trust is committed to improving the physical health of our patients, staff and carers. We recognise that patients with mental health problems have a reduced life expectancy of 10 - 20 years. We therefore wish to acknowledge and agree with the NHS Statement of Support for Tobacco Control.

2.4 The NHS Statement of Support for Tobacco Control (see Appendix 1).

### 3. Current Actions to meet the Conditions of the Statement

3.1 The Tavistock and Portman NHS Foundation Trust are currently meeting the conditions of the statement through the following actions:

- Having appointed a Physical Health Specialist Nurse delivering smoking cessation/harm reduction clinical interventions.
- Promoting/hosting smoking cessation clinic with our local partners.
- Developing and delivering the Living Well Programme for patients, carers and staff.
- The Trust also has a specific CQUIN relating to improving physical health and smoking cessation.
- The Physical Health Specialist Nurse has joined the Smoke Free Action Coalition (SFAC) and the British Thoracic Society.

3.2 Our Physical Health Specialist Nurse, Tim Quinn, discussed our current actions on smoking with Emily James at ASH. She confirmed on 8<sup>th</sup> June 2016 that our actions are sufficient for us to be able to sign up to the NHS Statement of Support for Tobacco Control. She has informed the Trust that we are making the necessary commitments, 'nothing is compulsory'. We have received further guidelines/suggestions from ASH that could be helpful.

**Tim Quinn**  
**Physical Health Specialist Nurse**

8<sup>th</sup> June 2016

## Appendix 1

# NHS Statement of Support for Tobacco Control

### We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people; two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

### We welcome the:

- Commitment from local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Opportunity to support partnership working with local government as part of delivering local tobacco control in line with NICE guidance;
- Endorsement of this statement by central government, Public Health England, NHS England and others.

### We, ....., commit from the date ..... to:

- Continue to actively support work at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reducing the harm caused by tobacco;
- Work with our partners and local communities to address the causes and impacts of tobacco use, according to NICE guidance on smoking and tobacco control;
- Play our role in tackling smoking through appropriate interventions such as 'Make Every Contact Count';
- Protect our work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities; and
- Participate in local and regional networks for support.

### Signatories

Local NHS leader

Chair of the Health and Wellbeing Board

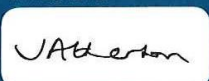
Director of Public Health

### Endorsed by

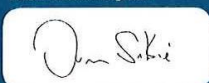
Jane Ellison,  
Public Health Minister,  
Department of Health



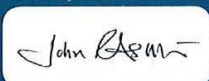
Dr Janet Atherton,  
President, Association of Directors  
of Public Health



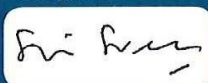
Duncan Selbie,  
Chief Executive,  
Public Health England



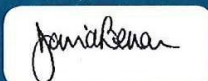
Professor John Ashton CBE,  
President,  
UK Faculty of Public Health



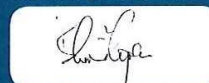
Simon Stevens,  
Chief Executive,  
NHS England



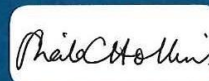
David Behan,  
Chief Executive,  
Care Quality Commission



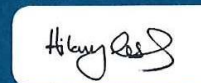
Sir Richard Thompson,  
President,  
Royal College of Physicians



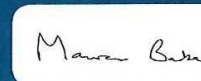
Baroness Hollins,  
Chair,  
BMA Board of Science



Dr Hilary Cass, President,  
Royal College of Paediatrics  
and Child Health



Dr Maureen Baker,  
Chair, Royal College of General  
Practitioners






## Board of Directors : June 2016

**Item : 15**

**Title :** Terms of Reference of the Management Team and Audit Committee

**Summary:**

The Management Team has reviewed its ToR and updated the membership, these are presented for approval.

The Audit Committee has reviewed its ToR and made some minor changes, the ToR are presented for approval.

**For :** Approval

**From :** Gervase Campbell, Trust Secretary

ToR

## **Terms of Reference for Approval**

### **1. Introduction**

- 1.1 The terms of reference for all board committees are periodically reviewed and updated, and changes need to be approved by the Board.

### **2. Management Team ToR**

- 2.1 The Management Team has reviewed its ToR and updated the membership of the Executive Team core to include the Director of Adult and Forensic services.
- 2.2 The Duties and other details of the ToR have not been changed.

### **3. Audit Committee ToR**

- 3.1 The Audit Committee has reviewed its ToR and made minor changes, as shown in 'track changes'. In section 10.1.2.1 and 13.2 reference to "declarations of compliance with the Care Quality Commission's Judgement Framework" have been removed. In 10.1.2.4 reference to "Secretary of State Directions" has been removed. Monitor has been updated as NHS Improvement throughout.

### **4. Approval**

- 4.1 The Board are asked to approve the Terms of Reference of both committees.

Gervase Campbell  
Trust Secretary  
June 2016



## Management Team Terms of Reference

Ratified by:	Board of Directors
Date ratified:	(June 2016)
Name of originator/author:	Paul Jenkins, Committee Chair
Name of responsible committee/individual:	Management Team / Team Chair
Previous Name of Committee	Management Committee until June 2014
Date issued:	July 2007; June 2009; July 2010: June 2014: July 2015; June 2016
Review date:	June 2017

## Management Team Terms of Reference

### 1. Constitution

- 1.1 The Board of Directors hereby resolves to establish an advisory committee to advise and support the Chief Executive in his role in the Trust, to be known as the Management Team. This Team has no executive powers other than those delegated in these terms of reference.

### 2. Membership

- 2.1 The Core membership of the Management Team, known as the Executive Team, shall be as follows:

- 2.1.1 Chief Executive (Committee Chair)
- 2.1.2 Deputy Chief Executive and Director of Finance
- 2.1.3 Director of Education and Training
- 2.1.4 Director of Quality and Patient Experience
- 2.1.5 Medical Director
- 2.1.6 Director of Children, Young Adults and Families Services
- 2.1.7 Director of Adult and Forensic Services
- 2.1.8 Nurse Director

- 2.2 The Additional membership of the Management Team, shall be as follows:

- 2.2.1 Commercial Director
- 2.2.2 Director of Human Resources
- 2.2.3 Director of IMT
- 2.2.4 Director of Marketing and Communications

### 3. Quorum

- 3.1 This shall be at least one third of members.

#### **4. Frequency of meetings**

- 4.1 The Executive Team membership of the Management Team will meet formally four times a month. In addition there will be two meetings a month of the full Management Team, the Executive members plus the Additional members, one of which will be formal and one strategic.

#### **5. Agenda & Papers**

- 5.1 Meetings of the Management Team will be called by the Team Chair. The agenda will be drafted by the Management Team Secretary and approved by the Chair prior to circulation.
- 5.2 Notification of the meeting, location, time and agenda will be forwarded to Management Team members, and others called to attend, at least three days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Management Team members at the same time as the agenda.

#### **6. Minutes of the Meeting**

- 6.1 The Management Team Secretary will minute proceedings, action points, and resolutions of formal meetings of the Team, including recording names of those present and in attendance.
- 6.2 Strategic meetings, occasional meetings and conferences will not be minuted unless resolutions or action points are to be agreed.
- 6.3 The Chief Executive will highlight pertinent issues and what action has been taken as a result in his reports to the Board of Directors.

#### **7. Authority**

- 7.1 The Management Team is constituted to advise the Chief Executive on the conduct and carriage of his role. The Chief Executive holds decision making rights, although in practice these are often delegated to the Management Team. The Management Team therefore gets its authority from the Chief Executive.

#### **8. Duties**

- 8.1 The Management Team is the central executive Committee of the Trust.

- 8.2 It advises the Chief Executive on the management of all aspects of the Trust's work.
- 8.3 It is responsible for leading, managing and co-ordinating the Trust's output activities, clinical work, training, consultancy and research, and for ensuring effective liaison and integration between the clinical and non-clinical directorates.
- 8.4 It is responsible for leading and managing the operation of the Trust and its performance in delivering the Operational Plan and Strategic Plan.
- 8.5 It is responsible for developing and proposing strategy to be agreed by the Board of Directors and for leading and delivering the Trust's strategic direction via the Committees that are accountable to the Board of Directors.
- 8.6 It is responsible for reviewing the Trust's management processes and structures and making changes to improve the quality of management.
- 8.7 It is responsible for reviewing changing demands, opportunities and pressures within the NHS and wider environment and leading the Trust's response to these changes.
- 8.8 It is responsible for planning and prioritising to set the annual budget with the Director of Finance and the Chief Executive, for agreement by the Board of Directors.
- 8.9 It is responsible for monitoring the budget on a monthly basis and conducting a mid-year review led by the Director of Finance.
- 8.10 It is responsible for ensuring the Trust's compliance with national standards and the requirements of the Care Quality Commission and other national monitoring bodies.
- 8.11 It has close liaison with other Committees that report to it and will receive regular reports from them. Staff leading in areas of the Trust's work will attend the Committee to report, and to widen consultation. It will need to be responsive to staff and to encourage enterprise and creativity.

## **9. Other Matters**

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

## **10. Reporting**

- 10.1 The minutes of the Management Team will be formally recorded by the Secretary and, approved by the Management Team. The Chair shall draw the attention of the Board of Directors to any issues in the minutes that require disclosure or executive action.

## **11. Support**

- 11.1 The Management Team will be supported by a Secretary from the Chief Executive's team.

June 2016



## Audit Committee

### Terms of Reference

Ratified by:	Board of Directors
Date ratified (current version):	June 2015
Name of originator/author:	David Holt, Committee Chair
Name of responsible committee/individual:	Audit Committee / Committee Chair
Date issued (current version):	May 2015
Review date:	May 2016

## **Audit Committee Terms of Reference**

### **1. Constitution**

- 1.1** The Board of Directors hereby resolves to establish a Committee to be known as the Audit Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

### **2. Membership**

- 2.1** The Audit Committee will be appointed by the Board of Directors.
- 2.2** All members of the Committee should be independent Non-Executive Directors of the Trust. For the avoidance of doubt, the Trust Chair shall not be a member of the Committee.
- 2.3** The Committee shall consist of at least three members.
- 2.4** The Board should appoint the Chair of the Audit Committee from amongst its independent Non-Executive Directors.
- 2.5** At least one member of the Audit Committee should have recent and relevant financial experience.

### **3. Attendance**

- 3.1** The Director of Finance and appropriate External and Internal Audit representatives shall normally attend meetings.
- 3.2** At least once a year the External and Internal Auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.
- 3.3** The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report.
- 3.4** The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.



- 3.5** The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.

#### **4. Quorum**

- 4.1** This shall be at least two members.

#### **5. Frequency of meetings**

- 5.1** The Committee shall meet at least four times per year.
- 5.2** The external or internal auditor may request a meeting when they consider it necessary.

#### **6. Secretary**

- 6.1** A Secretary shall be appointed for the Audit Committee.

#### **7. Agenda & Papers**

- 7.1** Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.
- 7.2** Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

#### **8. Minutes of the Meeting**

- 8.1** The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.
- 8.2** Approved minutes will be forwarded to the Board of Directors for noting.
- 8.3** In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.

## 9. Authority

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

## 10. Duties

### 10.1 Governance, Risk Management and Internal Control

10.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

10.1.2 In particular, the Committee will review the adequacy of:

10.1.2.1 all risk and control related disclosure statements (in particular the Annual Governance Statement ~~and declarations of compliance with the Care Quality Commission's Judgement Framework~~), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors

10.1.2.2 the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

10.1.2.3 the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Clinical Quality, Safety, and Governance Committee

10.1.2.4 the policies and procedures for all work related to fraud and corruption ~~as set out in Secretary of State Directions and~~ as required by NHS Protect

10.1.2.5 the financial systems

- 10.1.2.6 the Internal and External Audit services, and counter fraud services
- 10.1.2.7 compliance with *Board of Directors' Standing Orders* (BDSOs) and *Standing Financial Instructions* (SFIs)
- 10.1.3 The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following:
- the process for the completion and up-dating of the Assurance Framework;
  - the relevance and quality of the assurances received;
  - whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and
  - Whether the Assurance Framework remains relevant and effective for the organisation.
- 10.1.4 The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
- 10.1.5 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, the Local Counter-Fraud Service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.
- 10.1.6 The Committee shall review at each meeting a schedule of debtors balances, with material debtors more than six months requiring explanations/action plans.
- 10.1.7 The Committee shall review at each meeting a report of tenders and tender waivers since the previous meeting.

## 10.2 Internal Audit

- 10.2.1 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by:

- 10.2.1.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- 10.2.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- 10.2.1.3 consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources
- 10.2.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- 10.2.1.5 monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework
- 10.2.1.6 ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation

### **10.3 External Audit**

- 10.3.1 The Committee shall review the work and findings of the External Auditor appointed by the Board of Governors, and consider the implications and management's responses to their work. This will be achieved by:
  - 10.3.1.1 approval of the remuneration to be paid to the External Auditor in respect of the audit services provided
  - 10.3.1.2 consideration of recommendations to the Board of Governors relating to the appointment and performance of the External Auditor
  - 10.3.1.3 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy
  - 10.3.1.4 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

- 10.3.1.5 review all External Audit reports and any work carried out outside the annual audit plan, together with the appropriateness of management responses

#### 10.4 Other Assurance Functions

- 10.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust
- 10.4.2 These will include, but will not be limited to, any reviews by ~~Monitor~~NHS Improvement, Department of Health Arm's Length Bodies or Regulators / Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)
- 10.4.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Clinical Quality, Safety, and Governance Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed.
- 10.4.4 In reviewing the work of the Clinical Quality, Safety, and Governance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.
- 10.4.5 The Audit Committee should incorporate within its schedule a review of the underlying processes for the Information Governance Toolkit and the Quality Accounts production to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced.

#### 10.5 Management

- 10.5.1 The Committee shall request and review reports and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control
- 10.5.2 They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements

## **10.6 Financial Reporting**

- 10.6.1 The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:
  - 10.6.1.1 the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
  - 10.6.1.2 changes in, and compliance with, accounting policies and practices
  - 10.6.1.3 unadjusted mis-statements in the financial statements
  - 10.6.1.4 major judgemental areas
  - 10.6.1.5 significant adjustments resulting from the audit
- 10.6.2 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors

## **10.7 Appointment, reappointment, and removal of external auditors**

- 10.7.1 The Committee shall make recommendations to the Council of Governors, in relation to the setting of criteria for appointing, re-appointing, and removing External Auditors
- 10.7.2 The Committee shall make recommendations to the Council of Governors, in relation to the appointment, reappointment, and removal of the External Auditors, providing the Council of Governors with information on the performance of the External Auditor
- 10.7.3 The Committee shall approve the remuneration and terms of engagement of the External Auditors

## **11. Other Matters**

- 11.1 At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.
- 11.2 The Committee should consider holding a discussion at the end of some meetings with regards to the effectiveness of the committee, considering those areas highlighted within this paper.

## 12. Sources of Information

- 12.1** The Committee will receive and consider minutes from the Clinical Quality, Safety, and Governance Committee. The Committee will receive and consider other sources of information from the Director of Finance.

## 13. Reporting

- 13.1** The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Audit Committee or the Board of Directors to any issues in the minutes that require disclosure or executive action.
- 13.2** The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement , specifically commenting on the completeness and integration of risk management in the Trust, and the integration of governance arrangements, ~~and the appropriateness of the self-assessment against the Care Quality Commission's Judgement Framework.~~
- 13.3** The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

~~23/6/15~~07/06/2016





## Board of Directors : June 2016

**Item :** 16

**Title :** Scheme of Delegation of Powers Review 2016

### **Summary:**

This document outlines amendments made to the Scheme of Delegation of Powers. The Scheme was reviewed by the Trust Secretary, with only minor changes needing to be made since the 2015 review.

The Board of Directors reserves some powers to itself, delegates some to be exercised by committees, but those functions of the Trust that have not been delegated or reserved are exercised by the CEO on behalf of the board. The CEO determines which functions he will perform personally and which will be undertaken by nominated officers. The Scheme of Delegation of Powers is a proposal of which functions the officers of the Trust shall be nominated to undertake.

The Board is asked to consider and approve the attached Schedule.

This report has been reviewed by the following Committees:

- Management Team, 7<sup>th</sup> May.

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

- Risk
- Corporate Governance

**For :** Approval

**From :** Gervase Campbell, Trust Secretary

## Scheme of Delegation of Powers Review 2016

### **1. Introduction**

- 1.1 The scheme was last reviewed in 2015 when only minor changes were made. This year there are a number of changes due to no longer having a Director of Corporate Governance and Facilities (CGF), as the responsibilities of that role have been reassigned. The title of Dean has been updated to Director of Education and Training/Dean. The complaints section has been expanded to cover student complaints.

### **2. Changes made to the Scheme**

- 4. a (Capital Schemes/selection of architects) – removed Dir. of CGF, added Finance Director, updated job title from Estates Officer to Operational Estates and Facilities Manager.
- 4. b (Financial monitoring) – removed Dir. of CGF, leaving Finance Director.
- 5.d (Opening Tenders) – added directors of CYAF and AFS.
- 9.b (Approval of Rents to be charged) – removed Dir. of CGF, leaving Finance Director.
- 10.b (Disposal...over £200) – removed Dir. of CGF, added Op. Estates and Facilities Manager and Director of IMT.
- 10.c (Disposal...over £1000)- removed Dir. of CGF, leaving Director of Finance.
- 10.d (Disposal...over £5000)- removed Dir. of CGF, leaving Director of Finance.
- 12.b (Reporting...violence)- removed Dir. of CGF and Governance Lead, added Health and Safety Manager, left Receptionist.
- 23. (Insurance & risk policies) – removed Dir. of CGF, leaving Finance Director and CEO.
- 24. (Complaints) – updated to cover Student complaints in addition to clinical.
- 24.a (Overall responsibility) – added Dean's Office Manager for DET complaints.
- 24.b (Responsibility for Investigation) – added Director of Education and Training.
- 24.c (Legal aspect of complaints – removed Dir. of CGF, added Chief Executive.
- 28. (Review fire precautions) – removed Dir. of CGF, added H&S Manager.
- 29. (Health and Safety compliance) – removed Dir. of CGF, added H&S Manager.
- 31. (Compliance with environmental regulations) – removed Dir. of CGF, added Operational Estates and Facilities Manager.
- 32. (Compliance with Data Protection Act) – removed Dir. of CGF, leaving Information Governance Lead and Senior Information Risk Owner
- 33. (Compliance with Access to Records Act) – removed Dir. of CGF, added Information Governance Lead.
- 42.b (Review of compliance with Risk Assurance Framework – governance declaration) – removed Dir. of CGF, added Finance Director.
- 44. (Operational Risk Register) – removed Dir. of CGF, added Associate Director of Quality and Governance.

### **3. Conclusion**

- 3.1 The Board are asked to approve the scheme of delegation of powers.

Gervase Campbell  
Trust Secretary, June 2016

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

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

Delegated Matter			Reference documents & notes												Directors of CYAF/AFS												Party Cash Holder		Other	
															Chief Executive	Finance Director	Medical Director	Director of Q&PE	Director of Education/Dean	Commercial Director	Trust Secretary	Line / Dept Manager	Procurement Manager	Budget Holder						
16. Contracts for NHS Clinical Services continued...	b) Signing agreements																								Director of CYAF/ Director of AFS					
	a) New training courses																								Management Team					
	b) Annual review of fees for all courses																								Director of Tavistock Consulting					
	c) Daily fee rates (range) to be charged for all consultancy work																								Unit Directors					
7. Setting of Fees for Training courses, Consultancy work and other services	d) Approval of fees for other services including the Gloucester House Day Unit etc.																													
	a) From grants received for specific purposes (e.g. research grants; donations for specific services)																													
	b) From staff earnings funds																													
	c) From all other funds:																													
8. Expenditure of Charitable Funds	(i) Up to £20,000																													
	(ii) Above £20,000																													
	a) Letting of premises to, or renting of premises from, outside organisations																													
	b) Approval of rents to be charged																													
9. Agreements/Licences																														
10. Condemning & Disposal - items which are obsolete, obsolescent, redundant, irreparable or which cannot be repaired cost effectively																														

Must authorise jointly authorise May authorise with approval





Delegated Matter			Reference documents & notes												Directors of CY/ARS					Other						
			Chief Executive	Finance Director	Medical Director	Director of Q&P	Director of Education/Dean	Director of Human Resources	Commercial Director	Trust Secretary	Directors of CY/ARS	Line / Dept Manager	Procurement Manager	Budget Holder	Party Cash Holder	Other										
18. Borrowing			SFI 10.1; Trust's Operating Cash Management Policy																							
19. Human Resources & Pay	a) Authority to fill funded post on the establishment with permanent staff.		Policy & Procedure for Recruitment & Selection																							
	b) Authority to appoint staff to long-term post not on the formal establishment.		SFI 8.2.3; Policy & Procedure for Recruitment & Selection																							
	c) Additional Increments - The granting of additional increments to staff within budget on appointment.		Agenda for Change Conditions of Service																							
	d) Banding, rebanding, and other remuneration matters - All requests shall be dealt with in accordance with Trust Procedure:		Remuneration Cttee ToR																							Finance Director with the HR manager or Director.
	e) Establishments:		Policy & Procedure for Recruitment & Selection SFI 8																							Remuneration Committee
	f) Pay:	(i) Authority to complete standing data forms affecting pay, new starters, variations and leavers (ii) Authority to authorise overtime (iii) Authority to authorise travel & subsistence expenses (iv) Approval of Performance Related Pay Assessment	SFI 8																							HR Officer
	g) Leave:	(i) Approval of annual leave	Remuneration Cttee ToR NHS Terms and Conditions of Service Handbook; Other relevant terms & conditions of service; Leave Policy																							Remuneration Committee

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

Delegated Matter		Reference documents & notes												Directors of CYR/ARS										Other																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
		Chief Executive	Finance Director	Medical Director	Director of Q&P	Director of Education/Dean	Commercial Director	Trust Secretary	Line / Dept Manager	Procurement Manager	Budget Holder	Party Cash Holder	Other	Director of relevant directorate	HR Officer																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																														
(19 Human Resources & Pay continued...)	(g) Leave continued...)	(ii) Annual leave - approval of carry forward (up to 5 days or in the case of Ancillary & Maintenance staff as defined in their initial conditions of service).																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											</

Must authorise Must jointly authorise May authorise with approval



Delegated Matter		Reference documents & notes												Other					
		Chief Executive	Finance Director	Medical Director	Director of Q&P	Director of Education/Dean	Commercial Director	Trust Secretary	Directors of CY/ARS	Line / Dept Manager	Procurement Manager	Budget Holder	Party Cash Holder	Other					
	n) Redundancy														Chief Executive and Remuneration Committee for senior staff				
	o) Ill Health Retirement - Decision to pursue retirement on the grounds of ill-health																		
	p) Dismissal														Dismissal Officer				
20. Authorisation of Sponsorship deals															Management Committee				
	21. Authorisation of Research Projects														Director of Research & Development				
	22. Authorisation of Clinical Trials														Director of Research & Development				
23. Insurance Policies and Risk Management																			
	24. Complaints: Student, Patients & Relatives														Complaints Officer for clinical/ Dean's Office Manager/Complaints Liaison Officer for DET				
															Relevant Director				
25. Relationship with the media																			
	26. Patient Services																		
	27. Facilities for staff not employed by the Trust to gain practical experience														Director of Marketing and Communications				
28. Review of fire precautions																			
	29. Review of all statutory compliance with legislation on health and safety														Health and Safety				
	30. Review of Medicines Inspectorate Regulations														Health and Safety Manager				

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



## Board of Directors : June 2016

**Item : 17**

**Title :** Corporate Governance Statement – declaration of compliance with conditions of our licence from NHS Improvement (Monitor).

**Summary:**

NHS Improvement require us to complete an annual self-certification declaring whether the Trust is compliant with aspects of the Risk Assessment Framework (RAF), appendix E of the RAF, and section s151(s) of the Health and Social Care Act.

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

This was reviewed by the Management Team in June 2016.

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

- Quality
- Risk
- Finance

**For :** Approval

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

## Corporate Governance Statement

### 1. Introduction

- 1.1 For submission to NHS Improvement (Monitor) by the end of June, the Board of Directors is required to consider 8 statements covering compliance with our licence conditions; and to confirm or not confirm each of the statements.

### 2. Statements in declaration

- 2.1 The following sections give the text of each of the statements. The Board of Directors is invited to confirm all 8 statements.

- 2.2 The first statement: "The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS."

2.2.1 The board of directors is invited to confirm this statement on the basis of: the system of committees, such as CQSG and audit, which report to the board, combined with the assurance framework and risk register, to give assurance.

2.2.2 A more detailed description is given in the Annual Governance Statement which was approved by the Audit Committee and the Board last month, as part of the Annual Report.

- 2.3 The second statement: "The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time"

2.3.1 The board of directors is invited to confirm this statement on the basis of: the director of finance, the trust secretary and the chief executive receive guidance from NHS Improvement and ensure that it is implemented within the Trust.

- 2.4 The third statement: "The Board is satisfied that the Trust implements:
- (a) Effective board and committee structures;
  - (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
  - (c) Clear reporting lines and accountabilities throughout its organisation."

- 2.4.1 The board of directors is invited to confirm this statement on the basis of: the effectiveness of our system of internal control is assessed by our internal and external auditors, each committee of the board assesses its own effectiveness, and the functioning of the board, including its relationship to its committees, is assessed annually.
- 2.4.2 Again, more detail is given in the Annual Governance Statement.
- 2.5 The fourth statement: "The Board is satisfied that the Trust effectively implements systems and/or processes:
- (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
  - (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
  - (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
  - (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
  - (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
  - (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
  - (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
  - (h) To ensure compliance with all applicable legal requirements."
- 2.5.1 The board of directors is invited to confirm this statement on the basis of: the existing system of internal controls, committees and the assurance framework and risk register which give assurance to the board.
- 2.5.2 Again, more detail is given in the Annual Governance Statement.
- 2.6 The fifth statement: "The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:
- (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

- (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
- (c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
- (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
- (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
- (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate."

2.6.1 The board of directors is invited to confirm this statement on the basis of: the regular reports and assurance from the CQSG to the board, the annual Quality Report and complaints report, the regular service line reports which are brought to the board, and the recent CQC inspection report.

2.6.2 Again, more detail is given in the Annual Governance Statement.

2.7 The sixth statement: "The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence."

2.7.1 The board of directors is invited to confirm this statement on the basis of: the reports of the annual board assessment, the annual appraisals conducted for all board members and senior directors.

2.8 The seventh statement concerns trusts which are, or are considering becoming, part of a major Joint Venture or Academic Health Science Centre. The AHSC we belong to does not have control over any part of the Trust's business or resources; and we are not part of any other major Joint Venture. The requirements of this statement therefore do not apply to us, and it can be completed as 'Not Applicable'.

2.9 The eighth statement: "The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."

- 2.9.1 The paragraph of the Act referred to reads, "A public benefit corporation must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such."
- 2.9.2 The board of directors is invited to confirm this statement on the basis of: in the past year training courses have been offered externally with Governwell on a range of topics, and a number of new and existing governors have taken these courses. Additionally, Governors have completed Information Governance training, and attended introductions to our services, to the structure of the Trust, and to the role of the Governors through the induction material and the introductory joint boards meeting held at the end of 2015.

### **3. Views of the Governors**

- 3.1 In approving the statements, we can confirm that we have taken the views of the governors into account. The Council of Governors also receives reports on the matters covered by these statements, including the annual letter from the external auditors, which is being considered at the meeting on 30<sup>th</sup> June; and representative members of the Council take part in the governance processes of the Trust.
- 3.2 Governors take part in several key committees in the Trust's governance structures, including the Clinical Quality, Safety and Governance Committee.

Simon Young  
Deputy Chief Executive and Director of Finance





BOARD OF DIRECTORS (PART 1)

Meeting in public

Tuesday 28<sup>th</sup> June 2016, 14.00 – 16.30

Lecture Theatre, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES				
1.	Chair's Opening Remarks Mr Paul Burstow, Trust Chair		Verbal	-
2.	Apologies for absence and declarations of interest Mr Paul Burstow, Trust Chair	To note	Verbal	-
3.	Minutes of the previous meeting Mr Paul Burstow, Trust Chair	To approve	Enc.	p.1
3a.	Outstanding Actions Mr Paul Burstow, Trust Chair	To note	Verbal	-
4.	Matters arising Mr Paul Burstow, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	Student Story – Clinical Psychoanalytic Portfolio	To discuss	Verbal	-
6.	Service Line Report – Clinical Psychoanalytic Portfolio Ms Anne Hurley, Portfolio Lead	To discuss	Enc.	p.10
7.	Trust Chair's and NEDs' Reports Mr Paul Burstow, Trust Chair	To note	Verbal	-
8.	Chief Executive's Report Mr Paul Jenkins, Chief Executive	To note	Enc.	p.20
9.	CQC Action Plan Ms Louise Lyon, Director of Quality & Patient Experience	To note	Enc.	p.23
10.	Board and CEO Objectives Mr Paul Burstow, Trust Chair	To approve	Enc.	p.29
11.	Finance and Performance Report Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.42
12.	Training and Education Report Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.50
13.	Annual Safeguarding Report Dr Rob Senior, Medical Director	To note	Enc.	p.55
14.	Statement of Support for Tobacco Control Ms Louise Lyon, Director of Q&PE	To approve	Enc.	p.66

15.	<b>Terms of Reference for Management Team and Audit Committee</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.70
16.	<b>Scheme of Declaration of Powers</b> Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p.86
17.	<b>Second Self-Certification to Monitor</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p.96
CLOSE				
18.	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"><li>Thursday 30<sup>th</sup> June 2016: Council of Governors' Meeting, 2.00 – 5.00pm, Lecture Theatre</li><li>Tuesday 12<sup>th</sup> July 2016: Leadership Group, 12.00-5.00pm, Lecture Theatre</li><li>Thursday 14<sup>th</sup> July 2016, 10am – 5.00pm and Friday 15<sup>th</sup> July 2016, 9.00am – 12.00pm: Board Away Day, Danubius Hotel</li><li>Tuesday 26<sup>th</sup> July 2016: Board Meeting, 2.00- 5.00pm, Board Room</li></ul>		Verbal	-