

## Board of Directors Part One

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

2.00pm–4.20pm  
Tuesday 24<sup>th</sup> May 2016

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



## BOARD OF DIRECTORS (PART 1)

Meeting in public  
Tuesday 24<sup>th</sup> May 2016, 14.00 – 16.20  
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>Service User Story – Camden CAMHS</b>	To discuss	Verbal	-
6.	<b>Service Line Report – Camden CAMHS</b> Dr Andy Wiener, Associate Clinical Director CYAF	To discuss	Enc.	p.9
7.	<b>Trust Chair's and NEDs' Reports</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
8.	<b>Annual Report, Quality Report and Accounts</b> Mr Simon Young, Deputy Chief Executive and Director of Finance, Mr Gervase Campbell, Trust Secretary, Ms Marion Shipman, Associate Director of Quality and Governance. a) <b>Annual Report</b> b) <b>Annual Accounts</b> c) <b>Quality Report</b> d) <b>Letters of Representation</b>	To approve	Enc.	p.25  p.29 p.98 p. (late)
9.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To note	Enc.	p.233
10.	<b>Finance and Performance Report</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.239
11.	<b>Training and Education Report</b> Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.245
12.	<b>Clinical Quality Safety &amp; Governance (CQSG) Quarter 4 Report</b> Dr Rob Senior, Medical Director	To discuss	Enc.	p.249
13.	<b>Clinical Quality Safety &amp; Governance (CQSG) Annual Report and Terms of Reference</b> Dr Rob Senior, Medical Director	To approve	Enc.	p.256

14.	<b>CQC Report Update and Timings</b> Ms Louise Lyon, Director of Q&PE; AFS	To discuss	Enc.	p.280
15.	<b>Corporate Governance Statement - Self-Certification for Monitor</b> Mr Simon Young, Deputy Chief Executive and Director of Finance	To approve	Enc.	p.290
<b>CLOSE</b>				
16.	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"> <li>• Tuesday 28<sup>th</sup> June 2016: Board of Directors' Meeting, 1.00pm – 5.00pm, Lecture Theatre</li> <li>• Thursday 30<sup>th</sup> June 2016: Council of Governors' Meeting, 2.00 – 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> </ul>		Verbal	-

## Board of Directors

Meeting Minutes (Part One)  
Tuesday 26<sup>th</sup> April 2016, 2.10 – 5.30pm

<b>Present:</b>			
Mr Paul Burstow Trust Chair	Mr David Holt NED	Ms Jane Gizbert NED	Dr Sally Hodges CYAF Director
Mr Simon Young Deputy CEO & Director of Finance	Mr Paul Jenkins Chief Executive	Ms Lis Jones Nurse Director	Ms Louise Lyon Director of Q&PE and A&FS
Dr Ian McPherson NED & Vice Chair of Trust	Ms Edna Murphy NED	Mr Brian Rock Director of E&T/ Dean	Dr Rob Senior Medical Director
<b>Attendees:</b>			
Mr Gervase Campbell Trust Secretary (minutes)	Mr Julian Stern, Director of Adult and Forensic Services	Mr Paul Dugmore, Portfolio Manager (item 6)	Mr Craig DeSousa, HR Director (item 9)
<b>Apologies:</b>			
Prof. Dinesh Bhugra NED			

### Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor amendments to be made to the minutes	GC	Immd.
2	12	Look into discrepancy between appraisal rates	GC	Immd.
3	15	Provide complaints comparisons to previous years for services where possible	AH	May.

#### 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 – (M55 revalidation) – included in E&T report, completed.

AP3 – (3/5 year financial view) – suggested that in might be brought to the planned board away day.

Outstanding Actions:

OAP3 – (carers discussion) – held at the board lunch today, completed.

OAP2 – (IMT reports) – monthly reports would start in May.

#### 5. Portman Clinic Service Line Report

Mr Ruszczynski presented the report, noting that whilst he felt the Portman

Clinic was currently in a strong position they had recently lost the probation service contract and the Personality Disorder Knowledge and Understanding Framework (PDKUF) contract would be first reducing before ending entirely in 2018. Overall the work of the Portman was divided almost half and half between clinical work and dissemination, which provided a healthy balance.

Dr McPherson asked where the clinical commissioning might sit if specialist commissioning was devolved. Mr Ruszczyński noted that this was unclear, but they were keeping in touch with commissioners over it. They currently had a rolling 12 month contract, and had a programme of material ready to take to local commissioners if it was required.

Mr Holt asked about how the Portman could demonstrate outcomes, given the long term nature of the treatment it offered. Mr Ruszczyński commented that this was an area they needed to improve in, and they were employing a research psychologist to begin pulling together better outcome data, but there were complications over choosing a measure of success that made sense for their patient population. Dr Senior commented that the Trust's health economist was looking at how the work of the Trust reduced the burden on other services, and capturing this for the Portman would be especially important. Ms Murphy concurred, and gave details of a piece of research done by the land economy department at Cambridge University.

Dr Hodges asked about plans for service user involvement with service development in the Portman, and Mr Ruszczyński explained that it was difficult to get their particular service users involved, but they had done some interesting work with CPD courses.

Mr Holt noted the key themes of the staff survey, additional hours being worked and some incidents not being reported, and asked whether they were reflective of the Portman too. Mr Ruszczyński commented he didn't think they were, but there was a general issue with morale due to the constant threats to the service from outside, both financial cuts and the social or political pressure against helping their particular service users. However, the team was strong and supportive.

Dr McPherson asked about the difficulties recruiting staff mentioned on page 23. Mr Ruszczyński explained that due to posts being rebanded at a lower level they had not been able to fill their vacancies until the third attempt at recruitment, and added that they looked for people who had the experience and confidence to teach and do consultancy as well as the clinical work. Dr McPherson commented that it was quite common throughout the NHS to need multiple rounds of recruitment to fill vacancies, and noted that the Portman had demonstrated the ability to bring people in and develop them into roles.

Mr Rock asked whether the consultancy work throughout the country led to increased income streams. Mr Ruszczyński commented that part of the remit of the Clinic was to disseminate their knowledge, and doing so did generate a decent income, but only in Nottingham so far had it really led to more growth. They discussed the possibility of expanding the education and training work, and the staff that would be required for it.

Mr Jenkins commented that the national contract was uncertain, and there were two ways to strengthen the Portman's future. The first was through education and training, both at a specialist level but also with a wider group of staff. The second was by increasing the Portman's public profile and giving voice to views that needed to be made heard to contribute to the public debate. In addition, they could be looking at embedding the work of the Portman in the pathways and referral routes being developed in the North Central London area.

Mr Burstow noted the concerns the CQC had voiced over assessing clinical risk, and asked if these had been addressed. Mr Ruszczyński commented that they had robust clinical practices but had not been good at recording them, and they had revisited their processes to correct this. Dr Stern commented that they were bringing CareNotes into the Clinic which would bring their recording practices into line with the rest of the Trust.

Mr Burstow summarised that the approach to the risks to the specialist contract were to be proactive in gathering evidence on outcomes so that they could make a combined clinical and economic case to CCGs; to continue to develop the training and education side; and to be ambitious and thoughtful about what the service has to offer and how to play that into the system. He thanked Mr Ruszczyński for the report, and for his work as Director.

The Board **noted** the report.

## 6. Trust Chair and NEDs' Reports

Mr Burstow noted that there had been a good in depth discussion of relocation with Governors at the Joint Boards meeting, which would provide a baseline to build on. He had met Karen Turner, Director of Mental Health at NHS England, and held a fruitful discussion. And he had chaired a working group for Action on Smoking and Health (ASH) on smoking and mental health, and commented that there was a good evidence base and a challenge on what more the Trust could do.

Ms Murphy commented that she had been working with Education and Training in preparing for the QAA visit, and there had been an excellent team effort.

Dr McPherson noted he had attended the Trust's equalities event on mental health in the workplace, and it had been fruitful, and boded well for the follow up in June.

The Board **noted** the reports.

## 7. Chief Executive's Report

Mr Jenkins highlighted the current QAA visit, and commended how staff were engaging with it, and the hard work that had gone into the preparations. He noted the positive meeting held with the Directors of Education and Quality at HEE over the national training contract, but stressed the need now to make tangible progress on the changes they had outlined.

He commented that HEE had given their annual report on the quality of the Trust's Child Psychotherapy training and found it outstandingly good. More good news was that all contracts for the year had now been signed, and there had been a significant uplift for GIDS, which would allow them to increase staffing to address the demand and waiting list. GIDS was now the 3<sup>rd</sup> largest service in the Trust, and to ensure they supported it properly a task and finish group would be formed to draw key stakeholders together.

On CareNotes significant work had been done and technical issues resolved, and the longer term work on optimisation begun – a report would come to the next meeting.

The Board **noted** the report.

### **8. Finance and Performance Report**

Mr Young noted that since the report had been completed they had reviewed the relocation project and a further £200k of costs had been judged non-capital, which reduced the year's surplus.

For the coming year the funding for GIDS was £1M above budget, and though there would be additional costs this was significant. Other contracts had turned out at least as well as expected, but there was uncertainty over a couple, for example Barnet YPDAS was going out to tender. A re-evaluation of the Trust's assets would lead to an increase in the dividend the Trust had to pay, and this had only been partially accounted for in the budget. There would be a meeting on the 12<sup>th</sup> May to assess these changes, and it was expected that the budget gap would be reduced.

Mr Holt asked whether the asset revaluation, which was largely driven by a general rent increase within the NHS, meant costs of decamping, and the dividend figure for the final building, in the relocation project should be re-examined. Mr Young noted that these would be covered freshly in the Full Business Case, but agreed an interim assessment before then would be possible.

The Board **noted** the report.

### **9. Training and Education Report**

Mr Rock confirmed the new staff structures were in place, and the transition team was working effectively with a directorate wide event planned for the 6<sup>th</sup> May to consolidate the changes made and look for ways to work collaboratively. The building work was almost complete, and looked promising. It would provide a student reception area and a separate administrative hub, which should be better both for students and staff.

Data management was much improved, and they were clearer on targets across categories. Some excellent communications work had been done and the website was much improved, with a good search function which should be more coherent

and navigable for potential students.

The QAA visit seemed to be going well, with the inspection team engaged and open. There would be no feedback at the end of the week; they expected the draft report in May.

Mr Rock explained that he had looked into the revalidation of M55 and was convinced it was routine business and there was no reason to have concerns about the relationship with their partner or the final outcome.

The board **noted** the report.

#### **10. Review of Strategic Objectives**

Mr Holt explained the committee had met for a trial run of the format to use to assess the strategic objectives, and had come away with useful ideas on how to report to the Board. The discussions had been rewarding, but there were questions on what should be considered at the committee, and what should be discussed by the executive. There were still questions over how to test the relevance of the objectives and success criteria, as opposed to the easier task of rating progress against the agreed objectives. In addition there were teething problems over time demands on the committee and fitting in their regular business.

The board discussed the issues and agreed the committee should report quarterly for assurance with a RAG rating of the objectives, and then at 6 monthly intervals with a more strategic report on changing direction or altering objectives.

The Board **noted** the report.

#### **11. Q4 Quality Report**

Ms Shipman noted that a lot of work had been done over the past four months to improve the validation of data following the introduction of CareNotes. She highlighted that the Trust was compliant on waiting times for all services except GIDS and City and Hackney. She noted two corrections to the report, the first two CQUIN targets on page 51 for completing the Goal-Based Measure had been achieved and should be green for Q4, not red.

She noted the red rating for one of the smoking cessation measures, and commented that the physical health nurse appointment had now been made and the postholder would be working on these and also the living well CQUIN.

Ms Gizbert noted that in the waiting time breaches on p.61 the reason given for 3 of them was 'delay in assigning clinician', and asked what this meant. Ms Shipman explained that was principally around administrative processes, and it had been addressed, and the referral processes reviewed.

Mr Burstow noted the lack of clinical capacity in the Lyndhurst unit, which was something that had been raised when he visited them, and asked how this was being addressed. Dr Stern explained it was due to a combination of loss of senior staff who were necessary for the initial consultations, with some administrative errors. He would be looking at these issues with the service lead.

The Board **noted** the report.

## **12. Performance Indicator Dashboards**

Mr Jenkins noted that the dashboards demonstrated clearly the growth in activity over the past few years, and the large proportion of incidents that came from Gloucester House, commenting that the increase there was due to the opening of the 3<sup>rd</sup> class.

The Board discussed the dashboards, making suggestions for changes to the format, requested that some of the information be broken down to team level, and that student numbers should be divided geographically. They also discussed the options for aligning the measures presented more closely with the strategic objectives. Ms Gizbert noted an inconsistency between the appraisal rate on page 79 of the dashboards, and that reported on page 116 in the HR report.

**AP2**

The Board **noted** the report.

## **13. Q4 Governance Statement**

Mr Young noted that for the finance declaration the text of the statement was that the anticipated maintaining a rating of at least 3 over the next 12 months, which echoed the operational plan for the year. In Governance, data completion remained good but had been impacted by a number of patients with unusual postcodes which had not been recorded correctly at first. This issue had been corrected and the Trust remained within the standard. Mr Young confirmed that the management team had considered the statements and confirmed there were no other incidents that would impact on our compliance with the licence.

The Board **approved** the statements.

## **14. Nurse Revalidation**

Ms Jones introduced the paper, noting the requirements came into effect on the 1<sup>st</sup> April. The new requirements were more robust than the previous registration system, and included elements such as reflective practice which were already basic elements of the Trust's approach. There were no concerns over our 30 nurses, and managerial support was in place for the process.

Dr Senior asked whether there would be external scrutiny of our systems, as was the case for medical revalidation, and Ms Jones explained that this was not part of the nursing process. Dr Holt asked whether we had a responsibility for the FNP nurses, and Ms Jones explained that we were responsible for the handful employed directly in the national unit, but all the other nurses were the responsibility of the organisations that employed them.

The Board **noted** the report.

**15. A) Annual Clinical Complaints and Whistleblowing Report**

Ms Hawke introduced the report, noting the increase in the number of complaints made over the past year, and in the number upheld. Ms Murphy asked whether there was a theme in the cases upheld, and Ms Hawke explained that there seemed to be one around poor communication, in some cases due to confusion following changes in organisational structure. Ms Hodges added that the increase was partly a cultural shift, with the organisation being more open to the patient’s point of view. Mr Jenkins commented that he was more confident in the system now than when he had joined the Trust, and there had been a shift in our attitude so the Trust was less defensive and more willing to look for lessons that could be learned from every case. The investigations had shown no reason to worry about fundamental clinical practice, but they would continue to monitor them. Dr McPherson welcomed the increase as a sign of a healthy organisation, and noted that the number of complaints remained low in comparison with other Trusts.

Mr Holt noted that low level issues were not included in the whistleblowing report, and asked if the guardian, Gill Rusbridger, would be attending a future meeting. Mr Jenkins commented that he was very pleased with the work of Guardian so far in promoting the role and dealing with the enquiries she had received, and she would be attending the board when she had been in post a little longer. With regards to low level and informal concerns, this was not the only way they were gathered and considered in the Trust, and Ms Lyon added that part of the role of the Associate Quality Director was to look at the soft side of feedback, through PALS and negative ESQ data, to triangulate with the complaints.

AP3

Mr Burstow noted the comparisons to previous years on p.98, and asked whether it might be possible to share comparisons for some of the services that had not been affected by the reconfigurations, such as GIDS, and if a more detailed breakdown could be used in the next year. He reflected that for our specialist services where there were not many alternatives there could be a perception amongst service users that they were dependent on us and so were hesitant to make challenges. It was important that they continue to work to ensure that no one felt inhibited from using the processes, and anything that could be done to encourage complaints should be. Dr McPherson suggested that making it clear that no one had ever had their service removed as a result of making a complaint might help put these fears to rest.

The Board **noted** the report.

**15. B) Education and Training Complaints Report**

Mr Rock introduced the report, noting that it was presented separately as there were different requirements and issues in the Education and Training directorate to align with their university partners. He noted that there had been a systematic review of procedures in the directorate, and improvements in logging, tracking, and responding to complaints, but there was still work to be done on sharing the learning more widely.

The Board **noted** the report.

#### **16. Human Resources & Organisational Development Annual Report**

Mr DeSousa introduced the report, noting it was both a look back on the past year but also a forward view of what needed to be focused on, including the corporate action plan in response to the Staff Survey, which had built on the work done locally.

The strategic HR plan would focus on changing how HR supports the business, aligning its work to the directorates and using metrics at local levels to support local actions. Dr McPherson asked about Business Partners, and Mr DeSousa explained that they were roles who would work closely with directors and senior managers to understand their needs and suggest ways HR can support them. They would be doing some work to explain the new structure and roles once the positions were filled.

The Board discussed the activities and objectives in the business plan, and whether they were outcomes that could be measured, and where they might best be held to account. They discussed the slow rise in sickness absence, which Mr DeSousa thought might be partly due to improved reporting, but which would be one area that the business partners would be investigating, using local data. It was agreed that although the area of staff not reporting violence was mostly an issue for CYAF it would be good to address it more widely. They clarified that the actions for the Time To Change programme were covered within the Equalities and Diversity objectives.

The Board **approved** the report.

#### **17. Any Other Business**

The Board discussed the implications of the new Junior Doctor contract, and agreed it was prudent to continue making preparations for adopting it, whilst also continuing the discussions with our doctors that had been begun by the Chief Executive.

The Board noted its future meetings.

Part one of the meeting closed at 4.55pm

## Board of Directors : May 2016

**Item :** 6

**Title :** SLR for Camden CAMHS (Open Minded Service)

**Purpose:**

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

This report has been reviewed by the following Committees:

- Management Team, 17<sup>th</sup> May 2016

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

- Quality
- Patient / User Experience
- Patient / User Safety
- Staff Experience
- Risk
- Finance

**For :** Discussion

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

## Service Line Report – CYAF- CAMDEN Executive Summary

### 1. Introduction

- 1.1 Camden CAMHS consists of 7 teams and 78 staff members (43.65 WTE). It is commissioned jointly by Camden CCG and Camden Council to provide a comprehensive CAMHS to the population of Camden, and is provided from within the CYAF directorate. This is the only “local” CAMH Service that the Trust provides, so is an opportunity for us to show how progressive and forward thinking we are in delivering local services, and how we put the needs of the children, young people and families above everything else, such as familiar ways of working or traditional service criteria.

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

- 2.1 There are three areas of risk/concern
- 2.2 In the months after transition to Carenotes we lost the capacity report robustly to commissioners about our activity and outcomes. We lost ground in terms of credibility, and it is a struggle to regain this ground. In the meantime the demands for a higher level and depth of reporting has increased so our task is not just to get back to where we were, but to then get up to the required level.
- 2.3 Partially as a result of the lack of feedback that clinicians were able to get from the data system when they used outcome measures the number of outcome measures being used by staff has dropped to critical levels, particularly the goal based measure, which should be used for every case in treatment. This needs to be addressed very urgently.
- 2.4 We have not progressed as far as we had intended with the implementation of the THRIVE model. This is partly because it took time to establish the project implementation structures within which we would deliver the programme. These structures are now in place so we need to move forward swiftly with this plan

### 3. Proposed Action Plan

- 3.1 We will prioritise work on the three areas highlighted using a project management approach. We will run staff engagements events to help our staff understand and progress these areas.

## Main Report

### 4. Overview of the Service

An overview of the service has been given in previous SLRs, and for those who wish to review this information, it is included here in Appendix 1

The NHSE CAMHS Transformation Plans were submitted in September 2015 by the Camden CAMHS Commissioners. The excellent partnership between the Camden Commissioners and the Trust was evidence by the fact that the Associate Clinical Director for the Service Line was invited to work in close collaboration with the commissioners on the plan. There are 7 local priority streams in the plan, 2 of which are for the Tavistock and Portman NHS Foundation Trust to implement. These are improved Crisis Care, and reorganisation of our CAMHS service within the Children Schools and Families Directorate of Camden Local Authority.

We are delighted, with the help of additional investment to have established a new Camden CAMHS Team called the Camden Adolescent Intensive Support Service (CAISS) aimed at supporting young people in the community who are at risk of admission to inpatient psychiatric units (Tier 4). This has been a gap in our services for some years. The aim is to help young people remain at home during periods of mental health crisis and avoid admission to psychiatric hospital (tier 4) This team is made up of 5 WTE staff, made up of some new appointments and some reorganised roles. The staff include nursing, social work, occupational therapy and psychiatry. The team started taking cases in March 16 and currently has 18 young people on the caseload.

The reorganisation of our CAMHS offer to Camden Local Authority has consumed a large amount of time and effort and will be completed by the end of June. Working very closely with our Local Authority partners in Social Work, Family Support, and other support services, our CAMHS input is highly valued. The changes in how we work with the Local Authority will have knock on effects on the whole Camden CAMHS System – see below.

#### 4.1 Reorganisation Principles

Within the Local Authority CAMHS (LA CAMHS) a method of integrated working has been developed which has an explicit “clinical lead” role for mental health staff where they offer consultation and supervision to support workers, but crucially have shared responsibility with the Local Authority managers for the work being undertaken. Alongside consultation and supervision they offer reflective practice skills, liaise with the CAMHS network, and do direct work.

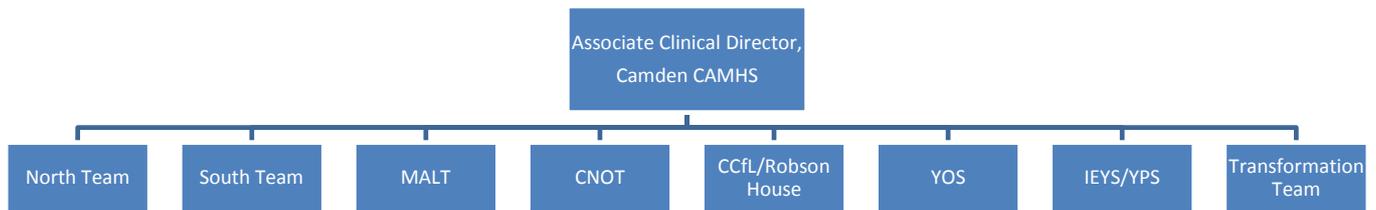
In community CAMHS and LA CAMHS, in line with the principles of THRIVE (which was discussed in last years SLR) one of the reorganisation principles is to introduce more clinical oversight of the work that is provided to children young people and families, to ensure that that work done is effective, and that resources are used wisely.

Currently there are referrals between different Camden teams who all have their own specifications and thresholds. Following the reorganisation we are anticipating that there to be one service specification for the whole service, and children and young people will be able to access clinical expertise from which ever part of the service will meet their needs best. They may for example initially be seen in a Children’s Centre but have a psychotherapist from one of the community teams join in the work. There will also be a lot of joint work between the new CAISS team, and the community teams.

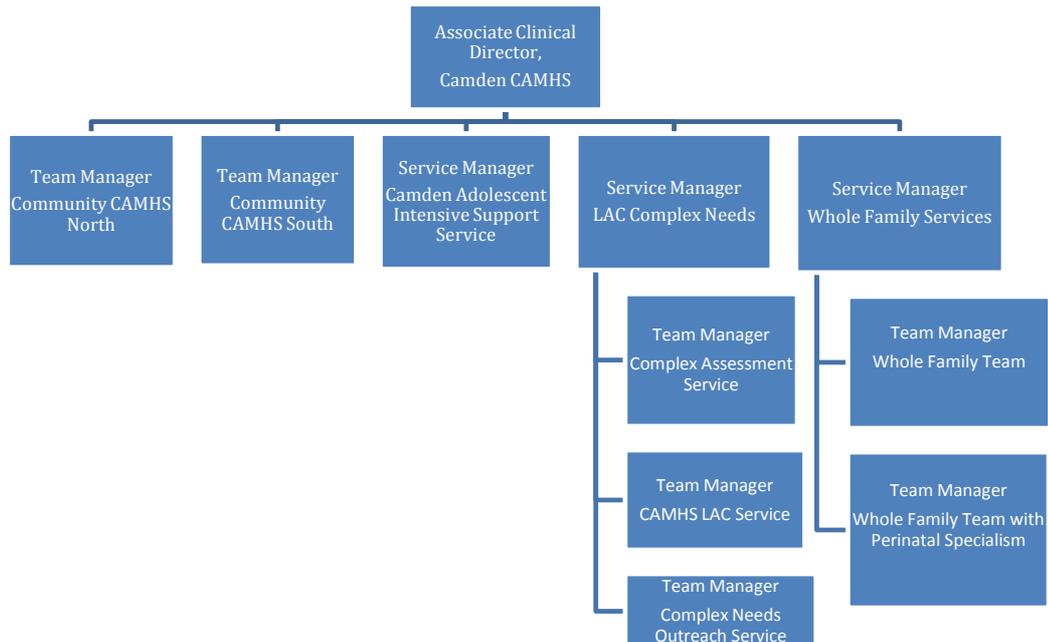
#### 4.2 Progress to date and current position

To achieve these aims we have pulled together our staff into a number of new teams in different areas of specialism such as perinatal work and a whole family approach. As stated above the reason for creating these teams is to allow us to deliver a service that is more responsive to need, rather than access to services being dictated by which part of the Local Authority service our staff were situated. For example in the old structure we could provide a service to a young person if they were on a Youth Offending Order, but not if they were accessing the Family Support Service. Now, which ever Local Authority service is involved, ever a child or young person can have access to CAMHS within a highly integrated delivery model. Alongside this integrated model they will have more CAMHS clinical oversight of the CAMHS work than at present.

The current management structure (excluding MOSAIC and EIS)



The new structure will be



This structure allows for a smaller senior leadership group (second row) who can work together with the Associate Clinical Director as a team, particularly focusing on care pathways and joint working between services. The management capacity will increase significantly from current levels, allowing more key tasks can be delegated appropriately. For example the Single Point of Entry referral system (Joint Intake) was chaired by the Associate Clinical Director but now is shared between the senior leadership team.

Appointments have yet to be made to some service manager and team manager posts. This will happen in June

In the last SLR the Minding the Gap project was described, which aims to improve transitions between CAMHS and Adult Services and to improve the capacity of mental health services to engage with hard to engage young people at risk of mental health problems.

The transition service is led by Camden and Islington Mental Health Trust and is performing well, with an increase in successful transition from CAMHS to AMHS from 3% to 27% and very positive user feedback about the process. A revised transition protocol has been written and is being signed off by the TPFT.

The service for hard to reach young people is now in place. The building where the service operates from has been named by young people as "The Hive", This is where young people can drop in and access activities, and attend to physical health needs etc, and the outreach service for young people who need individual support has been named by young people "Axis". A young person board steers the work of the Hive, and of the activities and projects that the HIVE provides.

The service is led by Catch-22 and is helping young people access help who do not normally use mental health services, either because they would feel this was stigmatising, or because they do not identify themselves as having a mental health problem. The staff story below is from a team lead in the service who is employed by the TPFT.

### **Service User Involvement**

In the last SLR the process of renaming Camden CAMHS was described, which was led by service users. Service user involvement remains central to much of the work in the Camden Service Line, but this work is no longer separate but is integrated with the Trust Wide Service User initiative, such as young people or parents being on interview panels as a matter of routine, pizza evenings to help shape the service etc, and the Tavi Art Project.

### **Staff Story**

I am a Team Lead in the Axis @ the Hive team. Before taking up this post I worked for Camden Council in the community for fifteen years, in youth work, managing a youth inclusion project, in management in the Camden Family Service and offering management support for the Early Help Team.

I remember hearing about the Minding the Gap Project in a Senior Managers meeting in Camden two years ago and thinking that it sounded like an amazing project, addressing a real need for Young People in Camden.

The Hive is the youth hub building and is open to all Camden 16 – 24 year olds, and the Axis team offers specialist 1:1 support for emotional wellbeing (the Axis Team also staff the Hive). These two aspects

intertwine and support each other, we have a large number of self referrals with Young People accessing the Hive, building relationship with the Axis team and requesting support with their emotional wellbeing, the model works well.

It has been exciting and challenging to be involved in the building of this project, helping to shape it from the beginning. Defining who we are, and how we work, building the structure, project and relationships. It has been an enormous challenge, living with uncertainty as we try to do something new, and together as a team it feels like we have shaped something unique that is proving to be a real resource for the Young People of Camden.

It is a privilege to be involved in this project. There is genuine co-production with Young People to create something new. The work with Young People is challenging and rewarding, it is humbling to see Young People overcoming adversity and complicated, difficult situations and wonderful to see Young People making progress towards their goals and growing in confidence.

## 5. Clinical Services and Activity Data

Below is a table summarising the activity data (Outputs) for the service. Although Camden CAMHS is a block contract, each team has a specification and most teams have targets for activity levels, unless activity is being baselines. The targets are broadly based on the whole time equivalents in the team. Some analysis of the figures is given below the table. Each quarter appointment by clinician reports are produced to ensure that our staff are not over-performing to unsustainable levels. North and South Camden tend to be the teams with the highest volume of work. For these teams we closely monitor the amount of staff activity. Comparing Q4 of 14/15 compared with Q4 of 15/16 staff have been doing, on average 2 appointments per half day. This is our target for activity levels, and these activity levels are stable over time.

Data for the MOSAIC (disability CAMHS) which is delivered in a partnership led by CNWL is not available, due to technical difficulties with a transition to a new data system in CMWL.

		Target	Actual (14-15)	Actual (15-16)
<b>CAMHS Social, Emotional and Behavioural Difficulties (SEBD) pathway - Robson House &amp; Camden Centre for Learning (Behavioural Support Service)</b>	<b>Outputs</b>			
	Number of pupils and/or carers in receipt of direct clinical involvement at any one time (across Robson House & CCfL)	45	63	57
	Total Number of cases seen per year	45+	107	84
	Consultation/Resilience Building to Professionals			129
<b>Early Intervention Service Camden CAMHS</b>	<b>Outputs</b>			
	First attendances per year	8	10	11
	Number of Open Cases at end of year	24	19	15
	Total Number of cases seen per year	24+	29	27
<b>Integrated Early Years Service (IEYS) (Children's Centre Services) &amp; Young Parents Service (YPS)</b>	<b>Outputs</b>			
	First attendances per year	140	166	89
	Subsequent appointments per year	600	508	771
	Number of Open Cases at end of year	60	89	77
	Total Number of cases seen per year	200	208	155
<b>MOSAIC CAMHS (Children's Disability Service)</b>	<b>Outputs</b>			
	Number of first attends	135	101	No data
	Attended appointments per year	3650	3167	No data
	Number of Open Cases at end of year	190	227	190
	Total Number of cases seen per year	270	291	No data
<b>Multi Agency Liaison Team (MALT)</b>	<b>Outputs</b>			
	Number of planning meetings per year	To be baselined	111	180
	Number of first appointments per year	To be baselined	No data	124
	Number of subsequent appointments per year offered (or attended) by practitioners	To be baselined	843	601
	Number of Open Cases at end of year	To be baselined	74	79
	Total Number of cases seen per year	To be baselined	80	151
	Comprehensive Family Reports (PLO and CP)	To be baselined	27	16
	Addendum Reports (PLO and CP)	To be baselined	8	9

		Target	Actual 14/15	Actual 15/16
<b>Refugee Team</b>	<b>Outputs</b>			
	First attendances per year	18	21	36
	Subsequent appointments per year	350	363	506
	Number of Open Cases at end of year	32	27	35
	Total Number of cases seen per year	54	43	62
<b>Complex Needs Outreach (includes tier 4 inreach)</b>	<b>Outputs</b>			
	Number of Open Cases at end of year	30	21	23
	Total Number of cases seen per year	50	40	33
<b>Youth Offending Service (YOS)</b>	<b>Outputs</b>			
	Number of Open Cases at end of year	10	4	5
	Total Number of cases seen per year	10+	22	12
<b>North Camden CAMHS</b>	<b>Outputs</b>			
	First attendances per year	240	328	334
	Subsequent appointments per year	4300	6732	6538
	Number of Open Cases at end of year	230	380	349
	Total Number of cases seen per year	470	652	604
<b>South Camden CAMHS</b>	<b>Outputs</b>			
	First attendances per year	242	322	285
	Subsequent appointments per year	3190	4549	4690
	Number of Open Cases at end of year	226	288	289
	Total Number of cases seen per year	422	516	508

### 5.1 Performance against contracts – current and for next financial year

This is a block contact so we do not get extra money for over performance. There has been a trend towards over performance, particularly in the North and South Camden CAMHS Teams. Last year there was concern that staff were becoming overstretched and that there appeared to be a year on year rise in demand. The anticipated further increase in demand has not happened this year, it appears to

be stabilising and the total number of cases seen per year has actually dropped in North and South Camden. There was a significant amount of discussion with our referring constituency about the high demand and that our services were becoming saturated. This may have made referrers more careful about when to refer. An alternative hypothesis is that more referrals are not being accepted, but this is not the case. In 14/15 referrals not accepted was 18 (1.1%) and in 15/16 was 22 (1.3%). This is a very low number compared to other CAMHS services and we are hoping that as THRIVE develops we will be able to appropriately redirect more cases than we do at present.

## 5.2 Waiting times.

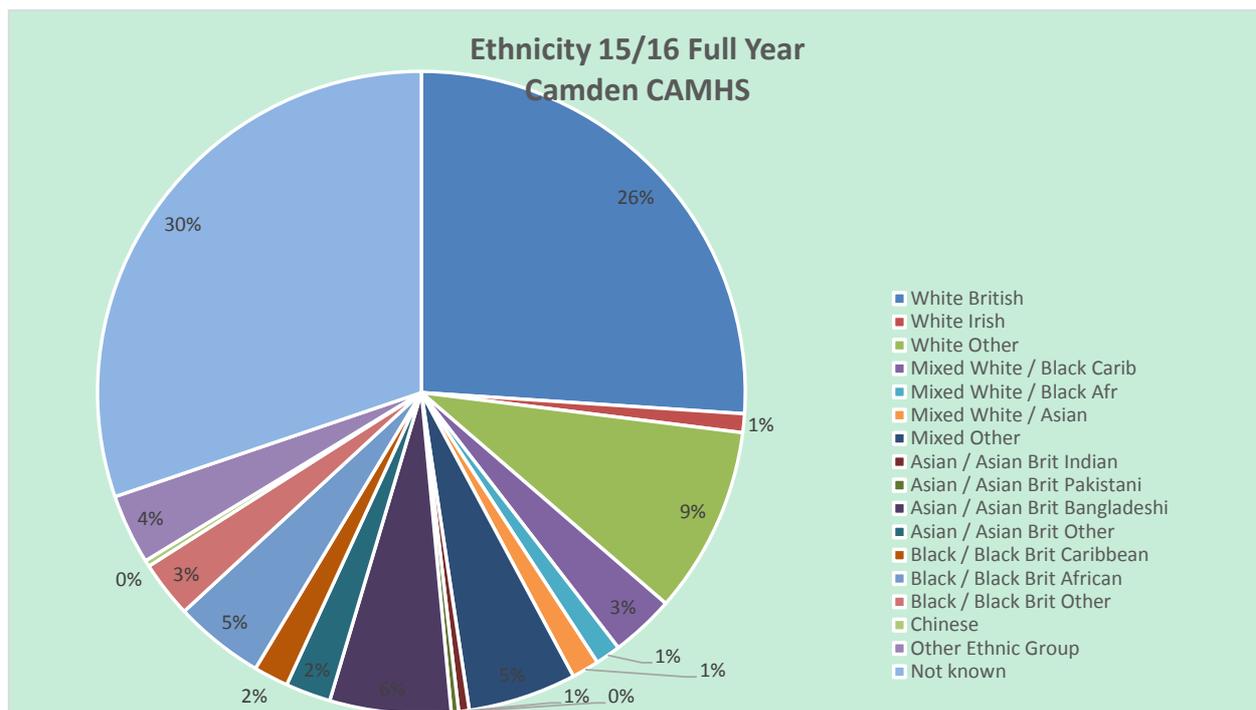
<b>Target less than 77 days (11 weeks)</b>	
<b>Total number of waiting time breaches in the year</b>	<b>7 of 1523 1<sup>st</sup> appointments</b>
<b>% Total of patients breached in the year</b>	<b>0.50%</b>

## 5.3 DNA rate

<b>Target &lt;10%</b>	<b>Camden CAMHS</b>
Total first appointments DNA's	130
Total first appointments	1532
<b>% 1st appointments DNA'd</b>	<b>8.50%</b>
Total sub. appointments DNA'd	1700
Total subsequent appointments	23137
<b>% DNA subsequent Appointments</b>	<b>7.30%</b>
<b>Total Trust DNA</b>	<b>7%</b>

5.4 The total percentage of dormant cases for Camden CAMHS is 11%. ie 1106 open cases across teams with 101 dormant. There is a work stream focused on keeping the number of dormant cases as low as possible

## 5.5 Ethnicity figures



33.4% of services users with a known ethnicity are from black or minority ethnic groups<sup>1</sup>. This is in line with the ethnic breakdown of Camden’s population. However for 30% of cases ethnicity is not known. This issue has been explored with team managers. The most likely reason for not having this data, is that many children and young people begin their treatment at a school or GP practice where the clinician has to do all the administration around the case including consent and ethnicity forms. Return rates are thought to be low in these circumstances. A review will be done to test this hypothesis, and appropriate action will be take to improve the reporting in this area.

## 6 Financial Situation

<sup>1</sup> All ethnic groups other than White (i.e. White British, White Irish or White Other)

	<b>Budget 14/15</b>	<b>Actual 14/15</b>		<b>Budget 15/16</b>	<b>Actual 15/16</b>
	£'000	£'000		£'000	£'000
Clinical Income	4,930	5,078		5,350	5,440
Training course fees and other acad income	0	0		0	0
National Training Contract	670	670		578	578
Total Training Income	670	670		578	578
Consultancy Income	0	0		0	0
Research and Other Income (incl Interest)	12	9		24	17
<b>Total Income</b>	<b>5,612</b>	<b>5,757</b>		<b>5,952</b>	<b>6,035</b>
Clinical Directorates and Consultancy	4,619	4,688		4,829	4,773
Other Training Costs	0	0		0	0
Research Costs	0	0		0	0
Accommodation	505	537		744	932
<b>Total Direct Costs</b>	<b>5,125</b>	<b>5,224</b>		<b>5,573</b>	<b>5,705</b>
Contribution	487	533		379	330
Central Overheads (excl Buildings)	1,002	1,077		728	737
Central Income	126	199		50	93
<b>Surplus/(-deficit)</b>	<b>-389</b>	<b>-345</b>		<b>-299</b>	<b>-313</b>

The reduction in training income in 15/16 is due to a change in the methodology of calculating the amount of training income allocated to clinical services. There was a deficit in 15/16 in line with the budgeted deficit

## 7 Clinical Quality and Outcome Data

### Goal Based Measure Improvement (more than one point improvement in score)

#### *By Team*

Patients Achieving Improvement on GBM				
Team	Time 1 - Time 2		Time 1 - Time>2	
	Percentage	N =	Percentage	N =
CCfL	100%	2	100%	1
Complex Needs	-	-	-	-
FAKC	100%	3	60%	5
IEYS	90%	20	71%	21
MALT	-	-	100%	3
North	83%	35	68%	57
Refugee	67%	6	80%	5
South	75%	20	85%	53
YOS	-	-	-	-
YPS	-	-	-	-

#### *All Teams*

Time Span	% Improved
T1-T2	<b>83%</b>
T1-T>2	<b>76%</b>

7.5 Although it is positive that there is a high rate of improvement on the Goal Based Measure (a use defined measure of goals of treatment) The main issue here is the low number of paired data. Our goal is to have 80% of cases in treatment with paired data on the Goal Base Measure. There needs to be a big drive to improve on this figure from the current levels. We are appointing a project manager to lead on this and other data issues and will be engaging with staff on this topic.

## 8 User Feedback

### Experience of Service Questionnaire (ESQ)

Experience of Service Questionnaire			
Team	Would Recommend	Good Help	N =
<b>AYA</b> (Camden Patients)	90%	95%	70
<b>FAKC</b>	81%	91%	16
<b>IEYS</b>	98%	96%	53
<b>MALT</b>	81%	92%	13
<b>North</b>	84%	90%	124
<b>Refugee</b>	92%	100%	6
<b>South</b>	89%	93%	180
<b>YOS</b>	50%	83%	3
<b>YPS</b>	93%	100%	7

#### *All Teams*

Question	% Agreed
Would Recommend	<b>89%</b>
Good Help	<b>93%</b>

8.5 It is very gratifying that our satisfaction levels are so high, and this is a testament to the quality and commitment of our staff to their clients.

## 9 Complaints

9.5 There were a total of 7 complaints across Camden, 5 of which occurred in North Camden and 2 occurred in MALT. The complaints were in areas such as clinicians not pursuing a diagnosis adequately or providing or not providing treatment that the parents wished for. Each situation was different and actions. 1 complaint was fully upheld regarding a GP letter being sent that contained too much sensitive information.

## 10 Serious Untoward Incidents and Safety Issues

10.5 There were no Serious Incidents in Camden CAMHS during 2015/16. Looking back there was 1 serious incident in 14/15 and another in 12/13, so it is not as if this service does not have such incidents, but that thankfully they are not frequent

There were a total of 29 incidents across Camden including all teams except YOS and IEYS&YPS and ranging from 1-6 in terms of the degree of seriousness. All incidents were reported with the follow up actions noted.

## 11 Staffing and HR issues

11.5 We remain fully staffed, which is a privileged position to be in for a CAMHS service. We are slowly reducing the number of 8C positions year on year, and replacing with lower banded staff. Some of our teams such as South Camden and MOSAIC has a staff structure which reflects a good balance of senior and junior banded staff, whereas North Camden, with the high contribution of its staff to training, have a profile of higher banded staff.

Dr Andrew Wiener  
Consultant Child and Adolescent Psychiatrist and Associate Clinical Director  
19/05/16

## Appendix 1

### Overview of Camden CAMHS (Open Minded Service)

Camden Open Minded is a group of clinical teams and outreach clinicians which serve the 0-18 year old population of Camden, approximately 44,000 children and young people. Via the outreach work they do the clinical teams receive referrals directly from the different agencies. They also receive referrals via a central system called Camden Joint Intake, which processes most of the GP referrals.

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

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

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

Beyond this there is a Disability CAMHS Team called MOSAIC CAMHS which is managed CNWL and an Early Intervention Psychosis Service managed by Camden and Islington Mental Health Trust.

Camden CAMHS clinicians employed by the Trust are also present in the Integrated Early Years Service in Children's Centres around the borough, the Youth Offending Service, Pupil Referral Units, all the Special Schools in Camden, and Primary Schools (TOPS). Clinicians in these services pick up referrals directly from the multi-agency teams they work with. A small group of CAMHS staff are also located in a local authority team called the Transformation Team who work with troubled families, using a multi agency whole family approach.

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

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

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



## Board of Directors : May 2016

Item: 08

Title : Annual Report and Accounts, Quality Report

**Note:**

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

**Purpose:**

The Annual Report and Accounts have been compiled in accordance with the *NHS Foundation Trust Annual Reporting Manual 2015/16*, issued by Monitor.

The report has been reviewed by the management committee and by the audit committee in May, as well as having been reviewed by our external auditors.

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

This report focuses on the following areas:

- Quality
- Communications
- Finance

**For :** Approval

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

## Board of Directors: May 2016

**Item :** 9

**Title :** Chief Executive's Report

**Summary:**

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

**For :** Discussion

**From :** Chief Executive

## Chief Executive's Report

### **1. Raising our profile**

- 1.1 We held an event with staff on 4<sup>th</sup> May to consider issues around how we can best work together to raise the profile of the Trust and of our contribution to public debate.
- 1.2 On 13<sup>th</sup> May the Today Programme included a substantial feature on our GIDS service including excellent interviews with a service user and parent from the service and Bernadette Wren, the Trust's Head of Psychology. We had also been successful, earlier in the work, in securing a substantial feature on the service in the Evening Standard.
- 1.3 Both features provided the opportunity to set out an informed and positive view of the issue of gender dysphoria and the work of the GIDS service.

### **2. Meeting with BME staff**

- 2.1 On 10<sup>th</sup> May Paul Burstow and I held an open, Chatham House meeting with BME staff as part of our efforts to give greater focus to promoting equality of opportunity across the organisation. The meeting was well attended by staff from different parts of the organisation and raised a number of issues for us to consider further. We will be preparing a communication for staff about the meeting.

### **3. CQC report**

- 3.1 We have received our draft CQC Inspection report and have responded, as requested, with points of factual accuracy. We expect the report to be published in the week commencing May 23<sup>rd</sup>. Our Quality summit is scheduled for 7<sup>th</sup> July.

### **4. QAA**

- 4.1 The Trust was visited between 26<sup>th</sup> and 29<sup>th</sup> April by a team from the Quality Assurance Agency (QAA). Preparation for the visit involved a considerable amount of work from staff across the Directorate of Education and Training and was handled in a very professional manner. I would particularly like to highlight the role of Louis Taussig Head of Academic Governance and Quality Assurance who acted as the facilitator for the visit.
- 4.2 We have been given some initial feedback on the likely recommendations in our QAA report. We are due to receive a draft

report at the beginning of June and the final report will be published towards the end of July.

## **5. North Central London Mental Health Programme**

5.1 We have continued to engage with work on the development of the Sustainability and Transformation Plan in North Central Plan. The plan is due to be submitted on 30<sup>th</sup> June.

5.2 A second stakeholder event was held on May 12<sup>th</sup>.

## **6. Care Notes Optimisation**

6.1 Toby Avery has been continuing to lead work on our Care Notes Optimisation Project. An update on progress is included at **Annex A** of this report.

Paul Jenkins  
Chief Executive  
16<sup>th</sup> May 2016

## **Annex A**

### **CareNotes Optimisation Update – May 2016**

#### **Background**

Following the implementation of Carenotes throughout the Trust in July 2015, a number of issues and challenges arose in regard to both user engagement and with the system itself and an action plan was developed to address these. In January – April 2016, work was undertaken to address the immediate problems caused by these complications and a number of milestones have been achieved. Work remains to be done in several areas, including staff engagement, outcome monitoring collection improvement, training, fixing remaining technical issues and further deployments. The solution further requires optimisation if the Trust is to derive the full benefits from the system.

#### **Progress to date**

Significant progress has been made between January and April, a detailed list of improvements/changes can be found at **appendix A**.

During late April and early May the project has been formalised with a clear brief being developed, milestones/deliverables agreed, project management resource assigned, project team established and clear links to ongoing outcome monitoring improvement work.

#### **Next steps**

A number of deliverables have been agreed in conjunction with clinical staff, the CareNotes user group, Informatics and IT. The aim is to achieve the majority of the deliverables by September/October so they are in place before we begin training new students on CareNotes.

#### **Risks**

A number of project risks have been identified:

- Availability/capacity of key staff to deliver changes and training within the timescales proposed
- Competing priorities for Informatics and others to deliver changes due to re-organisation of services.
- Funding needs to be confirmed for the project management resource.

## Appendix A – Optimisation to date

### Informatics

- Not applicable reasons and linked tick box to auto populate once valid reason is given
- Manual forms disabled Trust-wide; ad-hoc manual Outcome Monitoring form creation by certain individuals when assist logic does not cater the need and is clinically required.
- Outcome Monitoring assist function to auto-populate Outcome Monitoring forms headers, so stage name, informant, due dates etc. is auto populated to improve data quality and time saving
  - These fields have also been made mandatory
- Due forms generated from closed cases marked as N/A
- Sections greyed out where appropriate (i.e. where Sent Date for non-sent forms; negative response to smoking/drinking in physical health form)
- Due forms generated from closed cases marked as N/A
- Work in progress with City and Hackney service to remove any locally managed excel reports for external reporting. Carenotes system changes and new reports development will ensure reporting from data warehouse only.
- Portman clinicians have been trained, now managing patient caseload and recording appointment activity in Carenotes. Since March we received 28 Carenotes change requests, 18 have been completed, 1 awaiting sign-off, 9 in progress pending

### Quality Team / Informatics

- 8,000 forms missing information amended to include necessary data
- Amending reporting system to reflect correct improvement in Outcome Monitoring measures
- Updating and advising on team logics
- Duplicate forms removed

### Quality Team

- Re-training of all teams on Outcome Monitoring
- Form collection for Q4 up 20% from Q3
- Goal Based Measures with missing goals and/or missing scores have been flagged and sent to clinicians and/or marked as N/A
- Forms with missing information (such as stage name, informant, N/A issue) and incorrect information (such as stage name, completed date, sent date, etc.) unable to be corrected by scripts corrected manually

- Crib sheet reference guide disseminated to AF and CYAF for best practice

#### **CYAF Admin**

- Clinicians contacted to provide missing OM information
- Clinician feedback regarding Carenotes collected and collated

#### **Comms**

- Weekly Carenotes Top Tips
- Carenotes User Group

## Board of Directors : May 2016

**Item :** 10

**Title :** Finance and Performance Report

**Summary:**

The Annual Accounts for 2015/16 are presented separately for approval.

For 2016/17, contract income and contribution is now higher than budget, which has met the productivity target. However, this is likely to be offset by some additional cost pressures.

After the first month of the new year, a surplus of £261k is reported, £161k above the planned surplus of £99k. We aim to have a surplus of £300k by the end of the year.

Analysis by service line is not provided this month.

The cash balance at 30 April was £5,070k.

**For:** Information.

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

## **1. External Assessments**

### **1.1 NHS Improvement**

1.1.1 NHS Improvement's assessment on Quarter 4 is awaited. It is expected that our Financial Sustainability Risk Rating will remain at 4, and the rating for governance remain green.

1.1.2 The 2016/17 Plan was submitted to NHS Improvement on 18 April. The Plan should lead to a Financial Sustainability Risk Rating of 4.

## **2. Finance**

### **2.1 2015/16**

2.1.1 The annual report and accounts are due to be approved at the May meeting of the Board. They will then be submitted to NHS Improvement, and will be laid before Parliament early in July. The surplus was £1,013k before restructuring costs of £773k; this is a reduction on the draft figures reported last month due to a reduction on the capitalised value of the Relocation project on the advice of the auditors.

### **2.2 Income and Expenditure 2016/17**

2.2.1 After April the trust is reporting a surplus of £261k before restructuring costs, £161k above budget. Income is £65k below budget, and expenditure £216k below budget.

2.2.2 The income shortfall for April of £65k is mainly due to the following reasons

2.2.2.1 Training is £64k below plan, mainly due to £33k LCPPD income deferred to reflect activity in a later period.

2.2.2.2 Consultancy Income is £32k below target mainly due to TC Income £29k below budget as two projects were moved from April to May.

2.2.2.3 Clinical Income is £29k above budget, Adult and Forensic Services income is £18k under budget due to a shortfall on NPA and Consultancy income which is offset by GIDU over performance from 2015/16.

2.2.3 The favourable position of £226k on the expenditure budget was due mainly to the under spends of £63k in Complex Needs and £54k in GIDU due to vacancies and lower than expected non pay costs. The remainder of the under spend was mostly vacancies spread across the organisation.

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

### **2.3 Budget 2016/17**

2.3.1 The income and expenditure budgets have been revised as a result of additional income secured by the Commercial team. There have also been a number of issues resolved detailed below. The outstanding productivity target of £441k has

been achieved and the Contingency reserve has increased to £176k.

<b>Movement from Opening Budget</b>	Income £000	Spend £000	Net £000
NHSE GIDU contract increase	1,491	1,233	258
FNP Contract Reduction	-187	-187	0
Camden TAP increase	109	67	42
City and Hackney increase	279	232	47
Other contract variations from initial budget	130	0	130
One Hackney performance fund	246	246	0
City & Hackney Care planning	-40	-32	-8
GIDS consultancy income	40	0	40
Other minor factors. Non Camden CAMHS		20	-20
CQC fee increase	0	20	-20
	<b>2,068</b>	<b>1,599</b>	<b>469</b>

2.3.2 However, offsetting these improvements, two new cost pressures may be a significant call on the reserve. Their effect will be evaluated shortly:

2.3.2.1 The revaluation of the Trust's land and buildings may have increased the annual charges for depreciation and dividend by more than the budget allowed for.

2.3.2.2 Some of the Relocation project costs will now be classified as revenue rather than capital.

## 2.4 **Cash Flow**

2.4.1 The actual cash balance at 30 April was £5,070k, an increase of £1,715k on the opening cash balance of £3,355k. The increased balance was mainly due to the quarterly payment in advance from HEE.

### **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 one month the income budget for named patient agreements (NPAs) is £6k above plan.

3.1.3 Day Unit income budget was increased by £215k to £1,054k in 2016/17 and is on target after April.

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

Carl Doherty  
Deputy Director of Finance  
17 May 2016

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



THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST  
INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2016-17

All figures £000

	Apr-16			CUMULATIVE			OPENING BUDGET	REVISED BUDGET
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE		
<b>INCOME</b>								
1 CENTRAL CLINICAL INCOME	627	642	15	627	642	15	7,397	7,526
2 CYAF CLINICAL INCOME	471	484	12	471	484	12	5,490	5,490
3 AFS CLINICAL INCOME	637	619	(18)	637	619	(18)	4,127	4,721
4 GENDER IDENTITY	415	435	20	415	435	20	3,487	4,978
5 NATIONAL TRAINING CONTRACT	605	605	0	605	605	0	7,254	7,254
6 CHILD PSYCHOTHERAPY TRAINEES	199	170	(29)	199	170	(29)	2,391	2,391
7 JUNIOR MEDICAL STAFF	70	75	5	70	75	5	838	838
8 POSTGRADUATE MED & DENT'L EDUC	7	2	(5)	7	2	(5)	88	88
9 PORTFOLIO FEE INCOME	411	399	(12)	411	399	(12)	6,072	5,859
10 DET TRAINING FEES & ACADEMIC INCOME	52	19	(33)	52	19	(33)	823	1,036
11 FAMILY NURSE PARTNERSHIP	257	268	10	257	268	10	3,274	3,086
12 TC INCOME	72	43	(29)	72	43	(29)	863	863
13 CONSULTANCY INCOME CYAF	4	5	1	4	5	1	48	48
14 CONSULTANCY INCOME AFS	16	13	(3)	16	13	(3)	193	193
15 R&D	4	4	0	4	4	0	53	53
16 OTHER INCOME	51	52	1	51	52	1	571	611
<b>TOTAL INCOME</b>	<b>3,899</b>	<b>3,834</b>	<b>(65)</b>	<b>3,899</b>	<b>3,834</b>	<b>(65)</b>	<b>42,967</b>	<b>45,035</b>
<b>EXPENDITURE</b>								
17 COMPLEX NEEDS	564	501	63	564	501	63	3,504	4,019
18 PORTMAN CLINIC	120	116	4	120	116	4	1,380	1,378
19 GENDER IDENTITY	265	211	54	265	211	54	2,795	4,027
20 DEV PSYCHOTHERAPY UNIT	10	8	2	10	8	2	124	124
21 NON CAMDEN CAMHS	451	457	(5)	451	457	(5)	5,273	5,295
22 CAMDEN CAMHS	400	394	6	400	394	6	4,803	4,803
23 CHILD & FAMILY GENERAL	58	62	(4)	58	62	(4)	699	699
24 FAMILY NURSE PARTNERSHIP	202	196	7	202	196	7	2,893	2,706
25 JUNIOR MEDICAL STAFF	83	68	14	83	68	14	993	993
26 HEE FUNDED CP TRAINEES	197	174	23	197	174	23	2,370	2,370
27 TAVISTOCK SESSIONAL CP TRAINEES	2	1	0	2	1	0	18	18
28 FLEXIBLE TRAINEE DOCTORS & PGMDE	20	29	(9)	20	29	(9)	242	242
29 EDUCATION & TRAINING	257	253	4	257	253	4	3,598	3,842
30 VISITING LECTURER FEES	85	103	(18)	85	103	(18)	1,229	1,215
31 CYAF EDUCATION & TRAINING	36	21	15	36	21	15	535	436
32 ADULT EDUCATION & TRAINING	32	6	26	32	6	26	513	380
33 PORTFOLIOS	146	147	(1)	146	147	(1)	1,749	1,749
33 TC EDUCATION & TRAINING	0	0	(0)	0	0	(0)	0	0
34 TC	57	39	19	57	39	19	687	687
35 R&D	13	15	(2)	13	15	(2)	155	155
36 ESTATES DEPT	170	168	3	170	168	3	2,045	2,065
37 FINANCE, ICT & INFORMATICS	213	205	9	213	205	9	2,562	2,562
38 TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	123	122	1	123	122	1	1,458	1,458
39 COMMERCIAL DIRECTORATE	39	39	(0)	39	39	(0)	464	464
40 HUMAN RESOURCES	54	63	(10)	54	63	(10)	642	642
41 CLINICAL GOVERNANCE	66	65	1	66	65	1	789	789
42 CEA CONTRIBUTION	10	10	(1)	10	10	(1)	117	117
43 DEPRECIATION & AMORTISATION	71	61	10	71	61	10	850	850
44 VACANCY FACTOR	0	0	0	0	0	0	0	0
45 PRODUCTIVITY SAVINGS	0	0	0	0	0	0	(441)	0
46 INVESTMENT RESERVE	0	0	0	0	0	0	0	0
47 CENTRAL RESERVES	16	0	16	16	0	16	150	176
<b>TOTAL EXPENDITURE</b>	<b>3,760</b>	<b>3,534</b>	<b>226</b>	<b>3,760</b>	<b>3,534</b>	<b>226</b>	<b>42,195</b>	<b>44,263</b>
<b>OPERATING SURPLUS/(DEFICIT)</b>	<b>139</b>	<b>300</b>	<b>161</b>	<b>139</b>	<b>300</b>	<b>161</b>	<b>772</b>	<b>772</b>
48 INTEREST RECEIVABLE	1	1	0	1	1	0	8	8
49 DIVIDEND ON PDC	(40)	(40)	0	(40)	(40)	0	(480)	(480)
<b>SURPLUS/(DEFICIT)</b>	<b>99</b>	<b>261</b>	<b>161</b>	<b>99</b>	<b>261</b>	<b>161</b>	<b>300</b>	<b>300</b>
50 RESTRUCTURING COSTS	0	4	(4)	0	4	(4)	0	0
<b>SURPLUS/(DEFICIT) AFTER RESTRUCTURING</b>	<b>99</b>	<b>256</b>	<b>157</b>	<b>99</b>	<b>256</b>	<b>157</b>	<b>300</b>	<b>300</b>

## Board of Directors : May 2016

**Item :** 11

**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 9<sup>th</sup> May 2016.

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

*(delete where not applicable)*

- Quality
- Risk
- Finance
- Productivity
- 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 9<sup>th</sup> May 2016 and discussed the issues presented in this report.

### 2. Visiting Lecturers Review

- 2.1 Susan Thomas and Pat Key attended for this item to present a report on the Visiting Lecturer (VL) review they have been conducting with Karen Tanner and Fiona Hartnett.
- 2.2 The paper highlighted the complexities and risks associated with the current system of engaging VLS.
- 2.3 A number of potential proposals were included in the report.
- 2.4 The programme board discussed these proposals and agreed they offered a helpful way forward in addressing issues relating to the employment of VLS and wider workforce requirement in education and training.
- 2.5 It was agreed that the proposals would now be developed to include a more specific and costed recommendation on the way forward. The aim would be to consider this at the June TEPMB prior to a paper going to the June Board of Directors.

### 3. Restructure and Office Reconfiguration

- 3.1 Brian Rock explained to the programme board that all posts had now been filled following the restructure and all existing team members had moved to their revised roles.
- 3.2 In addition he advised the programme board that the building work in the DET offices was now complete and a student reception area was now available to students. This will provide a more visible contact point for students to engage with professional support staff and would enable members of the core administrative team to focus on their workload without unnecessary interruption.

### 4. Education Funding Reforms

- 4.1 Catrin Bradley, Head of our Child Psychotherapy Programme, and Bidy Youell, Trust Child Psychotherapy Head of Discipline, attended for this item.

- 4.2 PJ explained to the group that a consultation for the reform of Education Funding had begun and was due to end on 30<sup>th</sup> June. While this did not specifically include Child & Adolescent Psychotherapy or Psychology, it is envisaged that the changes following this consultation will have an impact on these courses.
- 4.3 The programme board discussed the implications of this review with particular emphasis on the lack of clarity as to what the proposed changes were.
- 4.4 The group discussed how it could be involved in raising awareness of the possible implications of these changes.
- 4.5 It was agreed that a small group would be convened to consider how courses may be developed were funding changes to take place with a greater burden on individual students than currently is the case.

## **5. QAA Visit**

- 5.1 PJ informed the programme board that he had received an initial letter from the QAA following their review of the department last month.
- 5.2 It indicates a positive outcome from the review and the Trust should receive a draft report in early June.
- 5.3 Elisa Reyes-Simpson, Associate Dean (Academic Governance & Quality Assurance) highlighted the engagement and hard work of all involved. PJ extended his thanks to Elisa and Louis Taussig in particular as well as to other members of the programme board that had been involved in making the visit a success.

## **6. Recruitment Update**

- 6.1 Laure Thomas, Director of Marketing & Communications, provided an update on student recruitment.
- 6.2 We are ahead in applications and are also arranging interviews and making offers at an earlier stage than previous years;
  - 6.2.1 There has been a 50% increase on the number of applications received compared with this time last year.
  - 6.2.2 Advertising continues in a variety of publications (The Guardian, Therapy Today and the Big Issue amongst others).

- 6.2.3 The recruitment team continue to attend conferences and events to promote the Trust's training portfolio.
- 6.3 Open evenings are continuing with course specific events being held in coming weeks;
  - 6.3.1 115 people attended the April open evening.
  - 6.3.2 140 people are signed up for the various course specific open evenings.
  - 6.3.3 There will be a forensic portfolio open evening on 8<sup>th</sup> June.
- 6.4 The recruitment team continues to monitor applications and will step in if any courses become a cause for concern.
- 6.5 PJ expressed how encouraging this was and highlighted the benefits of having clear data surrounding student recruitment.

## **7. The National Contract**

- 7.1 PJ advised the programme board that work on the national contract continues and that a task and finish group is being established with members of HEE to take this forward.
- 7.2 Oversight for the work of this group will be provided by Paul and Liz Hughes on a bi-monthly basis.

## **8. SIMS Project Update**

- 8.1 BR explained to the group that a revised project board had now been convened to provide oversight for the implementation of the system given where we now are in the procurement. This board meets monthly and has NED representation by Edna Murphy.
- 8.2 Geraldine Crehan has agreed to undertake a session a week for the project to provide faculty engagement and input through the implementation phase.

**Brian Rock**  
**Director of Education and Training/Dean of Postgraduate Studies**  
**15<sup>th</sup> May 2016**

## Board of Directors : May 2016

**Item** : 12

**Title** : CQSG Committee Report, Q4, May 2016

### **Purpose:**

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

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

- Clinical Quality, Safety, and Governance Committee
- Executive Management Team

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

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

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

**For** : Discussion

**From** : Rob Senior, CQSG Chair

## Clinical Quality, Safety, and Governance Committee

### Notes from a meeting held at 11:00, Tuesday 3<sup>rd</sup> May 2016, Boardroom

Members	Present?
Rob Senior, Medical Director (& CQSGC Chair)	Y
Paul Burstow, Trust Chair	Y
Dinesh Bhugra, Non-Executive Director	Y
Anthony Levy, Public Governor	Y
George Wilkinson, Public Governor	A
Paul Jenkins, Chief Executive	Y
Simon Young, Senior Information Risk Owner	Y
Louise Lyon, Patient Experience and Quality Director	Y
Sally Hodges, CYAF Director	Y
In attendance	
Irene Henderson, Clinical Governance Manager	Y
Caroline McKenna, CO & CA Lead	Y
Jessica Yakeley, PSCR Lead	Y
Elisa Reyes Simpson, Associate Dean for Academic Governance and Quality Assurance	Y
Marion Shipman, Associate Director Quality and Governance	Y
Jonathan McKee, Governance Manager (& CQSGC Secretary)	Y

AP	Item	Action to be taken	By	Deadline
2 [Nov 15]	5 (a)	<i>generate robust clinical data quality reports enabling management of team or individual clinician practice [via CQPE work stream report]</i>	MS, LL	31.3.16
1	5 (a)	<i>SY to explore with Quality Team and Informatics managers whether plans to address IG toolkit requirements can be developed in order to meet standards sooner</i>	SY	31.5.16
2	5 (b)	<i>Doctors to be prompted to read the prescribing procedure when it has been updated and published</i>	RS	31.5.16
3	5 (b)	<i>An audit of compliance with the completion of the prescription table in CareNotes will be undertaken and findings reported to directors of clinical services, with completion of this task noted in the PSCR report</i>	JY	30.9.16
4	5 (b)	<i>A protocol is to be added to the safeguarding procedure outlining how clinicians and team leaders will be informed, discuss in teams, and disseminate further, information relating to safeguarding</i>	IH	30.6.16

Items in italics should be reported through the respective work streams.

## Preliminaries

Action

### 1 Chair's opening remarks

Rob Senior welcomed Irene Henderson, who will be in attendance in her role as Clinical Governance Manager from now on (and will take the notes).

Rob thanked Jonathan McKee for all his work in establishing the committee and work in supporting it over the last five years.

### 3 Notes from the last meeting

These were accepted as a true record.

### 4 Matters arising

Elisa Reyes-Simpson reported that DET was reporting on various areas for clinical trainees, as if they were employed staff, and that the figures are included in the main figures.

Other items were addressed under the respective work streams

### 5 Reports from work stream leads

#### a) Information Governance

Simon Young presented his previously circulated report and highlighted:

- Overall ~the Trust had not achieved the minimum standard required by the Health and Social Care Information Centre on the IG Toolkit (the self-assessment tool for IG compliance), due to failing on five items -three in the clinical data quality area, and two in relation to clinical coding. These outcomes were in the 'secondary uses' domain.
- Despite these shortcomings, the Trust achieved 82% overall, but this is not satisfactory according to HSCIC criteria
- For some areas the Trust performed exceptionally well, eg for mandatory IG training

The committee

- ❖ Noted that the EMT had commissioned a project to address the weak areas to plan for change to enable a better performance outcome in future years, and to learn from the episode so as not to repeat it
- ❖ Noted that the risk of not achieving the level had been apparent, at least as early as Q3 (as noted at the last meeting) and had been quantified further by EMT in February, with additional reports in March. EMT had expected the standard to be reached nevertheless.
- ❖ Simon Young was disappointed that plans put to him to address the weak

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areas were not going to reach the standard required by the deadline that he had set; the committee were dissatisfied and asked that the proposals be reviewed and improved if possible

15Y

- ❖ Progress on two of the items on the action tracker was noted

The committee accepted the report as assurance on performance, or as satisfactory progress towards attaining assurance where action plans were in place, subject to the action point above. The proposed red rating was confirmed.

## b) Patient Safety and Clinical Risk

Jessica Yakeley presented her previously circulated report and highlighted:

- There had been only two SIs in 2015/16, one fewer than in the previous year; action plans were being implemented
- There had been a small increase in the number of complaints, but there did not appear to be a trend in those received
- The safeguarding children assurance line remains amber due to systems changes in both Camden Local Authority and at the Trust, until these are embedded it is not possible to eliminate the possibility of anomalies in data reconciliation exercises so the rating is amber
- The Trust had engaged with the 'Sign up to Safety' national initiative
- A number of reporting lines appeared to under-report concerns, given that the CQC had raised some issues, in retrospect some of the greens should have been reported amber

The committee

- ❖ Was concerned that the committee's action on the action tracker (relating to prescribing practice) had not been addressed in the report. The procedure needs to be updated. Change in practice will be followed-up by the discipline head; whether the change in practice is followed will be the subject of a clinical audit 2JY 3RS
- ❖ Noted that more needs to be done to address lessons learned and ensure that dissemination of learning was reported
- ❖ Declined to change the terms of reference for the Safeguarding Committee as the committee was working well; -it is already the task of this workstream to take an overview of all safeguarding activity and management, so no change is indicated
- ❖ Wished to see safeguarding reports discussed at team meetings, with team managers taking responsibility to review all new cases as they arise - a new protocol is to be drafted by the lead manager [as an appendix to the respective procedure] 4IH
- ❖ Decided that there would be an extraordinary meeting to review the draft CQC action plan

The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in

place; subject to the directions given to be addressed on the work stream action tracker, the proposed amber rating was confirmed.

### c) Clinical Quality Effectiveness and Patient Experience

Louise Lyon presented her previously circulated report and highlighted:

#### ***Clinical Outcomes***

- A lot of progress had been made on CQUIN targets, despite the shortcomings in clinical data quality noted by the IG work stream; however, the lack of systems, data quality management, and capability meant that a huge effort had been required and this approach was not sustainable
- A general review of data collections had begun

The committee

- ❖ Appreciated the progress made but was mindful that the Trust would not be able to deliver its ambition without good data informing strategy planning discussions; moreover, external data requests must never be allowed to dominate the Trust's own needs and activity to improve care
- ❖ Was concerned that quality improvement was not being driven by data, leaving the impression that data collections was process driven and not for patient benefit

#### ***Clinical audit***

- The committee wished to see the proposed investment in this area addressed without further delay
- Noted that this will be a priority for the Clinical Audit Lead and the Clinical Governance Manager who will be leading development in this area; Rob Senior has discussed this with Louise Lyon, and he will be bringing a paper to EMT.

The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place. An amber rating was allocated.

#### ***PPI/ patient experience***

- Louise Lyon had found that there had been 64 interview panels that had users serving on them.
- The committee noted that tasks in this area had been completed as planned

#### ***Overall***

Louise Lyon reported that the work stream would be reporting against its terms of reference from Q1 2016/17.

The committee accepted the report as assurance on performance or as

satisfactory progress towards attaining assurance where action plans were in place. An amber rating was allocated overall.

#### **d) Corporate Governance and Risk**

Marion Shipman presented her previously circulated report and highlighted:-

- Four IG risks had been added to the Trust's risk register by the SIRO
- Marion Shipman was dissatisfied with her predecessor's reporting of incidents to the NRLS system, citing differences of opinion about weightings given to individual incidents

The committee

- ❖ Declined to change the arrangements for the CQC oversight assurance, feeling strongly that the Trust should map out its own course to its own governance as suited local practice based on experience and patient feedback.
- ❖ Wished to see all national standards interpreted in the context of Trust's good performance and management approach. Respective work stream leads will continue to report on applicable elements of regulatory standards as the always have done

The committee accepted the report as assurance on performance or as satisfactory progress towards attaining assurance where action plans were in place. The proposed green rating was confirmed.

### ***Conclusion***

#### **6 Annual Review**

The committee was pleased to receive the report on the work of 2015/16, which despite having been challenging as it had highlighted some weak areas, had certainly discharged its terms of reference. Paul Jenkins summarised by saying the committee was fit for purpose, as had been confirmed by the CQC when they visited.

Following the minor changes to the TOR in February, no further change was indicated (but some reporting metrics will be updated, especially concerning CQC recommendations).

The report was accepted and will be submitted to the Board.

#### **7 Notice of future meetings**

11am, Tuesday 6th September  
11am, Tuesday 1st November

The annual scheduling exercise has been expanded to include the Safeguarding Committee; all meeting dates for key committees will shortly be released.

**Discussion on the duty of candour** ~Marion Shipman tabled a paper on this topic and offered an opinion on the way the Trust discharged its duty, suggesting that the Trust failed to meet national standards. The committee was concerned that this opinion was not supported by data. The committee directed that Marion should undertake an audit, with findings reported to EMT in the first instance, and should the findings give the EMT concern, then it could decide whether this was a matter to pursue.



## Board of Directors : May 16

<b>Item :</b> 13
<b>Title :</b> CQSG: Annual Performance Review, 2015/16
<b>Summary :</b> <p>The Board of Directors has directed all committees to review and report on their performance annually. Each work stream lead is also required to undertake a review of their performance against their terms of reference; this work contributes to the report overall and these submissions are attached as appendices. There are four work streams, all but CQPE have reported against their terms of reference at the end of each quarter (CQPE reported against the 2011-15 TORs for previous workstreams pending the development of new arrangements in the Quality Directorate). The respective reviews from the leads are attached.</p> <p>Overall, the committee has discharged its terms of reference, as evidenced by the work stream submissions and subsequent discussion at the CQSG and at the Board.</p> <p>An updated version of the terms of reference that includes organisational changes and changes to the PSCR and CGR work streams is presented for ratification.</p>
<b>For :</b> Discussion and agreement
<b>From :</b> Jonathan McKee, Governance Manager

## Information Governance work stream annual review 2015/16

### Key Points for 2015/16

- 98% completed basic mandatory training successfully
- Governance and corporate records management scored at the highest levels
- Satisfactory outcomes were found for confidentiality, data protection assurance, and clinical information assurance, albeit with some improvements required
- For secondary use assurance the Trust was below level 2 in five areas. Remedial project work is in progress.

Duty –to provide assurance that:	Review of performance in providing the assurance
<p>prospective submissions to HSCIC are fit for purpose, and where there are short falls in performance that action plans are drawn up and then monitored</p> <p>that the Trust maintains an effective IG strategy and associated procedures that are fit for purpose</p> <p>that IG risks are effectively identified, assessed and managed and that the risk register is kept up to date with information about the management of these risks</p>	<p>The Trust achieved 82% overall, but unsatisfactory due to not achieving the standard on 5 requirements. The shortfall in performance is subject to a project which shall report direct to EMT.</p> <p>All policies and procedures are up to date following a comprehensive review.</p> <p>Gaps in the management of project risks, and confusion about getting items from a departmental risk register to a Trust risk register need to be resolved.</p>

that IG incidents are being managed effectively and in line with the Trust's procedures, and that all 9+ incidents are appropriately investigated, out outcomes documented in a quarterly report	There were no incidents above 9. All incidents were reviewed by the SIRO, Caldicott Guardian, and IG Lead; then also reviewed by the IG work stream group.
that information security matters are effectively managed as confirmed by receipt of reports from the ICT Manager	Assurance was received that routine reports were being reviewed; an audit of cyber security was undertaken and action plan is being worked through.
that information assets are managed in accordance with the respective procedures	The growth in the number of assets indicates that all assets are known and managed safely, though the increase will have implications on capacity eventually.
that external information governance submissions are accurate	These receive scrutiny at various levels, and are verified by the IG manager and validated by the SIRO.
that reports on responding to the recommendations made by external bodies following reviews and inspections are made on time and that the risk register is updated where appropriate	This is managed through the CGR work stream, there were no applicable recommendations for IG in 2015/16
that all requests for information made under the Freedom of Information Act were responded to by the statutory deadline and that any trends are explored	Despite a large increase in volume, improvements have been made to the time taken to respond to requests.
A comprehensive IG training programme has been delivered by the Governance Manager	The Trust attained the highest level to date: 98%

### **Key risks for 2016/17**

- The National Data Guardian's Report is awaited, the CQC report on clinical data awaits that report, HSCIC's implementation guidance will follow these reports; further delay will be unhelpful.
- If the new training tool is not available by early summer this will make completion of mandatory training a challenge
- Robust and extensive improvements are needed in the areas of clinical data quality

## Patient Safety and Clinical Risk work stream annual review 2015/16

### Highlights for 2015/16

The ToR were reviewed, updated and approved in January 2016 by the CQSG committee. Additional responsibilities relating to Sign up to Safety programme assurance and CQC 'safe' domain updates were added and membership was reviewed. Before December 2015 the evidence required to provide assurance to the CQSG committee was reviewed by the Trust Patient Safety Lead, Dr Jessica Yakeley with Risk Lead, Jane Chapman.

A work plan has been developed for the Patient Safety Clinical Risk (PSCR) Workstream and standing agenda items for each meeting are set out below. Meetings are now formally minuted.

- Patient Safety Clinical Risk Report
- Clinical incident reports
- Sign up to safety updates
- Serious incident updates and action tracker
- Review of risk register – clinical risks
- Revalidation report
- Safeguarding minutes
- CQC 'safe' domain update
- Clinical supervision

	Duty -to provide assurance that:	Review of performance in providing the assurance
The Trust follows its processes on managing clinical incidents, complaints and claims.		Clinical incidents, complaints and claims were reviewed on a quarterly basis.
The Trust learns lessons arising from clinical incidents, complaints and claims.		A summary of lessons learned has been included in the quarterly Corporate Governance and Patient Safety (CGPS) Risk Compliance Report. A process to monitor lessons learned and actions taken from 'upheld' or 'partly upheld' complaints was established from

	January 2016 and information included from the Q3 CGPS report.
In the event of a serious incident the Trust follows its investigation procedure in relation to investigation, whilst being open with patients and relatives, and supports staff directly involved.	The Incident form and incident database were both updated in January 2016 to include Duty of Candour information. Being Open information was included in staff mandatory training sessions and induction sessions during 2015/16. This was updated to reflect 'duty of candour' information from October 2015.
The Trust follows any agreed action plan arising from the investigation of a serious incident.	A serious incident Action Tracker was implemented from January 2016 to monitor serious incident actions.
Trust evidence for compliance with CQC Safety domain is fit for purpose and where there are short falls in performance, that action plans are drawn up and then monitored [agreed January 2016]	
The Trust effectively supervises all clinical practitioners	Audit of all clinicians in Trust showed all were receiving clinical supervision except one clinician. Discussion of clinical governance and risk issues was also audited. Audit was shared with heads of discipline. Audit to be repeated in 2017, and thereafter every three years.
Appropriate clinical risks are included on the Trust's risk register, including Trust wide risks arising from the Safeguarding Committee.	Information is included on the quarterly Corporate Governance and Patient Safety (CGPS) Risk Compliance Report.
Clinicians receive adequate training and updating on clinical risk management.	In the past year, clinical risk training was provided at clinical induction for all new starter clinicians. Trainings for CYAF are conducted regularly by Caroline McKenna, and a training session for adults and forensic services was given in November 2015 by Jessica Yakeley. All clinicians will be required to attend these trainings every 3 years.
The Trust responds in an appropriate and timely fashion to all relevant clinical safety alerts.	This was achieved over the past year.
The Trust's revalidation processes for doctors are working	A medical revalidation background paper was received at the

effectively.	December PSCR meeting where it was agreed a quarterly update report would be provided to subsequent meetings.
The Trust complies with the Health Act 2006 on reducing HCAIs that actions are undertaken and any recommendations are considered and implemented where appropriate.	Information has been included in the quarterly Corporate Governance and Patient Safety (CGPS) Risk Compliance Report. Information on training relating to infection control matters is included in the quarterly HR Workforce Report received by the workstream.
The Trust participates in relevant confidential enquiries, monitor these reports and receive assurance that appropriate lessons from these reports are learned in the Trust.	
Monitor progress against the Trust's 'Sign up to Safety' work programme. [agreed January 2016]	The four Sign Up to Safety Leads report to the quarterly PSCR meeting. The PSCR lead monitors progress.

#### Key risks for 2016/17

- Learning from complaints and incidents is not sufficiently shared across teams/services/directorates
- Not all clinicians complete clinical risk training.

# Clinical Quality and Patient Experience Annual Review 2015/16

## Highlights for 2015/16

- The work stream brings together three former work streams within which there has been variable performance over the year largely due to problems post implementation of CareNotes. The Patient and Public Involvement Team have successfully delivered on their plans and are in a strong position to take forward developments for 2016-7

<b>Duty –to provide assurance that</b>	<b>Review of performance in providing the assurance</b>
<p>directors of clinical services have plans in place to improve the culture and practice of data collection, management, and quality</p>	<p>Following the implementation of CareNotes a number of issues arose in terms of data collection, management and quality especially in relation to clinical outcome data. These issues are being addressed and further work will be led by the CareNotes optimisation programme</p>
<p>reports provide assurance that outcome data has improved outcomes at individual and patient group levels and that the results, where they can be benchmarked, compare favourably against those of other providers</p>	<p>Joined benchmarking network to increase capacity for benchmarking. Increased quantity as well as quality of data is required to provide assurance ; data available demonstrates improved outcomes for over half of patients where Time 1 and Time 2 data are available</p>
<p>outcome monitoring methodology and practice best suits the Trust’s patient population</p>	<p>Under review, health economics analysis work may lead to the adoption of fewer and simpler measures</p>
<p>data to be collected have been agreed with the commissioners and other appropriate external parties</p>	<p>Agreement on CQUINS and KPIs was late in 15-16 due to factors external to the Trust.</p>
<p>the annual audit programme is aligned with organisational priorities as set out in the annual operational plan</p>	<p>The audit programme has been limited due to staffing changes over the year. Plans for the coming year place clinical audit as a central tool to support the quality</p>

<p>the implementation of outcomes of the recommendations of clinical audits leads to improvements in patient care</p>	<p>improvement programme. Implementation of outcomes has led to improvement but the scale of impact could be increased when audit is aligned more closely to the quality improvement programme</p>
<p>information on outcomes facilitates patient choice and that any published information is of consistent good quality and is accessible and available to prospective patients and referrers</p>	<p>There have been data reporting problems as mentioned above. Data is made available to commissioners but more work needs to be done to make information available to patients and referrers to inform choice</p>
<p>the feedback from Experience of Service Questionnaires is dealt with effectively, both individually, and by analysing trends and common issues</p>	<p>Analysis of ESQ data has improved through developing thematic analysis of the free text feedback on ESQ forms. Data has been provided at clinical team level. Quality Stakeholders group continues to review ESQ feedback. PALS feedback now quarterly and will be include in CQPE reports for 16-17</p>
<p>members contribute to strategic discussions to aid planning based on data from all available sources</p>	<p>Members have contributed to strategic discussions and the development of strategic objectives for the improvement of clinical quality</p>
<p>the Trust has prepared for inspections from the regulator of clinical services</p>	<p>Preparations achieved in time with good engagement from staff across the Trust. Draft final report awaited and publication expected in early May</p>

**Plans for 2016/17**

The Clinical Quality and Patient Experience Workstream will report on progress on the clinical quality and aims and indicators set out in the Clinical Quality Strategy under the Caring, Responsive and Effective headings.

The workstream will review the following reports :

Diversity and Inclusion data for clinical services  
Outcome monitoring data- quantity and quality of data, assessment of clinically significant change and comparison with available benchmarks  
Experience of Service Questionnaire quantitative data and thematic analysis of free text responses  
Review of quarterly PALS report  
Reports from the Quality Stakeholders Group  
Quarterly Quality Report  
Standard and mandatory clinical audit reports

The workstream will review:

Completed Quality Impact Risk Assessment Tools  
Clinical Service Line Report template and review the clinical quality sections of the report to ensure that the reports are fit for purpose  
Clinical Quality Priority progress  
Evidence of patient and care involvement in clinical service design and delivery

### **CQC feedback and action plan**

Formal feedback has not yet been received at the time of writing this report. Informal feedback strongly recommended the development of an overall integrated Trust clinical quality improvement programme.  
A quality improvement task force will be set up with the aim of ensuring that all CQC requirements are addressed appropriately and a coherent approach to quality improvement is developed with full engagement with relevant stakeholders.

The programme will be led by the Director of Quality and Patient Experience. Core group membership will comprise

Medical Director  
Associate Medical Directors  
Associate Director, Quality and Governance

Additional membership will be determined once the shape of the programme is developed. The reporting line will be discussed with the Executive Management Team.

## Corporate governance and risk work stream annual review 2015/16

### Highlights for 2015/16

The ToR were reviewed, updated and approved in January 2016 by the CQSG committee. Additional responsibilities relating to CQC domain updates and Emergency Planning Resilience and Response (EPRR) arrangements were added and membership was reviewed.

A work plan has been developed for the Corporate Governance Workstream and standing agenda items for each meeting are set out below. Meetings are formally minuted.

- CQC compliance update with well-led domain
- CQC submissions
- Incident reports – non clinical incidents
- Operational Risk Register
- Workforce Report
- Health and Safety
- Estates and Facilities
- Responses to recommendations and requirements of external bodies
- EPRR
- Health and Safety Committee minutes

<b>Duty –to provide assurance that</b>	<b>Review of performance in providing the assurance</b>
Trust evidence for compliance with well-led domain CQC standard is fit for purpose and where there is a short fall in performance, an action plans is drawn up and then monitored. –[new responsibility from April 2016]	To be updated following receipt of the CQC inspection report. A draft action plan based on verbal CQC feedback was discussed at the CQC Steering Group in March and is to be led by the Director of Quality and Patient Experience.
Submissions to CQC are fit for purpose and where there are short falls that action plans are drawn up and then monitored.	Trust currently awaiting draft CQC inspection report for ‘factual’ review.
That the Trust maintains an effective risk strategy and associated procedures that are fit for purpose,	Verbal reporting has been provided. Going forward for 2016/17 a more formal assessment report against NHSLA risk management standards will be provided.
That non-clinical risks are effectively identified, assessed and managed and that the operational risk register is kept up to date with information about the management of these risks	An operational risk register was provided quarterly. This was not fully updated for the Q4 CGR meeting.
That non-clinical incidents are being managed effectively and in line with the Trust’s procedures, and that all 9+ incidents are appropriately investigated, though receipt of a quarterly report	Non clinical incidents were reviewed on a quarterly basis. It as noted in April that with the changing of the incident form during 2015/16 the position of risk grading information was moved and has resulted in an unknown number of incorrect entries onto the 2015/16 database.
That Health and Safety and Estates and Facilities matters are effectively managed	A single report including both health and safety and estates and facilities information was received quarterly and all relevant matters were covered.
That risks for the Board assurance framework are	The operational risk register has been received by the CGR

<p>appropriately escalated to the Deputy Chief Executive.</p> <p>that HR submissions of compliance with mandatory regulations are fit for purpose</p>	<p>workstream and discussed with the Deputy Chief Executive when elevated.</p> <p>HR reports were received quarterly. For the first three quarters these were limited to reports on mandatory training. In Quarter 4 the annual Workforce report was received which going forward form the basis of the quarterly reports with the addition of the mandatory training information.</p>
<p>That reports on responding to the recommendations made by external bodies following reviews and inspections are made on time and that the risk register is updated where appropriate</p>	<p>Reports have been received quarterly with updates on reviews and inspections – both those undertaken and planned.</p>
<p>The Emergency Preparedness, Resilience and Response (EPRR) arrangements are robust and that the Trust has met external EPRR compliance requirements</p>	<p>The reporting on EPRR arrangements were included in the workstream reporting from Q3 2015/16. The Trust undertook a self-assessment against the NHS England EPRR Core Assurance requirements in Q3 which was validated by NHSE and peer provider EPRR leads and submitted to NHS England in December. The Trust assessment of the Level of Compliance was 'substantial' which was notified to the Trust Board and confirmed by them in January by Rob Senior, the Trust Accountable Executive Officer (AEO) for EPRR. A work plan for 2016/17 is in place which will include work with teams to develop individual business continuity plans.</p>

**Key risks for 2016/17**

- Incident reporting and learning lessons

- Risk process – identifying all operational risks and establishing a robust process between these and the corporate risk register
- Business continuity planning across the organisation



# Clinical Quality, Safety and Governance Committee

## Terms of Reference, v5

Ratified by:	Board of Directors
Date ratified:	
Lead Manager:	Clinical Governance Manager
Lead Director:	Medical Director
Date issued:	
Review date:	May 2019

## Clinical Quality, Safety and Governance Committee Terms of Reference

### **1. Constitution**

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

### **2. Membership**

- 2.1 Membership of the Committee shall be as follows:

2.1.1 Medical Director (and Committee Chair)

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

2.1.3 Up to two Governors

2.1.4 Chief Executive

2.1.5 CYAF Director

2.1.6 Adult and Forensic Director

### **3. Attendance**

- 3.1 The following staff shall be in attendance:

3.1.1 Senior Information Risk Owner

3.1.2 Director of Quality, Patient Experience

- 3.1.3 Clinical Governance Manager
- 3.1.4 Associate Medical Director (Patient Safety, Revalidation)
- 3.1.5 Association Medical Director (Clinical Audit)
- 3.1.6 Associate Dean for Governance
- 3.1.7 Associate Director for Quality and Governance

#### **4. Quorum**

- 4.1 This shall be at least one third of members, to include at least one Non-Executive Director.
- 4.2 Each member will be expected to attend at least 75% of meetings in any year.

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

- 5.1 The Committee will meet four times per year.

#### **6. Agenda & Papers**

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

## **7. Minutes of the Meeting**

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

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

## **8. Authority**

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

## **9. Duties**

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

### **9.2 Information Governance**

To receive assurance that

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

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

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

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

9.2.5 information security matters are effectively managed

9.2.6 information assets are managed in accordance with the respective procedures

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

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

### 9.3 Patient safety and clinical risk

To receive assurance that

- 9.3.1 the Trust follows its processes on managing clinical incidents, complaints and claims
- 9.3.2 the Trust learns lessons arising from clinical incidents, complaints and claims
- 9.3.3 in the event of an SI the Trust follows its investigation procedure in relation to investigation, whilst being open with patients and relatives, and supports staff directly involved
- 9.3.4 the Trust follows any agreed action plan arising from the investigation of an SI

- 9.3.5 Trust evidence for compliance with CQC Safety domain standards is fit for purpose and where there are short falls in performance, that action plans are drawn up and then monitored
- 9.3.6 the Trust effectively supervises all clinical practitioners
- 9.3.7 safeguarding arrangements for children and adults are effective and in line with the Trust procedure and pan-London procedures
- 9.3.8 appropriate clinical risks are included on the Trust's risk register, including Trust wide risks arising from the Safeguarding Committee
- 9.3.9 clinicians receive adequate training and updating on clinical risk management
- 9.3.10 the Trust responds in an appropriate and timely fashion to all relevant clinical safety alerts
- 9.3.11 the Trust's revalidation processes for doctors are working effectively
- 9.3.12 the Trust complies with the Health Act 2006 on reducing HCAs, that actions are undertaken and any recommendations are considered and implemented where appropriate
- 9.3.13 the Trust participates in relevant confidential enquiries, monitor confidential enquiry reports and receive assurance that appropriate lessons from these reports are learned in the Trust
- 9.3.14 monitor progress against Trust's 'Sign up to safety' work programme

#### 9.4 Care Quality and Patient Experience

To receive assurance that

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

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

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

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

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

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

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

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

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

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

## 9.5 Corporate Governance and Risk

To receive assurance that

9.5.1 Trust evidence for compliance with CQC standards is fit for purpose and where there are short falls in performance, that action plans are drawn up and then monitored.

9.5.2 Submissions to CQC are fit for purpose and where there are short falls that action plans are drawn up and then monitored.

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

- 9.5.4 that non-clinical risks (except information governance related risks, see above) are effectively identified, assessed and managed and that the operational risk register is kept up to date with information about the management of these risks
- 9.5.5 that non-clinical incidents (except for information governance incidents, see above) are being managed effectively and in line with the Trust's procedures, and that all 9+ incidents are appropriately investigated, though receipt of a quarterly report
- 9.5.6 that health and safety matters are effectively managed
- 9.5.7 that risks for the Board assurance framework are appropriately escalated to the Deputy Chief Executive.
- 9.5.8 that HR submissions of compliance with mandatory regulations are fit for purpose
- 9.5.9 that reports on responding to the recommendations made by external bodies following reviews and inspections are made on time and that the risk register is updated where appropriate
- 9.5.10 the Emergency Preparedness, Resilience and Response (EPRR) arrangements are robust and that the Trust has met external EPRR compliance requirements

## **10. Liaison**

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

## **11. Other Matters**

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

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

## **12. Sources of Information**

12.1 The Committee will receive reports from the following:

12.1.1 Senior Information Risk Owner

12.1.2 Patient Safety and Risk Lead

12.1.3 Director of Clinical Quality and Patient Experience

12.1.4 Associate Director of Quality and Governance

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

## **13. Reporting**

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

13.2 A quarterly report on the findings of the committee will be presented to the Board of Directors.

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

## **14. Support**

14.1 The Committee will be supported by the Medical Director's team.



## Board of Directors:

**Item:** 14

**Title:** CQC Inspection Update

**Purpose:**

The purpose of this report is to update the Board on the next steps with regard to the CQC inspection report and planning our actions in response to their findings.

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

- Quality

**For:** Information

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

## Care Quality Commission Inspection Update

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1. On 26<sup>th</sup> April 2016, the Trust received the final draft of the Care Quality Commission Quality Report. This comprised an overall Quality Report and more detailed reports on the three areas of core service inspected. These were Specialist Psychological Therapy Services; Other Specialist Services; and Specialist Community Mental Health Services for Children and Young People.
2. The reports had been through the internal quality control systems at CQC. At this stage, we were invited to submit any factual accuracy corrections by 11<sup>th</sup> May 2016.
3. Factual accuracy corrections were collected, collated and submitted to CQC on 11<sup>th</sup> May.
4. CQC anticipate publishing the report in the week beginning 23<sup>rd</sup> May 2016. They are aware that we hold our May Board meeting on 24<sup>th</sup> May and would appreciate publication of the report by this date in order to include our CQC rating and other findings in our Annual Report. Until it is formally published, findings remain confidential for external purposes. Our Communications team are aware of the timeline and are preparing for internal and external communications on publication of the report.
5. The draft final report includes a small number of areas which must be addressed and a greater number of areas which should be addressed. Action plans are in development to make improvements in the areas we need to address. These plans will be presented to an Extraordinary Clinical Quality, Safety and Governance Committee meeting on 7<sup>th</sup> June 2016.
6. A Quality Summit will be held in the Lecture Theatre, Tavistock Centre on 7<sup>th</sup> July 2016, from 2.00pm to 5.00pm.

The attached guidance notes set out the format for the meeting. In brief, CQC will present their findings and the Trust is invited to demonstrate how we will address the areas which require improvement. A range of stakeholders will be invited to attend the meeting and to participate in discussion of the quality of the trust's services and plans for improvement.

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

May 16<sup>th</sup> 2016

## Quality Summit Guidance

A key part of the inspection process before publication of the report is a Quality Summit. This briefing explains:

- the purpose of the Quality Summit
- how it fits into the overall inspection process
- what will happen during the event
- what will happen after the Quality Summit has been completed.

This briefing should be sent to all members of the Quality Summit including any observers.

### 1. Purpose of the Quality Summit

The purpose of the Quality Summit is to develop a plan of action and recommendations based on the inspection team's findings as set out in the inspection report. This plan will be developed by partners from within the health economy and the local authority.

Each quality summit will consider:

- The findings of the inspection.
- Whether planned action by the trust to improve quality is adequate or whether additional steps need to be taken.
- Whether support should be made available to the trust from other stakeholders such as commissioners to help them improve.

### 2. How does the Quality Summit fit into the inspection process?

2.1 The inspection model for NHS providers (including acute, mental health, community combined and ambulance providers, both foundation and aspirant), is a specialist, expert and risk-based approach to inspection, which allows us to get to the heart of what really matters to patients and the public. It aims to better enable us to highlight where care is good or outstanding and to expose where care is inadequate or requires improvement.

2.2 All comprehensive NHS ambulance inspections will follow the following stages:

- Preparation (including intelligent monitoring and planning)
- Inspection visits
- Reporting (including making judgements and ratings, quality assurance and quality summits).

### 3. Quality Summit Pre-Meeting: Determining who should attend the Quality Summit

3.1 In order for action planning to be effective, it is important to ensure that the right people/organisations are represented at the Quality Summit. It is vital that the provider leads in identifying the relevant attendees for the Quality Summit. To assist in this, CQC have provided a list of standard attendees for the Quality Summit (Appendix A).

3.2 Prior to the Quality Summit, CQC Inspection Team Leader/Head of Inspection (HOI) will hold a pre-meeting, via telephone conference, one or two weeks before the Quality Summit with appropriate representatives from the Trust, NHS Improvement and NHS England to ensure,

based on the inspection findings, that those organisations whose input is necessary are going to be represented at the Quality Summit. If the provider has any significant partnerships with other providers, it is important they are invited to join the quality summit.

- 3.3 If the inspection raises concerns about a provider which may call into question its suitability as a learning and training environment, please ensure that the HCPC, GMC and NMC are invited to the Quality Summit as appropriate (please note, HEE should be invited to all Quality Summits, with the exception of ambulance trusts where they are an optional invitee).
- 3.4 Public representatives are invited to attend the quality summit to represent the interests of the public and to enable on-going public accountability of trusts following CQC inspections. Public representatives also play an important role in encouraging improvement and explaining our work to the local community. At least one local Healthwatch and at least one health overview and scrutiny committee should attend each summit and this should be decided by the inspection planners in discussion with the local public representatives as described below (not solely on the advice of the trust).

The following public representatives will be invited:

- Local lead Healthwatch chair and manager for the main area in which the trust is based. The inspection planner will liaise with this Healthwatch to check they are the most appropriate Healthwatch to attend, and to encourage them to provide an update to other neighbouring Healthwatch following the summit. In the case of ambulance trusts and larger trusts covering several local authority areas, it may be appropriate to invite a sample of Local Healthwatch from across the patch. This should be decided following discussion with the local Healthwatch to the trust.
- Local lead health overview and scrutiny chair and lead officer for the area in which the trust is based. Similarly the inspection planner will liaise with the local lead OSC to check they are the most appropriate OSC to attend, and to encourage them to provide an update to other neighbouring OSCs following the summit. Inspection planners should check if there is a Joint Health Overview and Scrutiny Committee or JHOSC (made up of councillors from several authority areas) which has been set up specifically to scrutinise the trust. If so, then their chair and lead officer should also be invited. In the case of ambulance trusts and larger trusts covering several local authority areas, it may be appropriate to invite representatives from more than one OSC from across the patch. This should be decided following discussion with the local OSC to the trust.
- In cases where specific Healthwatch or OSC have been particularly engaged in the pre-inspection period, the inspection planner should also ensure they are both given personal feedback from the inspection team or also invited to the quality summit.

**N.B:** It is useful to confirm which Healthwatch and OSCs are the lead to contribute to the trust's quality accounts – as this can help identify the most relevant attendees where needed.

#### 4. Prior to the Quality Summit

- 4.1 The draft report should be shared **in confidence** with NHS England and NHS Improvement at the same time as it is shared with the Trust for factual accuracy comments, unless there are legitimate reasons not to share the draft report. When you speak to the Trust before sending the report, you should inform the Trust that the draft report is being shared with these stakeholders, to ensure the Quality Summit is as effective as possible. If the provider wishes to circulate the draft report to a wider audience, they are welcome to do so.
- 4.2 If the Chief Inspector of Hospital's recommends entry/exit of special measures, this should be raised with NHS England and NHS Improvement during the Quality Summit pre-meeting.
- 4.3 The final report will be published shortly before the quality summit.

#### 5. Quality Summit Agenda

The session will last approximately 3 hours. It will be split into two parts:

- 5.1 Part One: The CQC Inspection Team Leader/Head of Inspection (HOI)/Inspection Chair) will chair this section and summarise the results of the Trust Inspection Report to the Quality Summit.

A power-point presentation template is available to use to present CQC's key inspection findings and this template can be found on the [intranet pages](#).

Following the CQC presentation, the Trust Chief Executive will present the Trust's response to the inspection findings, what the Trust is doing to address the issues raised and where they feel additional support will be needed.

- 5.2 Part Two: The second part will be facilitated by a representative from NHS Improvement or the provider and will be focused on agreeing a high level action plan in response to the findings of the inspection. The summit will provide a robust challenge to ensure that actions are not short term but are focused on sustainable change. The actions should be agreed by the Trust, CQC and other regulators and professional partners.

This part of the summit will consider:

- Whether planned action by the provider to improve quality is adequate and whether additional steps should be taken.
- Whether support should be made available to the provider from other stakeholders such as commissioners to help them improve.
- Any areas that may require regulatory action in order to protect patients.

A suggested agenda is set out in appendix B.

- 5.3 Chairing Arrangements for Part 2

The following applies to determine who will act as the chair for Part 2 of the Quality Summit:

- If the trust has been rated overall as good or outstanding, the provider will chair part 2.

- If the trust is a rated as inadequate or requires improvement, NHS Improvement will act as chair, subject to local discretion. If it is decided that it would be disproportionate for NHS Improvement to chair part 2, then the provider should consult the HOI to decide who should chair (for example, the local CCG).

## **6. After the Quality Summit**

- 6.1 CQC will circulate the minutes from the Quality Summit to all invited parties within a week of the Summit.
- 6.2 The recommendations for action will be captured in a high level action plan(s). Further work will be required by the Trust and its partners following the Quality Summit to develop the detail beneath the high level actions before moving onto implementation. This should be completed within approximately one month of the Quality Summit. Action plans are owned by the Trust and the Trust should use their own action plan templates and tools. CQC will expect to be consulted on the adequacy of the action plan before it is agreed.
- 6.3 Once agreed, action plans should be shared with the CQC Inspection Team Leader/Head of Inspection to ensure all key areas highlighted during the inspection have been appropriately addressed and stored on CQC systems.

## Appendix A

### Quality Summit Attendees and Roles

The Quality Summit will include the following people:

Role	Purpose
Inspection Chair	Chair part 1 of the Quality Summit. Provide professional input on the findings of the inspection from a clinical perspective.
CQC Inspection Team Leader/ Head of Inspection	Provide professional input on the findings of the inspection from a regulatory perspective. Responsible for circulating minutes of the Quality Summit to all attendees.
Regional Director for the relevant CQC region or CQC relationship holder (if not the Head of Inspections)	Provide professional input on the findings of the inspection from a regulatory perspective.
Clinical Expert and Inspection Chair from Inspection Team	Provide specialist input on the findings of the inspection for a specific clinical area if needed.
Expert by Experience or public and patient representative from Inspection Team	Provide input from a patient/public perspective.
Trust representatives (Chair, Chief Executive, Medical Director, Director of Nursing)	Provide the Trust perspective on the inspection findings. Set out what the Trust is doing to address the issues raised and where they feel additional support will be needed.
NHS Improvement representative	Recommend where the Trust can become more effective, efficient and economic whilst maintaining or improving the standard of services, in accordance with their statutory roles, and support the Trust in developing and taking forward their action plan.
NHS England regional representative	Provide a regional perspective on both the issues raised and additional support available to the Trust, in accordance with their statutory roles.
Quality Surveillance Group regional representative	Provide input from a regional perspective and support the Trust in developing and taking forward their action plan.
CCG representative	<p>Provide input from a commissioning perspective, in accordance with their statutory roles, and support the Trust in developing and taking forward their action plan.</p> <p>Please note that for ambulance trusts there will be 20-40 CCGs for each ambulance trust and one or two will be nominated leads. Invite lead CCGs who may advise on other CCGs to be invited if they take a lead on a particular commissioning strand or there are specific local issues.</p> <p>Lead CCG(s) have the responsibility to share information from the quality summit with other CCGs in the ambulance trust's region. Please note, QSG and CCG may nominate to send a representative who can provide input from both perspectives.</p>
Overview and Scrutiny Committee chair and lead officer	Council health scrutiny have statutory powers to hold health services to account on behalf of their community. They can request information and call in NHS managers to report on their progress.

	They can provide input based on their local scrutiny of health services and encourage improvements. Some providers will work with a joint health overview and scrutiny committee or with several individual committees if they cover several authorities – see guidance above.
Local Healthwatch manager	Local Healthwatch share the views of local communities about their healthcare to providers and commissioners to support improvements in line with their statutory powers. Some providers will work with more than one Healthwatch if they cover several authorities – see guidance above.
Health Education England representative  <i>(Note: optional for ambulance trusts)</i>	Provide professional input from an educational and workforce perspective, in accordance with their statutory roles.  In particular, the CQC will ensure the HEE is present at the Quality Summit where there are concerns and relevant information about a provider which may call into question its suitability as a learning and training environment.
CQC Recorder	Ensure discussion is accurately recorded, minuted and stored and that principles of the Quality Summit are followed.

**Other attendees, as determined by the pre-Quality Summit telephone conference, may include:**

Health and Wellbeing Board representative	Provide input from a healthcare system point of view and identify where opportunities for cross sector working may help address the findings, in accordance with their statutory roles.
Health and Care Professions Council representative	Provide professional input from a workforce perspective, in accordance with their statutory roles, and support the Trust in developing and taking forward their action plan.  In particular, the CQC will ensure the HCPC is present at the Quality Summit where there are concerns and relevant information about a provider which may call into question its suitability as a learning environment for paramedic students. Or if any concerns and relevant information arise relating to the general delivery of paramedical care which may call into question issues of paramedical leadership.
General Medical Council representative	Provide professional input from a workforce perspective, in accordance with their statutory roles, and support the Trust in developing and taking forward their action plan.  In particular, the CQC will ensure the GMC is present at the Quality Summit where there are concerns and relevant information about a provider which may call into question its suitability as a learning environment for students for doctors in training. Or if any concerns and relevant information about a healthcare organisation arise which may call into question the robustness of its systems of medical appraisal and clinical governance.
Nursing and Midwifery Council representative	Provide professional input from a workforce perspective, in accordance with their statutory roles, and support the Trust in developing and taking forward their action plan.

	In particular, the CQC will ensure the NMC is present at the Quality Summit where there are concerns and relevant information about a provider which may call into question its suitability as a learning environment for nursing or midwifery students. Or if any concerns and relevant information arise relating to the general delivery of nursing and midwifery care which may call into question issues of nursing or midwifery leadership.
Health and Safety Executive representative	<p>Provide professional input from a health and safety perspective, in accordance with their statutory roles, and support the Trust in developing and taking forward their action plan. HSE is responsible for the enforcement of the Health and Safety at Work Act 1974 and associated legislation throughout Great Britain. Its work includes ensuring that 'risks to people's health and safety from work activities are properly controlled'.</p> <p>Within the healthcare sector, HSE's role includes health and safety risks to healthcare workers and others who might be affected by the work activity. HSE also has a role in relation to patient safety under section 3 of the Health and Safety at Work etc. Act 1974 (HSWA) and investigates certain patient related deaths and serious incidents in accordance with its incident selection criteria.</p>
Local Authority representative (most likely an ASC officer lead)	Provide input from a local authority perspective, in accordance with their statutory roles, and support the Trust in developing and taking forward their action plan. (In the case of large or complex NHS trusts, this may include representatives from a number of different local authorities).
Other professional regulators	Provide professional input as required, in accordance with their statutory roles, and support the Trust in developing and taking forward their action plan.
Chairs of local resilience forums  (Note: ambulance trusts only)	<p>Local resilience forums are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others. They are organised at police force level.</p> <p>Invite these as necessary.</p>
Relevant third party providers	Provide input from a provider perspective on any issues relating to partnership working.
NHS complaints advocacy service	Commissioned by each local authority to ensure people are supported to make NHS complaints. They may be particularly useful to attend when there are improvements needed to how the trust deals with complaints.

<b>Session</b>	<b>Timing</b>	<b>Lead</b>	<b>Additional Information</b>
Welcome and introductions	5 mins	CQC Team Leader/Head of Inspections	
Presentation of inspection team key findings	15 mins	CQC Team Leader/ Head of Inspections and Inspection Chair	The inspection team present the key findings from their visit.
Questions and clarification	10 mins		Opportunity for Quality Summit attendees to ask clarification questions of the Inspection Team and / or provide their own perspective on issues being considered
Summary of key risks and actions	5 mins	NHS Improvement	
Presentation by Trust	30 mins	Trust Chief Executive	The Trust will present its response to the inspection findings
Questions and clarifications	10 mins		Opportunity to ask questions of the Trust to further develop an understanding of the Trust's perspective on the review findings and plans for improvement.
Break – 15 minutes			
Development of outline action plan	60 mins	Facilitated by NHS Improvement or NHS England	Agree key actions to be taken to rectify each problem identified in the inspection report.
External support offer	15 mins	Facilitated by NHS Improvement or NHS England	Agree key areas in which external support may be required to enable implementation of the action plan.
Agreement to next steps	15 mins	Facilitated by NHS Improvement or NHS England	Agree: <ul style="list-style-type: none"> <li>• Timescale for development of detailed action plan.</li> <li>• Handling and communications plan.</li> <li>• Monitoring arrangements.</li> </ul>

## Board of Directors : May 2016

**Item :** 15

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

**Summary:**

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

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

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

- Quality
- Risk
- Finance

**For :** Approval

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

## Corporate Governance Statement

### 1. Introduction

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

### 2. Statements in declaration

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

#### 2.2 The first statement is:

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

#### 2.3 The second statement is:

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

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

### 3. Views of the Governors

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

Simon Young  
Deputy Chief Executive and Director of Finance

**BOARD OF DIRECTORS (PART 1)**

Meeting in public

Tuesday 24<sup>th</sup> May 2016, 14.00 – 16.20

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

**AGENDA**

<b>PRELIMINARIES</b>				
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	-
<b>REPORTS &amp; FINANCE</b>				
5.	<b>Service User Story – Camden CAMHS</b>	To discuss	Verbal	-
6.	<b>Service Line Report – Camden CAMHS</b> Dr Andy Wiener, Associate Clinical Director CYAF	To discuss	Enc.	p.9
7.	<b>Trust Chair's and NEDs' Reports</b> Mr Paul Burstow, Trust Chair	To note	Verbal	-
8.	<b>Annual Report, Quality Report and Accounts</b> Mr Simon Young, Deputy Chief Executive and Director of Finance, Mr Gervase Campbell, Trust Secretary, Ms Marion Shipman, Associate Director of Quality and Governance. a) Annual Report b) Annual Accounts c) Quality Report d) Letters of Representation	To approve	Enc.	p.25 p.29 p.98 p. (late)
9.	<b>Chief Executive's Report</b> Mr Paul Jenkins, Chief Executive	To note	Enc.	p.233
10.	<b>Finance and Performance Report</b> Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p.239
11.	<b>Training and Education Report</b> Mr Brian Rock, Director of Education and Training/Dean	To note	Enc.	p.245
12.	<b>Clinical Quality Safety &amp; Governance (CQSG) Quarter 4 Report</b> Dr Rob Senior, Medical Director	To discuss	Enc.	p.249
13.	<b>Clinical Quality Safety &amp; Governance (CQSG) Annual Report and Terms of Reference</b> Dr Rob Senior, Medical Director	To approve	Enc.	p.256

<b>14.</b>	<b>CQC Report Update and Timings</b> Ms Louise Lyon, Director of Q&PE; AFS	To discuss	Enc.	p.280
<b>15.</b>	<b>Corporate Governance Statement - Self-Certification for Monitor</b> Mr Simon Young, Deputy Chief Executive and Director of Finance	To approve	Enc.	p.290
<b>CLOSE</b>				
<b>16.</b>	<b>Notice of Future Meetings</b> <ul style="list-style-type: none"> <li>• Tuesday 28<sup>th</sup> June 2016: Board of Directors' Meeting, 1.00pm – 5.00pm, Lecture Theatre</li> <li>• Thursday 30<sup>th</sup> June 2016: Council of Governors' Meeting, 2.00 – 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> </ul>		Verbal	-