CAMDEN AND ISLINGTON
NHS FOUNDATION TRUST
MEETING OF THE BOARD OF DIRECTORS
HELD IN PUBLIC

CONFERENCE HALL
ST PANCRAS HOSPITAL
4 ST PANCRAS WAY
LONDON, NW1 0PE

Thursday 24 April 2014 at 2:00pm

Membership of the Board of Directors:

Ms Leisha Fullick          Chair
Ms Wendy Wallace           Chief Executive
Ms Cha Patel               Deputy Chair / Non-Executive Director
Dr Sylvia Tang             Deputy Chief Executive and Medical Director
Mr Richard Brooman         Non-Executive Director
Mr Paul Calaminus          Chief Operating Officer
Ms Sarah Charles           Senior Independent Director / Non-Executive
Dr Sue Goss                Non-Executive Director
Ms Angela Harvey           Non-Executive Director
Ms Claire Johnston         Director of Nursing and People
Mr David Wragg             Director of Finance
Mr Colin Plant             Director of Integrated Care (non-voting member)

This meeting is held in public

Enquiries to Trust Secretary
Telephone 020 3317 3184
Email: trust.secretary@candi.nhs.uk
Meeting Ground Rules

a) Apologies for non-attendance or lateness to be provided to the Board Secretary before the meeting. Chair will ask for apologies at the meeting.

b) All actively engage and are individually accountable.

c) Views are listened to and built on constructively.

d) There is mutual respect.

e) The Board works within a climate of giving and receiving constructive challenge (of ideas and not people).

f) Everyone is equal in the process while having regard to role of the Chair.
## PUBLIC BOARD AGENDA
### Thursday 24 April 2014
2:00pm

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<tr>
<td>1.1</td>
<td>Welcome, Apologies and Quoracy</td>
<td>2:00-2:05pm</td>
<td>Verbal</td>
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<td>1.2</td>
<td>Declaration of Interests</td>
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<td>1.3</td>
<td>Service Users’ Experience Presentation on Welcoming</td>
<td>2:05:20pm</td>
<td>Video</td>
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<td></td>
<td>A video presentation introduced by Claire Johnston</td>
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<td>The Board are requested to approve this video for presentation to a wider audience</td>
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<td>1.4</td>
<td>Previous Minutes</td>
<td>2:20-2:30pm</td>
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<tr>
<td>1.41</td>
<td>Minutes from the previous Public Board meeting on 27 March 2014</td>
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<td>1.42</td>
<td>Minutes from the joint Board/Council of Governor meeting, also on 27 March 2014</td>
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<td>Matters arising from the previous Public Board meeting on 27 March 2014</td>
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<td><strong>STATUTORY / REGULATORY</strong></td>
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<td>2.1</td>
<td>Monitor Finance Declaration; Quarter 4, 2013/14</td>
<td>2:30-2:40pm</td>
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<td>(1 January – 31 March 2014)</td>
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<td></td>
<td>A paper presented by Mr David Wragg</td>
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<td>2.2</td>
<td>Monitor Governance Declaration; Quarter 4, 2013/14</td>
<td>2:40-2:50pm</td>
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<td>(1 January – 31 March 2014)</td>
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<td>Monitor submission presented by Dr Sylvia Tang</td>
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<td><strong>STRATEGIC / GOVERNANCE</strong></td>
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<td>Social Work Strategy</td>
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<td>A report presented by Ms Claire Johnston / Ms Natasha Sloman</td>
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<td><strong>OPERATIONAL</strong></td>
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<td>4.1</td>
<td>Chief Executive’ Report</td>
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<td>A report presented by Ms Wendy Wallace</td>
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<td>4.2</td>
<td>2013/14 Annual Accounts</td>
<td>3:25-3:40pm</td>
<td>Verbal</td>
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<td>A presentation by Mr David Wragg</td>
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<td>4.3</td>
<td>Safer Staffing Arrangements for Nursing</td>
<td>3:40-3:55pm</td>
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<td>A paper presented by Ms Claire Johnston</td>
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<td>4.4</td>
<td>Implementation of Choice</td>
<td>3:55-4:10pm</td>
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<td>A paper presented by Mr Colin Plant</td>
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## 5. SUB-COMMITTEES

### 5.1 Quality Committee

(No minutes due at this meeting)

### 5.2 Service User and Staff Experience Committee

Approved minutes from the Committee’s meeting on 7th January 2014.

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<td>3:10-4:15pm</td>
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## 6. ANY OTHER BUSINESS

### 6.1 Any other business that the Chair considers urgent

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<td>4:15pm</td>
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### 6.2 New risks identified during the meeting or risks referred to/from other Committees

### 6.3 Public Board Meeting Planning Document

For information, any required changes should be notified to the Board Secretary.

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### 6.4 Date of next meeting

27 May 2014

*Please note this meeting will commence at 9:30am*

## 7. CLOSE

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<td>4:20pm</td>
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# Board of Directors – Register of Interests

<table>
<thead>
<tr>
<th>Board Member:</th>
<th>Interest Declared:</th>
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<tbody>
<tr>
<td>Ms Leisha Fullick (Trust Chair)</td>
<td>Governor of City &amp; Islington College.</td>
</tr>
<tr>
<td>Ms Cha Patel (Deputy Trust Chair / Non-Executive Director)</td>
<td>Trustee of the Shaw Trust charity; Director of Igloo Consultants Limited; Director, and Finance &amp; Audit Committee Chair, for CityWest Homes; Director, and Audit &amp; Risk Committee Chair, for Gateway Housing Association; and Vice Chair and Audit &amp; Risk Committee Chair, Bromley Healthcare.</td>
</tr>
<tr>
<td>Ms Sarah Charles (Senior Independent Director / Non-Executive Director)</td>
<td>Chair of Croydon Care Solutions Ltd; and Married to a Non-Executive Director for Barnet, Enfield and Haringey Mental Health Trust.</td>
</tr>
<tr>
<td>Mr Richard Brooman (Non-Executive Director)</td>
<td>Deputy Chairman of Invesco Perpetual UK Smaller Companies Investment Trust plc; Director of HgCapital Trust plc; Director of Acal Plc; Director Governor and Trustee for Merchant Taylors’ School Limited; Founder and Director of Incrementum Limited; Trustee for Leonard Cheshire Disability; and Trustee of the British Youth Opera.</td>
</tr>
<tr>
<td>Ms Sue Goss (Non-Executive Director)</td>
<td>None.</td>
</tr>
<tr>
<td>Ms Angela Harvey (Non-Executive Director)</td>
<td>Councillor, Westminster City Council; Director of Topaz Leadership Consulting Limited; Director of Westminster Gardens Limited; and Married to a Westminster City Councillor, who is currently the Adult, Heath, Community Protection Policy &amp; Scrutiny Chair.</td>
</tr>
<tr>
<td>Ms Wendy Wallace (Chief Executive)</td>
<td>Trustee for Interactive – a charity for inclusion in sport; and Married to a Director of CareTech plc – provider of community care &amp; children’s services.</td>
</tr>
<tr>
<td>Dr Sylvia Tang (Deputy Chief Executive / Medical Director)</td>
<td>Psychiatric Advisor to CARIS Bereavement Counselling Service; and Non-Executive Director for Vision Mental Health Care.</td>
</tr>
<tr>
<td>Mr David Wragg (Director of Finance)</td>
<td>Married to the National Development Lead at the Healthcare Quality Improvement Partnership (HQIP), which is a charity and a company limited by guarantee that promotes clinical audit and has contracts with the Department of Health and NHS Bodies.</td>
</tr>
<tr>
<td>Ms Claire Johnston (Director of Nursing &amp; People)</td>
<td>None.</td>
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<tr>
<td>Mr Paul Calaminus (Chief Operating Officer)</td>
<td>Married to the Assistant Board Secretary at the Department of Health.</td>
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<tr>
<th>Non-Voting Board Member:</th>
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<tr>
<td>Mr Colin Plant (Director of Integrated Care)</td>
<td>Trustee for Ponayi - a charity that provides health support and advice for people from South African origin.</td>
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</table>
Board Members Present:
Ms Leisha Fullick  
Ms Wendy Wallace  
Ms Cha Patel  
Dr Sylvia Tang  
Mr Richard Brooman  
Mr Paul Calaminus  
Ms Sarah Charles  
Dr Sue Goss  
Ms Angela Harvey  
Ms Claire Johnston  
Mr David Wragg  
Mr Colin Plant

In Attendance:
Mr Kevin Monteith  
Mr Karl Heidel  
Ms Shirley Scott-Norton  
Mr Ericho Jacobi  
Ms Ruth Appleton  
Mr Martin Zielinski

This meeting was open to the public
GENERAL BUSINESS

1.22.14 Welcome, Apologies & Quoracy

Ms Fullick welcomed those present and, with all members present, the meeting was quorate.

1.23.14 Declarations of Interest

The declared interests of all Board members were presented as part of the papers and no changes were requested. The Board were satisfied that there was no conflict between these declared interests and any item on the agenda.

1.24.14 Service User Experience Presentation

Ms Johnston introduced Ms Scott-Norton and Mr Jacobi who were in attendance to provide a verbal presentation on the contribution compassionate nursing makes to a service user's care. Ms Scott-Norton was very positive about the care she has received from the Trust, having been a SMS service user for 10 years. She highlighted one instance where her key worker had changed and she found that the new member of staff lacked compassion. She talked about the negative impact this had on her and the time it then took to regain the progress she had made prior to that incident. Mr Jacobi concurred with Ms Scott-Norton, stressing the negative effect a lack of compassion from staff can have on a service user. He acknowledged that each individual had a differing degree of compassion in their personality, and that compassion itself was not readily taught. He did consider compassion to be an essential element of nursing care and he did feel that it could be encouraged by allowing staff time to reflect on the effect of their actions. Ms Johnston thanked Ms Scott-Norton and Mr Jacobi for their presentation and concluded that compassion was a key part of the therapeutic relationship between staff and service users and assisted recovery. Board members discussed a number of issues with the presenters including; the identification of compassion as part of the Trust’s recruitment process; and the supporting of patients who were taking more control of their own care. The importance of supporting all service users in viewing how they plan for their own recovery was noted. Ms Fullick thanked the presenters for attending and providing the Board with a valuable insight into patient care from the service user’s perspective.
1.25.14 Minutes of the Meeting of the Board of Directors Held in Public on 30 January 2014

The minutes of the last public meeting on 30 January 2014 were reviewed and a small number of non-material amendments were agreed.

The Board AGREED the minutes of its meeting on 30 January 2014 as an accurate and complete record, subject to the agreed amendments.

1.26.14 Matters Arising

The Board considered the matters arising from its previous meeting on 30 January 2014. These were considered to have been completed; superseded; or covered elsewhere on the agenda, with the exception of:

- **MA1: Service Users’ Experience Presentation: “Safewards”**
  
  The outstanding briefing on how the “safewards” process would be rolled out to other areas was being prepared by the Deputy Director of Nursing and would be circulated to Board members once completed.

- **MA8: Quarterly Performance Report, January 2014, Q3**
  
  Ms Charles advised the Board that, due to more critical work pressures, she would defer her intention to meet with the Director of Nursing & People to consider this format of the Quality Performance Report. This action should be considered closed for now.

- **MA 10: Month 9, 2013/14 - Financial Position**
  
  The issue of the capital plan, and remaining within tolerance limits, was discussed later on in this agenda.

**STATUTORY / REGULATORY**

1.27.14 Strategic & Operational Planning for 2014

Ms Fullick introduced this item advising on the new requirement for the Trust to submit a 2 year plan to Monitor by 4 April 2014, and a subsequent 5 year strategic plan in June.

Ms Wallace highlighted the importance of this 2 year plan, in its almost final version, and invited the Board’s comments and approval. She commended the large number of Trust staff who had provided input into this document and Mr Monteith as the main co-ordinator and author of the presented version. Six key measures, set out on the cover sheet, were highlighted as the basis of Monitor’s initial assessment of the 2 year plan.

Ms Wallace took the Board through the sections of the 2 year plan detailing: short-term challenges; quality plans; operational requirements and capacity; productive, efficiency and cost improvement programmes; and financial plans. She concluded that increasing financial pressures focused the need to work with partners in establishing a health care community and ensuring that...
such an integrated system actually worked.

Ms Fullick made a general comment on the drafting of the plan, stating that outcomes should be phrased more positively, stating actual outcomes rather than a potential or desired position. It was also noted that a number of dates had yet to be added to the plan.

Dr Goss commended the work undertaken in preparing this plan and suggested that the managerial actions related to the ‘effectiveness’ priorities could be strengthened by stating actual actions to be taken.

Ms Charles suggested that a risk should be associated to the Trust’s ability to recruit to current nursing vacancies.

Mr Wragg provided assurance to Mr Brooman that the prepared 2 year plan was financially robust, due to the Trust’s conservative estimates on income growth; sensible reserve levels; strong balance sheet; track record of CIP achievement; and the number of targeted schemes already firmly identified. Mr Brooman particularly queried the potential effect of failing to achieve the planned capital expenditure programme, as had happened this year. Mr Wragg responded that capital projects had proved to be a challenge due to the condition of the estate taken on by the Trust and the number of schemes required to be undertaken. He acknowledged that there had been a significant level of slippage during 2013/14 but this had not damaged the Trust’s finances. A large part of the works programme had been environmental improvements. He added that, in future, capital expenditure would be more focused on areas with the potential for income generation. Mr Brooman also stressed the importance of being able to produce cash flow predictions, adjusted for variations in the capital programme, as these would be monitored by the regulator.

Ms Charles stated that, at a recent mental health network conference, it had been stated that NHS England was not allowing CCGs to apply anything other than the recommended price deflator to funding for mental health trusts. Where this was the case, trusts could challenge such action. The Board discussed this point and concluded that the Trust had not challenged the application of a deflator to its CCG income due to the fact it had obtained material increases in its 2014/15 contract negotiations, including additional monies for demographic growth for the first time. It was agreed that all aspects of contractual income had to be considered as a whole and that, overall, management were satisfied with the outcome achieved.

Ms Fullick made reference to the pressures of increased demand and reduced income that were frequently reported in the press. Dr Tang responded that the Trust had already undertaken major organisational changes to offset pressures of this nature. It was acknowledged that such issue may present bigger problems when considering the longer term future and the Trust's 5 year plan.
Mr Wragg acknowledged Ms Fullick’s comment that income would remain flat over the 2 year plan, excepting changes associated to the transfer of Pentonville Prison Health Service to another provider. He advised that there was always the risk of further income changes but that the presented position was as realistic as possible and complied with Monitor’s expectation to be prudent.

The Board of Directors APPROVED the 2 year plan, subject to the agreed changes and review points.

1.28.14 Internal Audit Charter

Mr Brooman presented this item to the Board advising that the Public Sector Internal Audit Standards required approval of this Charter. He added that the Charter would be refined over future years and require annual re-approval. He proposed that the Board delegate future approval to its Audit & Risk Committee, except in the instance it would be combined with the appointment of a new internal auditor.

Ms Patel highlighted the Trust’s responsibility to plan and agree internal audit coverage. She suggested that this should be more clearly emphasised in the Charter. Mr Brooman agreed with this point clarifying, that while the internal auditor may propose coverage, it was the Trust’s duty to review and amend this as necessary. He would pass this feedback to internal audit and ask them to amend the document.

The Board of Directors APPROVED the Internal Audit Charter, subject to the agreed amendment. The Board of Directors also DELEGATED authority for further approval of the Charter to its Audit & Risk Committee, unless such approval was in conjunction with the appointment of new internal auditor.

STRATEGIC / GOVERNANCE

1.29.14 Board Assurance Framework (BAF) 2014/15

Dr Tang presented the 2014/15 BAF to the Board, highlighting that it set out the Trust’s priorities for the forthcoming year, along with the risks associated to achieving them. She assured the Board that all their feedback from the Board seminar on previous draft versions had been incorporated into this final BAF and that a Director level lead had been allocated responsibility for each identified risk.

Mr Wragg assured Ms Fullick that, while the Trust did not have one all-encompassing information system, adequate compensatory controls were in place.

Ms Wallace was satisfied that this final version of the BAF accurately reflected previous Board discussions and that its content, including the detailed risks and pressures, had been appropriately mapped across to other Trust documents.

Ms Fullick commended all staff involved in preparing and updating the BAF.
The Board of Directors APPROVED the Trust's Board Assurance Framework for 2014/15.

OPERATIONAL

1.30.14 Chief Executive’s Report

Ms Wallace presented her regular update and highlighted a number of key points to the Board. She drew attention to the need to engage with commissioners as progression was made towards ‘value based commissioning’, although there was still significant work to be undertaken in establishing how this process would work. The Board was asked to note the development of the ‘UCL Institute for Mental Health’ and the benefits to be obtained for such an organisation.

The improved results from the 2013 Staff Survey were highlighted to the Board, demonstrating the amount of work undertaken to engage and communicate with staff after what had been material and unsettling organisational changes over recent years. Ms Wallace highlighted that concerns about bullying and harassment had been highlighted from the survey’s findings and that further work was planned to establish and address the causes of these concerns.

Ms Wallace went on to focus on the number of recent visits from other organisations to the Trust, including the Foundation Trust Network and the Department of Health, advising that formal feedback on these visits had yet to be received.

The Board were asked to note a number of staff changes, including the retirement of three highly commended clinicians: Prof John Cape; Dr Anthony Katz; and Dr Robert Pugh, who had all made significant contributions to mental health services.

Ms Harvey queried whether national pay negotiations had been concluded for 2014. Ms Wallace advised that this was the case, although the final position had only been notified within the last few days. She advised that increases would be restricted to 1%, with those already receiving an annual increment excluded unless their increment was below 1% where an additional payment would be made to reach the 1% level. Ms Wallace highlighted the complexity of the 2014 increase, which was required to be introduced at the same time as a new staff appraisal process removing automatic incremental increases which would now have to be fully linked to performance. Mr Wragg estimated that these measures would add around £1.5m to the Trust’s pay bill, against the £1.8m budgeted for in the Trust’s plan.

Ms Patel noted that Monitor had reverted to its earlier position that a Non-Executive Director should chair the Council of Governors’ Nominations & Remunerations Committee. She was advised that the restructured Committee was yet to meet and agree its Chair.

The Board of Directors NOTED the Chief Executive’s update.
1.31.14 **Financial Position – Month 11, 2013/14**  
Mr Wragg advised the Board that the Trust’s finances had continued to travel in the expected direction, with the retained surplus increasing to almost £700k ahead of the planned position as at month 11. He added that he expected this position to improve further in month 12 as CCGs and Health Education England released additional funding from their reserves.  
Ms Fullick queried whether the Trust’s CCGs had agreed to provide additional funding for the cost of private placements. Mr Wragg responded that this issue had not been pursued as the commissioners had provided additional funding, and not enacted penalties, in other areas. The agreed income position was being viewed as a whole. Mr Calaminus advised that the Board should expect to see a similar number of private placements in month 12 as, while all the privately placed PICU cases in month 11 had been resolved, there had been a subsequent increase in demand for acute inpatient care requiring the need to place new patients privately.  
Mr Wragg added that the Trust retained a strong cash position, with good liquidity, and would retain the top continuity of service rating of ‘4’. His main financial concern was that the Trust’s capital expenditure programme was 27% behind its planned position, which exceeded Monitor’s 15% tolerance window. He advised that his Estates Team was quite new, only having been developed since the Trust took over the St Pancras site in the previous year. He added that the team was now being permanently staffed and that an even larger capital programme planned for 2014/15 would require careful monitoring and management. He added that 2013/14’s capital programme had already been re-modelled on one occasion with that change notified to Monitor. It was noted that Monitor had been kept briefed on the Trust’s capital programme and seemed satisfied that it did not contain any surprises. Ms Fullick stated that she was deeply concerned about the Trust’s ability to manage the next year’s even larger capital programme, given the level of drift incurred this year. She stated that the Board had been advised in January that any drift from plan would be addressed by year end and now this was evidently not the case. The Board discussed this matter in depth, agreeing that the capital programme was unlikely to return within the required 15% tolerance limit by year end. It was acknowledged that there had been a steep learning curve in managing a large capital programme after taking over responsibility for the Trust’s largest site at St Pancras, and that this had been further affected by the poor condition of the buildings taken over. It was agreed that more effective monitoring and management processes would have to be in place for 2014/15 to ensure that current slippage did not negatively affect the new year’s plans and to ensure that any drift was noted and addressed much earlier to keep the programme on plan during the year. Mr Wragg advised that management of the programme was improving and that he would continue to keep the Board appraised on activity, escalating any concerns where necessary.

Ms Harvey, referring to temporary staffing, queried whether the issue of back dated bookings had been addressed. Mr Wragg
responded that work was on-going to address this issue, although the short notice need for additional staff would never be fully negated. He agreed to prepare a further paper on this matter considering the scale of the issue and the validity of the late bookings being made. Ms Wallace added that the Trust’s Local Counter Fraud Specialist undertook a number of reviews related to shifts worked, and related concerns, each year.

The Board of Directors NOTED the Financial Position – Month 11, 2013/14

1.32.14 Nursing Strategy - 2014 - 2017

Ms Johnston presented this strategy to the Board, highlighting that it sought to unite every nurse in the Trust around the aim of providing the best possible care for its service users and their families. She highlighted the thought that had gone into the strategy’s title “Time to care, time to lead, time to reflect” and how it tied into the earlier presentation to the Board on the importance of compassion within nursing.

The Board were advised that the strategy presented a truthful picture, reflecting staff passions and the obstacles they faced, developed from a number of workshops and forums. The Trust’s agreed values and behaviours were also embedded within this strategy.

Attention was drawn to the 7 nursing standards, detailed in the strategy, and how they would be embedded and developed, along with a table of responsibilities in supporting these standards.

Ms Johnston concluded by thanking Ms Zoe Peel, Graduate Management Trainee, for supporting the work in compiling this strategy document.

Ms Patel was pleased to note that this strategy read as if it had been written by nurses, with a full understanding of their profession. She stated that it was commonly reported nationally that there was a shortage of adequately skilled nurses available and queried how the Trust would resolve this issues. Ms Johnston acknowledged that this presented a strategic challenge to the Trust and that it had to fully understand what benefits it could highlight to attract staff to work at C&I. She agreed that this challenge should be evidently included in the strategy.

Ms Patel also referred to the medicines management element of the presented nursing standards framework and queried whether restraint and medical devices training had been taken into account.

Ms Johnston assured her that such training was covered elsewhere in the document.

Ms Charles found the reference to qualified nurses interesting and asked how enacted changes to have more lower graded nursing staff could be justified, except on a cost basis. Ms Johnston responded that an appropriate skill mix was the essence of quality nursing. The current skill mix made the contribution of qualified nurses even more important as they supervised a mixed skill and flexible workforce. She added that the skill contribution brought by

Mr Wragg

Ms Johnston

Ms Patel
non-qualified nurses was equally important. She confirmed to Ms Charles that the current skill mix was considered to be the most appropriate and had not been dictated purely by cost.

Ms Charles also picked up on the aim to recruit competent and compassionate nurses. She queried how compassion could be evaluated as, in the earlier presentation, it was considered to be more of a personality trait and difficult to teach. Ms Johnston responded that criteria were being developed to test for compassion during recruitment as part of the values assessment, but it would take up to 3 years to establish subsequent measurements for compassion provided during the provision of day to day services.

Dr Goss was interested to note the repeated use of ‘time’ in the title of this strategy. She commented that service user feedback and the national press indicated a sense that time with healthcare professionals was increasingly restrained. Ms Johnston advised that the Deputy Director of Nursing was currently undertaking a study on time spent with service users. Early indications were that it was not the amount of time, but the how time was spent with the service user, that was important. This piece of work was on-going.

Dr Goss also raised the issue of the Trust’s aim to increase productivity and sought assurance that increased productivity would not further reduce time spent with service users. She added that compassion was difficult to provide in a time pressurised environment. Mr Calaminus responded that, to improve productivity, the Trust was reviewing the workload and every step involved in each care pathway. The aim was to achieve the best results and not to reduce time spent with patients.

Ms Harvey commented that she found the strategy’s introduction to be more aspirational than practical. Ms Johnston agreed that further consideration would be given to this section.

Dr Tang commented on the importance of ensuring that, at the end of the strategy’s 3 year timeline, the Trust was able to evidently assess whether it had achieved its stated aims.

The Board of Directors APPROVED the Nursing Strategy 2014–2017, subject to the discussed and agreed amendments, noting the 7 Nursing Standard within the document.

**1.33.14 Human Resources & Workforce Performance Report, Q3 2013/14**

Ms Johnston presented this report. She highlighted slight increases in the Trust’s vacancy rate; a similar increase in the usage of bank staff; and significant improvement in the uptake of mandatory training. The Board’s attention was also drawn to the report’s ‘hot topic’ of turnover, which was presented with comparative data. Ms Johnston added that the end of protected pay rates, which resulted from previous organisational changes, had not evidently affected turnover. She asked the Board to note the report and invited questions.

Ms Harvey was pleased to note that the number of new disciplinary and grievance cases had remained constant, but highlighted the
increase in new absence management cases. Ms Johnston responded that she had been pleased to see this increase as significant work had recently been put into ensuring that managers understood and used the absence management processes correctly.
Ms Fullick thanked Ms Johnston for a helpful and easily understood report.

The Board of Directors NOTED the Human Resources & Workforce Performance Report, Q3 2013/14

SUB-COMMITTEES

1.34.14 Quality Committee

The Board RECEIVED the agreed minutes of the Quality Committee’s meeting on 21 January 2014.

1.35.14 Service User Experience & Staff Experience Committee

(There were no minutes due to be received from this Committee)

OTHER BUSINESS

1.36.14 Any Other Business that the Chair Considered Urgent

No other matters of urgent business were raised at this meeting.

1.37.14 Risks Identified During the Meeting or Referred to / from any other Committee

The Board noted the range of risks associated to failing to effectively manage the Trust’s capital expenditure programme and the related need for tighter monitoring and control.

1.38.14 Public Board Planning Document

No changes were requested to the public Board planning document.

1.39.14 Date of Next Meeting

24 April 2014.

1.40.14 CLOSE

The Chair declared the meeting closed at 4:20pm.

I certify that these are fair and accurate minutes of the stated meeting.
Note: *Board minutes are numbered sequentially throughout the calendar year.*
Notes from the Joint Board/Council of Governor Session on Operational & Strategic Planning; and the CQC’s Planned Trust Visit in May 2014
Held in the Conference Hall, St Pancras Hospital,
4 St Pancras Way, London, NW1 OPE
on Thursday 27 March 2013 at 5:30pm

**Present:**
Mr Leisha Fullick Trust Chair (Chair)

**Public Governors – Camden:**
Ms Ruth Appleton
Ms Kathryn Southworth
Ms Mala Wijeweera

**Public Governors – Islington:**
Mr David Barry
Mr Henri Okereafor
Prof Wendy Savage
Ms Monika Schwartz

**Public Governor – Rest of North Central London**
Ms Saira Nawaz

**Service User Governors:**
Ms Richard Fletcher

**Staff Governors:**
Ms Diana Brown

**Nominated Governors:**
Ms Maureen Brewster Nominated Governor – Voluntary Action Camden
Dr Angela Hassiotis Nominated Governor – UCL Medical College
Cllr Jean Kaseki London Borough of Islington
Mr Gareth Pountain Voluntary Action Islington

**Trust Board Members**
Ms Wendy Wallace Chief Executive
Mr Richard Brooman Non-Executive Director
Mr Paul Calaminus Chief Operating Officer
Ms Sarah Charles Senior Independent Director
Dr Sue Goss Non-Executive Director
Ms Angela Harvey Non-Executive Director
Ms Claire Johnston Director of Nursing & People
Ms Cha Patel Deputy Trust Chair
Mr Colin Plant Director of Integrated Care (Non-voting member)
Dr Sylvia Tang Deputy Chief Executive & Medical Director
Mr David Wragg Director of Finance

**In attendance:**
Mr Jonathan Fisher Membership Project Manager
Mr Kevin Monteith Associate Director, Strategy and Corporate Development
Ms Acosia Nyanin Head of Quality Assurance & Regulation (item 3 only)
Mr Martin Zielinski Board Secretary (Minutes)
**Apologies had been received from:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Zaheer Afridi</td>
<td>Public Governor, Camden</td>
</tr>
<tr>
<td>Mr Shahnewaz Ahmed</td>
<td>Public Governor, Camden</td>
</tr>
<tr>
<td>Ms Lucy McLean</td>
<td>Staff Governor</td>
</tr>
<tr>
<td>Ms Martha Wiseman</td>
<td>Public Governor, Islington</td>
</tr>
</tbody>
</table>

**Absent without apologies:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Nadia Du Plessis</td>
<td>Staff Governor</td>
</tr>
<tr>
<td>Mr Mohamed Ismail Ibrahim</td>
<td>Service User Governor</td>
</tr>
<tr>
<td>Mr Alasdair Macdougall</td>
<td>Service user Governor</td>
</tr>
<tr>
<td>Cllr Tulip Siddiq</td>
<td>Nominated Governor, London Borough of Camden</td>
</tr>
<tr>
<td>Ms Natasha Sloman</td>
<td>Staff Governor</td>
</tr>
<tr>
<td>Ms Brenda Williams</td>
<td>Service User Governor</td>
</tr>
</tbody>
</table>
1. **Welcome & Quoracy**

Ms Fullick welcomed everyone to the meeting, and gave an outline of the evening’s format and the topics to be discussed.

This meeting was in line with the quoracy requirements of both the Board of Directors and the Council of Governors.

2. **Operational & Strategic Planning**

Ms Wallace gave a slide based presentation outlining a 2 year service plan and a 5 year strategic plan for the Trust. She highlighted that the timetable and format for these plans had been set by Monitor, the regulator for NHS Foundation Trusts. It was drawn to everyone’s attention that there was a requirement for the Trust’s Board to consider the views of the Governors in setting these plans. The Governors, in turn, were required to represent the Trust’s membership and the community at large.

Ms Wallace detailed the main proposals behind the Trust’s 2 year plan and explained how feedback from the Trust’s membership, obtained via a recent survey, had been incorporated. In addition an open meeting had been held on 13 March 2014 allowing members to voice their opinions in person.

Ms Wallace invited questions on the 2 year plan.

Ms Appleton, referring to the statement made that people with psychosis die on average 18 years younger, queried whether this included the London Borough of Camden. Ms Wallace advised that this was a national statistic. Dr Tang added that these national figures were not broken down over individual boroughs.

Prof Savage queried whether smoking was still a big issue. Dr Tang advised that this was the case with statistics stating that 42% of people with severe mental health problems were smokers and that, overall, 40% of all tobacco used in the UK was by people with a mental health problem. Ms Wallace added that it was illegal to smoke on wards and that service users had to go outside if they wished to smoke. She advised Prof Savage that there were still members of staff who smoked, but that the actual numbers were not available.

Cllr Kaseki asked whether the Trust was working with local pharmacies to reduce the number of staff smoking. Ms Johnston confirmed that this was the case, as part of a larger funded programme for health and wellbeing.

Ms Wallace moved on the 5 year strategic plan, explaining that all NHS bodies were now required to prepare such a plan. A final Board approved version of this plan had to be submitted to Monitor by the end of June 2014. Monitor had advised that these longer term plans should be big and bold, and cognisant of the restricted funding for the NHS. They were also required to include a detailed assessment of the challenges facing the Trust; its environment; and its viability as an ongoing organisation. The Board would be required to make a formal
declaration on the Trust’s sustainability.

Ms Wallace explained how patients would be given more control over their own health care and that the barriers would be broken down between primary, secondary and community care. For the NHS to remain sustainable, in the long term, all aspects of the service would have to work together. More integrated care should also lead to improved quality and efficiency within care pathways.

In response to a question from Mr Fletcher, Ms Wallace advised that GP practices would still be a key initial contact point and that processes were already underway to improve GPs’ understanding of mental health and the availability of related services.

Ms Wallace invited those in attendance to break into groups and consider which integration path they thought would most benefit current service users and the local community. At the end of the discussion session she invited a show of hands on the favoured part of the NHS that the Trust should consider integrating with. Each attendee was allowed a maximum of 2 votes and the votes cast were:

- 20 votes for integration with primary care;
- 12 votes for integration with community care;
- 7 votes for integration with acute services; and
- 7 votes of integration with other mental health service providers.

Ms Wallace thanked everyone for taking part and was especially pleased to see Governor involvement in choices that provided a lot for future management consideration and discussion.

3. **Update on Planned CQC Inspection of the Trust in May 2014**

Ms Johnston led this item and commenced by detailing 3 Governor pledges, distilled from a previous meeting of the Council on 4 December 2013. She proposed that, if Governors agreed, these pledges would be posted on the Trust’s public website.

Ms Johnston gave a short slide based presentation setting the context and operating model for the forthcoming CQC inspection visit, which would commence on 27 May 2014. It was highlighted that all of the Trust’s stakeholders would be engaged as part of the inspection process, including the Trust’s Governors and its membership. It was possible that the CQC inspectors would seek a private meeting with individual Governors. Governors were similarly welcomed to submit any questions they may have to the inspectors. She suggested that everyone involved with the Trust should be able to state 3 areas in which the thought the Trust excelled and 3 areas where performance could be further improved. To assist with this matter she provided two ‘heat maps’ detailing the currently gathered view on what the Trust did well and where it could perform better. She suggested that Governors could use the information contained in these charts to form their own opinions on the Trust’s performance.

Dr Hassiotis asked why whistle blowing was listed as an area for improvement. Ms Johnston responded that only a few such reports had been received in the last year whilst the most recent staff survey
indicated that there were concerns over bullying and harassment. Ongoing work was required to establish what lay behind these concerns, and whether they should have resulted in a higher level of whistle blowing. If this is shown to be the case then the underlying reasons why whistle blowing was not taken place would have to be investigated and addressed.

Ms Brown queried whether there was any specific remit for Staff Governors, in relation to the CQC inspection. Ms Nyanin stated that Staff Governors were welcome to assist her in undertaking internal quality reviews which should ensure that services were ready for the external inspection. Ms Johnston added that all Governors were welcome to take part in this process and left a sign-up sheet in the meeting room for those interested in taking part to register their interest.

In response to a question from Ms Appleton, on how Governors could monitor improvements made, Ms Johnston referred her to a previous slide in her presentation and advised that the CQC would publish all reports and action plans on their public website. She added that Governors were welcome to have input, or raise questions relating to the CQC inspection, at any time, via the Trust Secretary e-mail account with which they were all familiar.

(Copies of the proposed Governor pledges and the slides used by Ms Johnston were distributed during her presentation.)

4. Closing Remarks

Ms Fullick asked the Governors present to formally approve the three Governor pledges, previously circulated by Ms Johnston, and their posting on the Trust website.

The Council of Governors APPROVED their three pledges, made in relation to the Francis Inquiry, and the posting of these pledges on the Trust’s public website.

Ms Fullick thanked everybody for attending and actively taking part in what had been an informative and useful meeting of the Trust’s Board and Council of Governors.

5. CLOSE

The Chair closed the meeting at 7:00pm.

I certify that these are fair and accurate minutes of the stated meeting.

(Council of Governors Chair) (Date)
# Matters Arising from the Board Meeting Held in Public

On 27 March 2014

<table>
<thead>
<tr>
<th>Minute no.</th>
<th>Matters Arising:</th>
<th>Action Owner:</th>
<th>By when:</th>
<th>Update/Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 1.26.14</td>
<td><strong>MA1: Service Users’ Experience Presentation: “Safewards”</strong>&lt;br&gt;The outstanding briefing on how the “safewards” process will be rolled out to other areas, being prepared by the Deputy Director of Nursing, and is to be circulated to Board members once completed.</td>
<td>Ms Johnston</td>
<td>15/04/14</td>
<td><strong>On-going.</strong> The current post-holder leading this work has been promoted and is leaving his post. Process is underway to fill this vacancy. Once appointed the leadership of this work will be taken up and rolled out to other wards. Discussions are taking place between the Director of Nursing &amp; People and the Chief Operating Officer regarding how further engagement from services can be achieved. It is proposed to develop a Programme Board with all stakeholders represented to move this work forward more rapidly. It is anticipated that this work will conclude during May 2014.</td>
</tr>
<tr>
<td>2 1.27.14</td>
<td><strong>Strategic &amp; Operational Planning for 2014</strong>&lt;br&gt;A number of amendments are to be made to the 2 year plan including: statements being phrased more definitely; the completion of missing dates; the managerial actions against priorities be strengthened; and a risk added in relation to the current vacancy rate.</td>
<td>Dr Tang (Mr Monteith)</td>
<td>02/04/14</td>
<td><strong>Completed.</strong> Plan submitted.</td>
</tr>
<tr>
<td>Minute no.</td>
<td>Matters Arising:</td>
<td>Action Owner:</td>
<td>By when:</td>
<td>Update/Status:</td>
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<td>-----------</td>
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</tr>
<tr>
<td>3 1.28.14</td>
<td>Internal Audit Charter</td>
<td>Mr Brooman</td>
<td>15/04/14</td>
<td>Completed - Mr Brooman met with Ms Nieboer (KPMG) on 17 April 2014 and she has arranged for the requested changes to the Charter.</td>
</tr>
<tr>
<td>4 1.31.14</td>
<td>Financial Position – Month 11, 2013/14</td>
<td>Mr Wragg</td>
<td>(review) 15/04/14</td>
<td>Completed. This will be routinely shared with the Board (and FTE and FEC) in the monthly finance report. The Month 12 position was reported through the Estates Group on 9 April 2014.</td>
</tr>
<tr>
<td>5 1.31.14</td>
<td>Financial Position – Month 11, 2013/14</td>
<td>Mr Wragg</td>
<td>15/04/14</td>
<td>Completed. In Month 12 retrospective bookings accounted for 4% of the total value of in-month bookings. This compares to the mean value of 12% for the 6 months prior to March 2014. However, there is significant divisional variation meaning that further investigation is required and further details will be reported to a future Finance &amp; Estates Committee meeting.</td>
</tr>
<tr>
<td>6 1.32.14</td>
<td>Nursing Strategy - 2014 - 2017</td>
<td>Ms Johnston</td>
<td>15/04/14</td>
<td>On-going. Strategy is to be launched at a Nursing Conference 08/05/14. Lead responsibilities identified. Initial recruitment campaign in Dublin later this month. (Mr Stanley Riseborough, Interim Deputy Director of Nursing)</td>
</tr>
</tbody>
</table>
|   | 1.32.14 | **Nursing Strategy - 2014 - 2017**  
Further consideration is to be given to the strategy’s introduction to consider whether it is factually accurate or more reflects a more inspirational position. | **Ms Johnston** | 15/04/14 | **Completed.** The strategy aims to be consultative and dynamic and it is important as a strategy document it maintains an aspirational position. The later sections of the report add more detail and outline the operationalising of the aspirations.  
(Ms Zoe Peel, Graduate Management Trainee) |

Code:  
- [ ] Completed / Not yet due.  
- [ ] Review /action required at meeting.
Executive Summary

Monitor requires NHS Foundation Trusts to provide Board statements certifying on-going compliance with their foundation trust provider licence. The Trust Board is required to certify that it has achieved a score of at least 3 on the continuity of service rating for quarter 4 and for 2013/14 as whole, and expects to maintain a score of at least 3 for the next financial year.

For every quarter in 2013/14 the Trust has been able to demonstrate a score of 4 on its continuity of service rating, up to and including quarter 4. The Trust has exceeded its planned cash at year end, and exceeded its planned normalised outturn, both of which would have led to the delivery of a score of 4 on each of the liquidity ratio (days) and capital service ratio (times). Therefore, a 4 continues to be delivered with headroom greater than planned.

The plan for 2014/15 to 2015/16 agreed at the March Board showed that scores of 4 on each of the component ratios, and on the overall ratio, were consistent with a robust contingency reserve position, realistic income projections and a relatively low CIP, with a significant element already identified.

Recommendations to the Board

The Board of Directors is requested to:

- certify that a continuity of service score of at least 3 was achieved for the whole of 2013/14; and
- certify that a score of at least 3 will be achieved during 2014/15.
Trust Strategic Priorities Supported by this Paper
E1  Delivering the highest level of quality and financial performance.

Risk Implications
The risks to the Trust's continuity of service rating are assessed by this paper.

Legal and Compliance Implications
In order to operate as a Foundation Trust demonstration of compliance with Monitor's provider licence and risk assessment framework is required.

Finance Implications
If the Board cannot declare compliance, then there may be costs associated with implementing remedial action plans.

Requirement of External Assessor/Regulator
Compliance with Monitor's risk assessment framework 2013/14.
Executive Summary
Monitor requires NHS Foundation Trusts to provide board statements certifying on-going compliance with their foundation trust provider licence. This includes an annual corporate governance statement and quarterly in-year monitoring reports for governance and finance.

In addition to financial information (the subject of a separate board paper), the trust must submit the following to Monitor by 30 April 2014:

- a declaration from the board certifying that the board is satisfied that plans in place are sufficient to ensure: on-going compliance with all existing governance targets and indicators, and a commitment to comply with all known targets going forward
- any exception reports
- a report on information relating to membership elections (not applicable this quarter).

The attached report provides information to the board in each of these areas to allow discussion of the Q4 governance submission.

Recommendations to the Board
The Board of Directors is requested to:

- Approve the submission of the positive statement on service performance targets;
- Certify compliance against the 6 Learning Disability criteria; and
- Approve the proposed exception report.
Trust Strategic Priorities Supported by this Paper

Excellence

E1 Continuously improving the quality and safety of service delivery, service user and carer experience and improving outcomes.

E2 Delivering the highest levels of quality and financial performance.

Risk Implications
This paper assesses whether there is a risk to compliance with the Trust’s provider licence and governance rating.

Legal and Compliance Implications
In order to continue to operate legally as a foundation trust, demonstration of compliance with Monitor’s provider licence and risk assessment framework is required.

Finance Implications
If the Board declares non-compliance with any service performance target, there may be costs associated with implementing related action plans.

Single Equalities Impact Assessment:
SEIA is relevant to achievement of service performance targets.

Requirement of External Assessor/Regulator
Compliance with Monitor’s risk assessment framework 2013/14.
Monitor Governance Declaration - Quarter 4: 2013/14

1. Background: Monitor’s risk assessment framework

1.1 Revised reporting requirements for foundation trusts are set out in Monitor’s new risk assessment framework published in August 2013 (updated April 2014). To become and remain a foundation trust, it is necessary to demonstrate to Monitor that the trust is well governed, financially robust, legally constituted and meets the required quality threshold. The board is required to make an annual corporate governance statement for quality, finance and governance and to make in year declarations each quarter for continuity of services (finance) and governance.

1.2 This report provides information to the board of directors to assist with making their quarterly governance declaration to Monitor.

2. Statement on service performance targets

2.1 The board is required to make a statement certifying that all targets and indicators have been met over the period and that sufficient plans are in place to ensure that all known targets which will come into force will also be met. The table below sets out the targets for 2013/14 and the service performance during Q4:

2.2 With regards the six criteria relating to meeting the needs of people with a learning disability, the board receives its annual assurance through receipt and scrutiny of the annual reports of the Islington and Camden Learning Disability Partnerships. These were received at the October 2013 board. The Trust is currently reviewing its overall implementation plan for the improvement of services to people with learning disabilities, with a view to making further improvements.

Table1: Targets and Indicators

<table>
<thead>
<tr>
<th>Service Performance Target</th>
<th>Threshold</th>
<th>Monitoring Period Relevant to Declaration:</th>
<th>Q4 Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Programme Approach (CPA) service users receiving follow-up contact within seven days of discharge from hospital</td>
<td>95%</td>
<td>Quarterly</td>
<td>98%</td>
</tr>
<tr>
<td>CPA service users receiving formal review in the last 12 months</td>
<td>95%</td>
<td>Quarterly</td>
<td>96%</td>
</tr>
<tr>
<td>Admissions to inpatient services had access to crisis resolution home treatment teams</td>
<td>95%</td>
<td>Quarterly</td>
<td>98%</td>
</tr>
<tr>
<td>Minimised delayed transfers of care</td>
<td>&lt;7.5%</td>
<td>Annual</td>
<td>0.99%</td>
</tr>
<tr>
<td>Number of new cases of psychosis served by EIS</td>
<td>95%</td>
<td>Quarterly</td>
<td>100%</td>
</tr>
<tr>
<td>Mental Health Minimum Data Set—Identifiers</td>
<td>97%</td>
<td>Quarterly</td>
<td>98.10%</td>
</tr>
<tr>
<td>Mental Health Minimum Data Set—Outcomes for CPA service users</td>
<td>50%</td>
<td>Quarterly</td>
<td>87.54%</td>
</tr>
</tbody>
</table>
3. Exception reports

3.1 Monitor expects foundation trusts to notify them in writing of any incidents, events or reports which may reasonably be regarded as raising potential concerns over compliance with their licence. Examples of exceptions are set out in the risk assessment framework, and reproduced here, with comments relating to the trust.

3.2 With regards compliance with CQC essential standards, the trust has now had a response from the Care Quality Commission to its recent compliance review of Stacey Street Nursing Home. The review took place on 6th February 2014 and included an assessment against six essential standards. The trust was found to be fully compliant against five of these, with one moderate concern relating to one standard.

The CQC report positively reflects that the trust achieved full compliance with the following outcomes:

1. Outcome 2 (Regulation 18) Consent to Treatment
2. Outcome 4 (Regulation 9) Care and Welfare of people who use services
3. Outcome 8 (Regulation 12) Cleanliness and Infection Control
4. Outcome 13 (Regulation 22) Staffing
5. Outcome 16 (Regulation 10) Assessing and monitoring the quality of service provision

The CQC has set the trust compliance actions for Outcome 9, Medicines Management. The trust has already drawn up a thorough action plan which is monitored weekly by the Quality Review Group that reports to the Quality Committee.

With regards exception reporting, it is proposed that the moderate concern relating to medicines management is included as an exception report for this quarter.

3.3 Examples of exception reporting to Monitor

<table>
<thead>
<tr>
<th>Area for Potential Exception Reporting</th>
<th>Information for Board to take into Account</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONTINUITY OF SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Unplanned significant reductions in income or significant increases in costs.</td>
<td></td>
<td>No risk or exception to report</td>
</tr>
<tr>
<td>2. Discussions with external auditors which may lead to a qualified audit report.</td>
<td></td>
<td>No risk or exception to report</td>
</tr>
<tr>
<td>3. Future transactions potentially affecting the continuity of services risk rating.</td>
<td></td>
<td>No risk or exception to report</td>
</tr>
<tr>
<td>4. Risk of a failure to maintain registration with the CQC for Commissioner Requested Services (CRS).</td>
<td></td>
<td>No risk or exception to report</td>
</tr>
<tr>
<td>5. Loss of accreditation of a CRS.</td>
<td></td>
<td>No risk or exception to report</td>
</tr>
<tr>
<td>6. Proposals to vary CRS provision or dispose of assets, including:</td>
<td></td>
<td>No risk or exception to report</td>
</tr>
</tbody>
</table>
• cessation or suspension of CRS;
• variation of asset protection processes.

Proposed disposals of CRS-related assets.

<table>
<thead>
<tr>
<th>FINANCIAL GOVERNANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Requirements for additional working capital facilities.</td>
</tr>
<tr>
<td>2. Failure to comply with the statutory reporting guidance.</td>
</tr>
<tr>
<td>3. Adverse report from internal auditors.</td>
</tr>
<tr>
<td>4. Significant third-party investigations that suggest potential material issues with governance.</td>
</tr>
<tr>
<td>5. CQC responsive or planned reviews and their outcomes.</td>
</tr>
<tr>
<td>6. Other patterns of patient safety issues which may reflect poor governance (e.g. serious incidents, complaints).</td>
</tr>
<tr>
<td>7. Performance penalties to commissioners.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOVERNANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Third party investigations that could suggest material issues with governance, (e.g. fraud, CQC concerns, medical Royal Colleges’ reports).</td>
</tr>
<tr>
<td>2. CQC responsive or planned reviews and their outcomes/findings.</td>
</tr>
<tr>
<td>3. Other patient safety issues which may impact compliance with the licence (e.g. serious incidents).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enforcement notices or other sanctions from other bodies implying potential or actual significant breach of a licence condition, (e.g. Office of Fair Trading).</td>
</tr>
<tr>
<td>2. Patient group concerns.</td>
</tr>
<tr>
<td>3. Concerns from whistle-blowers or complaints.</td>
</tr>
</tbody>
</table>

4. Changes to the council of governors – membership election report
   There have been no further governor elections or changes this quarter.
Executive Summary
This strategy for social work sets out the direction of travel for the social work profession over the next 3 years. This will require the trust to commit to focus on the needs of this professional group. There are resource implications, as we are requesting that we dedicate social care leadership which will have particular responsibility for social care performance and implementing the strategic goals set out here within the division. There is a detailed action plan and appendices relate to the statutory duties, training plans and relevant associated documentation.

Recommendation to the Board
The Board of Directors is requested to:


Trust Strategic Priorities Supported by this Paper

**Excellence**

E1 Continually improve the quality and safety of service delivery, service user experience and improving outcomes.

E2 Delivering the highest level of quality and financial performance.

**Innovation**

I1 Rapidly adopt best practice and maintain a culture of innovation in service development.

**Growth**

G1 Pursue organic and inorganic growth opportunities through strategic partnerships and research and development.
Risk Implications
The trust must demonstrate its commitment to social care or risk relationship difficulties with the boroughs who may decide to withdraw from its contract with the Trust.

Legal and Compliance Implications
The Trust has statutory duties it manages on behalf of the local authority and these must be adhered to.

Finance Implications
Resource is already within Divisions however it is important that time is given to identified social care leads to carry out and deliver on the actions within this strategy.

Single Equalities Impact Assessment
N/A

Requirement of External Assessor/Regulator
None.
Strategy for Social Work

Camden and Islington Foundation Trust
2014-2017

By Natasha Sloman
Head of Social Work and Social Care
Jan 2014
1. Executive Summary

Camden & Islington Foundation Trust can be justifiably proud of its long commitment to providing integrated health and social care services. In 2002 it became one of the first Mental Health and Social Care Trusts in the country, and by early 2003 it was providing a fully integrated model of medical, nursing and social care.

Social workers, doctors, nurses and other professionals have made the multi-disciplinary team the bedrock of mental health services, and there is much to applaud in this model.

This strategy document acknowledges the strengths of the multi-disciplinary approach and seeks to strengthen and consolidate integration of health and social care, highlighting the benefits to vulnerable people with mental health problems.

While this strategy focuses on the role of social work in mental health, it also acknowledges that social care is delivered by a range of professionals. A positive effect of integration is that it is now virtually impossible to imagine effective mental health services that do not rely on a social care dimension – and much of that care is provided by nurses, psychologists, occupational therapist and doctors.

The strategy seeks to re-position social work within health, reinforcing the values and traditions of the profession. It also serves as a reminder to the Trust that there have been significant developments in the world of social work, with which it must engage.

It is therefore essential that:

- Social workers’ skills and expertise are targeted, so that service users receive the full benefit of their interventions.
- The tasks social workers undertake are disseminated fairly and are clearly linked to the Local Authority agendas.
- Social workers are leaders in social care functions delegated to the Trust under the S75 agreements.
- Clear trajectories are mapped out for social workers’ career development.
- That modern social work practice is embedded in evidence of what works well.
The underpinning strength and consensuality of the strategy set out in this paper is that it was developed as a result of consultation with, and the active involvement of, frontline social workers through a working party over a nine-month period (see Appendix 1 for list of working party members). Contributions to the strategy were also made by The College of Social Work and by both of the relevant local authorities – the London boroughs of Camden and Islington.

The strategy is also committed to living the values set out by the trust who have worked closely with staff and people using services to create a set of values that make sure people who use our services get the best possible chance of a rapid recovery. These values are part of a wider campaign: Changing Lives which is helping to drive up the standards of care across the Trust.

Social workers have responsibility to guarantee certain standards for individuals using mental health services such as:

- a warm welcome throughout the journey to recovery
- their dignity will always be respected
- that care will be founded on compassion and kindness
- a positive approach to care as they journey to recovery

As a trust we want to ensure that people receive the very best care from a highly trained team of professionals.

As a result of this consultative process with these frontline staff and other key stakeholders we have drawn up six priorities. These will address key challenges for social work and enable managers to prioritise social care tasks appropriately. These are set out in detail in the Strategic Priorities Action Plan that forms the core of this document. In precis, the priority areas cover:

1. **Workforce development** – enhancing skills and confidence, and developing clear career development plans and working with the Local authority to achieve this. Monitoring appraisals, supervision and training for social work staff. This is particularly essential as social work staff remain seconded to the trust.

2. **Leading the profession and managing practice** – clarifying lines of accountability, improving practice, ensuring that high standards are maintained, and becoming leaders in social care audit and embracing a culture of learning.

3. **Delivering outcomes** – effective measurement of social work interventions, with the focus on engagement, empowerment and personalisation, and using technological advances to improve outcomes.

4. **Leading on personalisation** – building the skills and confidence needed to lead on implementing a whole systems approach to personalisation.
5. **Promoting and embedding safeguarding and managing risk** – continuous professional development and training to ensure that skilled, confident practitioners assess and manage risk, manage complex safeguarding situations, and leading safeguarding investigations.

6. **Promoting the profession** – developing the skills and tools to challenge and reverse negative perceptions of social work in the media and in the general public.

Frontline social workers were keen to see a revised and re-invigorated statement of their responsibilities within a mental health trust and how their accountability is recognised.

It is often said that describing social work is difficult, and that the role of mental health social work is often misunderstood. By setting out the national context for social work within a strategic framework, clear expectations can begin to be set for the role of social workers within a mental health arena. This is essential given their position as seconded employees who may fall between organisations.

Establishing these priorities for social workers will give clarity and direction for the profession over the next three years.

Social workers are in the vanguard of the human rights agenda for service users. They routinely make important differences every day to the lives of people with difficult and complex problems, but the overwhelmingly positive achievements in dealing with the impact of poverty, discrimination, social disadvantage, neglect and abuse often go unreported and unrecognised. Instead, negative media caricatures of the profession’s interventions can lead to a demoralising feeling among staff of being “damned if we do, damned if we don’t”.

This strategic plan aims to develop frontline social workers into leaders and champions of social care, and will play a major part in helping to develop the skills and confidence to make significantly positive changes to the way social work is often perceived by the media and general public.
2. Definition of the role of social work
2.1 The National and Local context

Social work is a professional and academic discipline that seeks to improve the quality of life and subjective well-being of individuals, groups, and communities through research, policy, community organizing, direct practice, crisis intervention, and teaching for the benefit of those affected by social disadvantages such as poverty, mental and physical illness or disability, and social injustice, including violations of their civil liberties and human rights.

Day after day, social workers make an important difference to people’s lives. They often work in the most challenging of environments, with people who face serious and complex problems, and have to deal with the impact of poverty, discrimination, social disadvantage, neglect and abuse.

They are unusually (although not exclusively) prime decision makers on the use of statutory powers which have long lasting ramifications and impact on service users and their families. This is particularly apparent in mental health and the use of the Mental Health Act 1983 where the majority of Approved Mental Health Professionals (AMHPs) continue to be social workers and they sit under Adult Social Care within the Local Authority who remain responsible for the AMHP role and function. This is also true within Children’s Social Care.

Unfortunately, the media and public perception of social workers is often negatively distorted, and the overwhelmingly good and valuable work they do to champion and protect the most vulnerable people in society is rarely reported or discussed.

It is therefore essential to help the public understand the role of social work and the positive influence it brings to bear when people face disadvantage and injustice.

This strategy sets out the Camden and Islington Foundation Trust’s vision and commitment to the social work profession within the Trust, and identifies the priority areas for social work for the next three years. Through this strategy, we will ensure that social work remains a valued and valuable resource, and that support for frontline social workers is relevant and meaningful to the profession.

Within the Trust, social workers – the majority of whom are AMHPs – comprise over 100 members of staff across the workforce. They are highly skilled, able to deal with major complexity and risk, and their expertise should be utilised in areas of work such as:

- Safeguarding ensuring adults at risk are protected from harm. Identifying child protection concerns particularly where parents or siblings suffer mental illness and safeguarding children.
- Human rights, including defence from potential interference in the right to liberty and right to family life.
- Detailed knowledge and application of the law and statutory duties in the areas of mental health/substance misuse/children and general adult social care.

- Personalisation. Ensuring that service users are offered services which are person centred which promote choice, control, independence and recovery.

- Application of recovery principles, including service user engagement and empowerment.

- Championing equality and diversity and anti-discriminatory practice and highlighting gaps and weaknesses in service provision.

- Understanding the strengths and assets of local communities and supporting communities to support individuals.
3. Introduction

Social workers have made a crucial contribution to the mental health system for many years, providing an alternative social understanding of ways in which recovery can be aided by a sociological and psychological perspective. Because they are educated in various aspects of the law and have a well-developed knowledge of the Local Authority agenda, social workers have played a very important part in assisting mental health services to look beyond the medical model and consider the individual by meeting a range of needs – including housing, employment, education, diversity and, crucially, family and community – to assist in the recovery process.

In 1999, the National Service Framework for mental health led services towards fully integrated community mental health teams, and current policy drivers continue to advocate seamless services that address the person as an individual with a unique set of needs. The focus of government policy maintains the commitment to integrated health and social care, and to the proliferation of this concept in the interests of better outcomes for service users and better efficiency. Integration is a key theme in the Health and Social Care Act (April 2012), and the government’s mental health strategy states:

“Many of the causes of mental health problems are socially determined, and many of the changes that can lead to better mental wellbeing and to recovery also lie in the wider social environment.”

The Future Vision Coalition, Opportunities for a New Mental Health Strategy (October 2010)
4. Background

Social workers were seconded to the Camden and Islington Foundation Trust in 2002, under S31 (now S75) of the Health and Social Care Act 2002. The Trust became a Mental Health and Social Care Trust. Nurses, psychologists and occupational therapists were expected to undertake a range of social care tasks, including those delegated under the S75 agreement. Integration, from the Trust's perspective, is generally regarded as desirable, and it was clear in 2002 that it would be beneficial to encourage the incorporation of a thriving social model into the closed world of acute hospital and mental health care. Social work aimed to ensure advocacy and championing of the “least restrictive” options of care and treatment, particularly for those at considerable risk of stigma and discrimination and potentially subject to oppressive measures under the Mental Health Act 1983.

Benefits to service users were self-evident, and this arrangement helps the Trust to deliver a service rated as “excellent” by the Care Quality Commission for 2011/12. It is in line with national guidance and policy – such as the National Service Framework, New Horizons and the NHS Plan – and it also helps the Trust to promote continuity and to extend the culture of partnership to those receiving its services. It ensures that the social model and inclusion are at the heart of Trust business.

Since 2002, there have been significant developments in the national context that impact directly on how services are designed and delivered. Social care policy has been thriving and is shaping a future which is very much driven towards greater integration and moving away from traditional models of care particularly hospital care. In Haringey the death of baby Peter has had major implications for social work reform and led to key developments within the social work world such as the creation of a College of Social Work.

These developments have implications for adult social care and mental health and sets out an agenda that is central to the developing role of modern social work. However, this agenda has been slower to take shape within mental health services. This is due to a variety of reasons – including the complexity of mental health in general, and competing demands from health and social care – so it has become necessary to reconsider the current position and strengthen the ties to the local authority. It is also important to state that integration has never been fully evaluated and that a number of Local Authorities have moved their staff out of NHS control and back under the direct management of the Local authority.

The strategy was drawn up by a group of frontline social workers who for 6 months met to reflect and generate the issues that they felt needed to be profiled. The outline strategy has also been presented to both Camden and Islington boroughs who welcome the principles of the strategy and are keen to see it adopted. The strategy has also been presented to our borough Learning and Development Teams whose input was key to its development. The College of Social Work also contributed as did senior managers within the trust via our Social Care Reference Group. (See Appendix 1) for list of people consulted for the strategy paper).
5. National context

In 2005 the Labour government launched its personalisation agenda. Significant national policy began to shape the personalisation agenda by pushing towards redressing the inequality of relationship between statutory services and service users and carers, recognising that there was a lack of choice and control over services. In 2007, the government launched a paper, Putting People First, aimed at transforming adult social care to meet the challenges of the future. The policy concentrated on four key themes:

- Better information.
- Better quality.
- More focus on prevention.
- More personalised care and support.

The personalisation agenda, which aims to put the service user at the centre of the care planning process, will continue to grow. It is based on the principles of prevention, plurality, protection, and partnership – essential to ensuring outcomes that see the person put first, as expressed in A Vision for Adult Social Care: Capable Communities and Active Citizens (Department of Health, 2010).

This commitment to moving forward with personalisation and community-based support is reinforced by Think Local, Act Personal: Next Steps for Transforming Adult Social Care, a sector-wide agreement that draws on lessons from implementing Putting People First across England over the past three years and focuses on areas where further action is required:

The Health and Social Care Act 2012 is now on the statute books and there is a legal basis for a strong role for local councils in working with clinical commissioning groups (CCGs) to ensure greater integration of social care and health, the promotion of health and wellbeing in their local populations, and the prevention of dependency on long term care and encouraging systems to be far more integrated. Yet to be clearly defined integration within health and adult social care is focusing on preventative services which support people with long term conditions to stay at home longer.

It is also important to consider the Law Commission Report into adult social care (May 2011), which recommended the establishment of a unified statute for adult social care for England and for Wales, to be accompanied by a single Code of Practice and a single over-arching statutory principle that adult social care must promote or contribute to the wellbeing of the individual. This is supported by a check list of factors that must be considered by decision-makers. Thus, wherever practical and appropriate, the decision-maker would be required to:

- Assume that people with the capacity are the best judges of their own wellbeing.
- Follow the individual’s views, wishes and feelings.
Ensure that decisions are based on individual circumstances and not blanket assumptions on the basis of age, appearance or condition.

Give individuals the opportunity to be involved in decisions.

Achieve a balance with the wellbeing of others.

Safeguard adults from abuse and neglect

Use the least restrictive solution.

The review recommends that there should be two levels at which adult social care services could be provided:

The first is a universal level, with the provision of universal services to the wider community to help prevent or delay the need for more targeted social care interventions. Here, local authorities would have a broader role to ensure the provision of information, advice and assistance to people who have not had or do not want an assessment, or who are not eligible for services.

The second level would be targeted social care services, provided following a community care assessment. The new statute would set out a single, clear duty to assess a person. As under the existing law, there would be a low qualifying threshold for an assessment, which is triggered where it appears to a local authority that a person may have needs that could be met by community care services.

Another important development in the world of both health and social care is the implementation and monitoring of outcomes rather than just counting numbers. The Adult Social Care Outcomes Framework has four clear domains which parallel the health outcomes framework

**Domain 1**: Enhancing quality of life for people with care and support needs i.e. self-directed support, control, carer quality of life, employment, community contribution

**Domain 2**: Delaying and reducing the need for care and support i.e. reducing permanent admissions and residential care, early intervention, re-ablement, reduced delayed transfers from hospital

**Domain 3**: Ensuring that people have a positive experience of care and support i.e. user and carer satisfaction, equal partnerships with carers, access to information, involvement, dignity, personalised sensitivity

**Domain 4**: Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm i.e. feeling safe, secure, helped to manage risks

The Munro Review of Child Protection in May 2011 also had implications for social workers. It was critical of the emphasis placed over the years on procedure and recording, and the insufficient attention paid to developing and supporting expertise. It recommended that social
workers be freed up to focus on the relationships with people, and that they should be trusted to deliver and be provided with the best possible training. It also recommended that frontline social workers should be properly supported to develop professional confidence and the ability to exercise professional judgment.

To see how the national picture translates to the practice please look at the priorities set out and the accompanying action plan.
6. Statutory duties of social workers

Under the S75 agreement, the Trust is contractually obliged to meet a number of statutory duties. Each division is responsible for delivering performance indicators in all the areas. The Trust is expected to ensure that it can demonstrate social care outcomes for service users (see Appendix 2 for full list of the statutory duties of social workers).

This is achieved in collaboration with the Local Authorities. Our councils set their local priorities. Social care provision is means tested by locally-defined financial assessment, and eligibility for social care services is determined by Fair Access to Services criteria.

The Social Care Bill will have significant implications for Local Authorities including general duties to promote well-being, prevention, promoting greater integration and providing information and advice. It is essential that all social workers are offered training and support to deliver the aims of the Social Care bill within the Foundation Trust.

7. Developing and training social workers

The London Borough of Camden has both an Adult Social Care Workforce Development Strategy and an Adult Social Care Learning and Development Strategy developed in 2012, which set out the local authority’s priorities with regard to the professional skills development of their social workers and the development of the ASC workforce as a whole. The London Borough of Islington is currently working on updating its workforce strategy. Both boroughs link in with the Foundation Trust Learning and Development Teams and the Approved Mental Health Professional Training Team, which is located within the Social Care Unit.

Both boroughs undertake training needs analysis to identify the development needs of the workforce. Learning and development plans take into account national priorities. Training that is identified is open to all social workers. Resources are also provided to enable social workers seconded from Camden to the Trust to access local training opportunities.

Both of the local authorities and the Trust expect their social workers to demonstrate a high level of competence, knowledge and professionalism, and are prepared to invest heavily in the training and development of social workers so that they are better able to meet the needs of service users and make a difference to people’s lives.

It is essential that social workers receive the right training at each stage of their professional development and career pathway so that they have the necessary skills to deliver a high standard of service, and to enable them to progress their own personal and career development.

The professional capabilities framework is the means by which those training needs are identified to enable career progression. With clear appraisal and development plans in place, this will ensure that social workers access the right learning, at the right time, to develop their knowledge, skills and expertise.
Nationally there is a drive to review the education of social workers with Norman Lamb, Minister for Care commissioning Professor David Croisdale-Appleby to undertake a independent report. It makes 22 recommendations for social work education. This report looks considers specifically;

- a generic qualifying course
- increased specialisation within the degree
- employers supporting education, including placements
- improving the ability to provide social workers with the right knowledge, skills and values
- fast track entry routes for top graduates into adult services
- value for money

The recommendations will inform talks about the future of social work education. The link to the review is here.

https://www.gov.uk/government/publications/social-work-education-review
7.1 Approved Mental Health Professionals

A major issue for the Trust is the regulation relating to the training and approval of Approved Mental Health Professionals. The Mental Health Act (AMHP) Regulations 2008 reg. 5, and schedules 1 and 2, set out the legal requirements. All AMHPs must complete 18 hours CPD each year in order to continue to exercise their legal obligations. Failure to undertake the requisite amount of hours could result in judicial review should practice contravene the law. The Trust has an AMHP Training and Development Manager, a post funded by both boroughs. All social workers should aim to move towards approval under the Act once they have the relevant experience in the community (at least 18 months to two years) qualification experience in a community mental health setting to train as AMHPs. Service Managers and Operational Managers within each division should identify suitable candidates and get agreement from the respective divisional manager for their areas of service to nominate those individuals. Managers in other departments, such as Children & Families, Adults and Learning Disability, are asked to identify suitable candidates who can be trained to offer an AMHP role within these departments if it is deemed necessary.

Currently, the Trust commissions a pre-AMHP Foundation course, in partnership with the University of Hertfordshire. This is a master’s level course designed for prospective AMHPs. It provides an opportunity for students to prepare for the full AMHP course by developing a holistic understanding of mental health, and obtaining the academic skills required to study at master’s level. The course runs twice a year.

Every five years, social workers must be re-warranted. It is essential that managers allow social workers time to complete the academic work required to present to the panel, so that the panel can confidently approve and authorise the AMHP for a further five years. It is essential that AMHPs undertake the necessary CPD every year, which is a legal requirement and consists of 18 hours each year.

7.2 Social work regulation

Social Work has been a regulated profession and social work a protected title since 2003. However, the General Social Care Council (GSCC) was abolished in July 2012 and its regulatory role for social workers has passed to the Health and Care Professions Council. www.hpc-uk.org/

The HCPC regulate social workers as a profession with a professional title that is protected by law. This means, for example, that anyone using the titles such as social worker or physiotherapist or dietitian must be registered with HCPC.

It is a criminal offence for someone to claim that they are registered with the HCPC if they are not, or to use a protected title that they are not entitled to use. Anyone suspected of doing so could face prosecution. A social worker who has not re-registered will also face disciplinary proceedings which will be managed by the Local Authority.
7.3 What the reforms mean for NHS and other health employers

As employers of social workers, it will be necessary for the NHS and other health employers to understand what the reforms mean for them, and to ensure that they meet the requirements of the regulatory body. It is likely that system regulators will use the Local government employer standards in the future during their assessments of organisations.

7.4 Social Work Task Force Reform Board

In January 2009 the Social Work Task Force was set up following a public inquiry into the death in August 2007 of Baby Peter in Haringey. It made a number of recommendations, not just for children's social care but also for social work in general, recognising that many challenges crossed all areas of social work. The Task Force was chaired by Dame Moira Gibb, who also chaired the Social Work Reform Board that was then established to take forward the recommendations of the Task Force, and which represented the views of a wide range of employer organisations, unions, educators, service users and carers. The reforms include:

- The establishment of The College of Social Work (TCSW), which was launched on January 3rd, 2012
- A single unified way of understanding what capabilities social workers should have at different points in their professional careers (see Appendix 5: Professional Capabilities Framework).
- The introduction of an “assessed and supported year in employment” (ASYE) when social work students qualify and begin their first job.
- A new Continuing Professional Development (CPD) framework that will enable more flexibility and choice, and will promote organisational and personal responsibility for CPD, which in turn will give greater priority to ongoing learning and development.
- The development of standards for employers of social workers and the supervision framework to ensure that Social Workers are able to work safely and to best effect.
- Advice to improve both the quality of candidates being recruited by universities to train as social workers, and the education they will receive.
- Principles for effective partnership working between employers and universities, as partnerships are pivotal to the delivery of the reforms.
7.5 The role of TCSW in the reform programme

The College of Social Work is a professional body for social work. It is responsible for supporting the implementation of the reforms concerning Partnerships, CPD framework, Education, and the Professional Capabilities Framework (PCF), and is responsible for leading work on further development in these areas. The Employer Standards are being developed by the Local Government Association (http://www.local.gov.uk/social-worker-standards), and the Centre for Workforce Intelligence has taken responsibility for workforce modelling. The British Association of Social Work (BASW) remains in existence also as a professional body.

7.6 Employer Standards – key points

- Develop an accountability framework to monitor the effectiveness of SW practice – for example, by adapting current governance frameworks to ensure the monitoring of issues specific to social work, including an annual report “health check” on social work practice, safety in the work setting, and feedback from users and carers.

- Identify a qualified, registered social worker to take on the strategic lead on social work within your organisation (The “Principal Social Worker” role).

- Support social workers to engage with TCSW.

- Engage with other local social work employers to form partnerships with social work education providers, ensuring that good quality placements are available in NHS settings.

- Have a clear work allocation system in place, and processes (linked to governance) that are able to flag up excessive workload problems.

- Ensure that social workers can work safely, and have access to personal welfare systems, as well as professional support from legal advisers, translators and interpreters as needed.

- Have access to professional supervision from a registered, qualified social worker. Supervision should take place weekly for a newly-qualified social worker, at least fortnightly in the first six months, and a minimum of 1.5 hours of uninterrupted time per month thereafter.

- Have access to CPD opportunities to ensure that they are able to maintain and develop their professional abilities, and meet the requirement of their regulator.

- Work closely with the regulator and TCSW to maintain and develop professional standards,

- Ensure that you have systems in place to highlight to the regulator any social workers whose practice is subject to serious concerns.
8. The role of social work – making a difference

The role of social work in mental health is to improve and enhance quality of life for those disadvantaged through suffering debilitating mental health problems. Social workers are a necessary counterbalance to the medical model of mental health care, ensuring that a wider social perspective is offered to increase understanding of illness. Social workers are also necessary to address social exclusion and protect vulnerable individuals and communities from harm.

Social workers provide a professional service to meet the assessed needs of individuals, families and their carers for support, care or safeguarding. This may be through a short-term specific intervention or may be a longer involvement because of the nature of the individual's needs or particular risks. Some individuals may need ongoing input in order to minimise and monitor risks posed to self or others through neglect, harm or exploitation. Social workers may also need to support family and carers so they can carry on in their caring role.

Social workers also contribute to ensuring that the communities in which we live reflect the values and compassion for those in need and contribute to ensuring that we live in a healthier, fairer, safer society. Social workers carry out an important role in protecting human rights and empowering individuals to reach their full potential through self-determination.

Social work is multi-faceted, requiring a range of skills to be employed to respond sensitively and effectively in order to intervene no more than is necessary to support people’s health, wellbeing and safety.

Social work can be placed into distinct categories:

- **Care and support** – assessing need and ensuring that people have access to the right support that promotes personalisation, social inclusion, and helps individuals to manage risk.

- **Prevention** – ensuring that intervention is early enough to minimise risk, promote independence, and increase quality of life and choices for individuals.

- **Advocacy and empowerment** – supporting people to make their own choices and to live independently, with the right access to the right service from the start.

- **Safeguarding** – ensuring steps are taken quickly and efficiently to reduce risk to adults at risk and children, and to intervene where necessary.

- **Choice and control** – exercising the powers provided under the MHA 1983/MCA 2005 to use the least restrictive alternatives and to abide by the principles of the code of practice in stepping in to help people at risk.
Outcomes – ensuring that it can be demonstrated that support and interventions improve outcomes, as defined by the people who use mental health services.

It is essential to ensure that social workers within the Trust are focused on these key areas, for which they must be trained. Each division has responsibilities to deliver on the delegated functions and must ensure that there is a clear lead worker for social care within each division to ensure that all the performance requirements are embedded within practice. There will also be a requirement for the lead worker to provide significant leadership in order to raise standards and improve quality.

It is recognised that all members of the multi-disciplinary team have an overwhelming contribution to make to the social care need of individuals. However, it must also be recognised that social work in mental health must refocus its role and reclaim some of the recognised responsibilities for which social workers are trained. It will be essential to review how the allocation of work is managed in teams, and to ensure that case work is allocated to social workers in an appropriate way through allocation meetings that address the following requirements:

- Comprehensive assessments, including risk assessment, which may identify how social workers can intervene early on. This will enable an individual to gain insight into their circumstances and connect people to appropriate resources, advocate on their behalf, or strengthen their relationships and social support systems.

- Allocating complex safeguarding referrals, ensuring adults at risk are protected, and proactively working with the needs of children within a family where there is parental mental ill health – ensuring that the needs of children are not lost or overshadowed by the needs of the adult.

- Working with people with long-term mental health problems who are subject to restriction and long stays on mental health wards, and addressing the need to ensure that independence is maximised and that social support systems are put in place so that choice and self-determination can eventually be achieved.

- Working with vulnerable individuals who are socially excluded, addressing the need to engage them in meaningful and valued activity.

- Working with people who require help and support to maintain their independence and ability to stay at home. Social workers should assess this need and provide packages of care, where necessary, in collaboration with carers, friends and family. Social workers should lead on ensuring that this can be done in the spirit of personalisation, and that personal budgets and direct payments are the route into social care services.

- Allocating cases to social workers where there is a need to consider balancing the rights, welfare and best interests of service users at risk with the needs and rights of others.
Social workers should respond to crisis situations and co-ordinate help for communities experiencing difficulties. They should assist families by ensuring that their welfare and economic chances are enhanced. They should seek to address accommodation problems and offer practical support for people either to return home or find alternative accommodation.

Social workers should help individuals to secure access to employment opportunities and promote recovery through self-determination. This should be provided in the spirit of optimism, hope, and by focusing on people’s strengths and abilities. Empowerment being the ultimate goal to achieve self defined ambitions.
9. Strategic priorities

Workforce development/building confidence to lead
Ensuring a high quality of social work means developing a workforce that is skilled, competent, motivated and committed. It must be recognised that social workers often carry out tasks that are incredibly demanding, and sometimes dangerous. This can result in workers feeling stressed, anxious and over-burdened. To minimise the emotional impact on social work staff, it is essential that they receive appropriate support and supervision, as the absence of this can leave social workers feeling demoralised, undervalued and de-skilled – which can have a significant impact on the quality of frontline practice.

Employers and managers have a particular responsibility to support the profession and ensure that opportunities are available for staff to develop and progress their career while remaining at the frontline. It is also essential to address excessive bureaucracy and minimise the time spent on administrative tasks, enabling staff to spend the bulk of their time engaged in social work,. This is particularly important for Trust social workers, who relate to two information systems and who are at risk of falling into a gap between two organisations when they are in their seconded position.

Leading the profession/managing practice in each service line
Professional leadership and management of social work are essential to ensure the discharge of duties and responsibilities to people who are most vulnerable. The demands of management have risen significantly over the last 10 years, with a plethora of performance measures, national targets, and an increase in the expectations of wider stakeholders and partners.

It is therefore crucial for managers to be able to negotiate these priorities and provide strong leadership and management to ensure that social workers are clear about their professional roles and are safely managing risk and complexity. It is also important to understand that management and leadership does not have to be delivered by “the manager”, but that this role can be fulfilled within the roles of specialist and lead practitioners and principle practitioner. Together, these practitioners and managers are the formal leaders of the profession and share responsibility for supporting and empowering staff to deliver a safe and effective social work service.

It is essential that social workers with ability and drive are built into the management structures and are available to provide that professional leadership.

Delivering outcomes/adding value in each service line
The Trust currently receives significant funding to deliver on the delegated functions. It is essential that investment is monitored to determine the value that social work adds to each service line. It is also necessary for social work to demonstrate what difference the intervention of a social worker has had for service users and their carers. This will enable resources to be targeted more efficiently and demonstrate the added value of social work in integrated services.
In order to do this effectively, social workers must be given clear tools to measure outcomes in order to get essential feedback from service users. Information systems must be accessible, easy to use, and must adopt lean methodology. It must be made clear to social workers the standards and expectations placed upon them. As a profession, social work must also develop greater awareness of the importance of research and audit, and must develop stronger evidence-based practices and technologies to improve practice. This must be done in co-operation with service users, who can help lead in these areas – particularly in the development of processes for outcomes, audit and research.

**Leading on personalisation**

Personalisation is more than a personal budget. This is an area in which we are still to adopt the cultural shift required to think about personalisation in a whole system approach. Personalisation is key to delivering recovery based mental health care and recovery and personalisation must go hand in hand.

Personalisation in its true form is values based and encourages organisations to redefine the relationship between state and service user. In order to convey the vision of personalisation it requires a strong leadership from frontline staff who can carry and assert the argument for personalised services. This is particularly essential within a mental health arena where many face disadvantage and discrimination.

From an organisational perspective this will also require all stakeholders to work in partnership to construct a comprehensive delivery model that works across the partnerships and interfaces with the wider reforms within the NHS, such as reforms to resource allocation systems (payment by results).

**Promoting and embedding safeguarding/managing risk**

Social work in mental health comes with particular risks and responsibilities. It is recognised and accepted that there is no such thing as risk-free social work. Social workers have a history of expertise in this area, whether relating to assessing risks to children or to adults at risk. However, social workers can never guarantee that they can protect all people at all times.

It is therefore essential that social work staff are fully equipped to help minimise the risk that is posed to vulnerable people, either to children living with an adult with mental health problems or to a vulnerable adult. They must use the skills they have acquired, through their training and experience, to lead on safeguarding. In the role of an AMHP, social workers have for many years been able to manage risk very successfully, and as such have often been able to maintain a level of positive risk taking with individuals who may otherwise have been made subject to more restrictive options. The role of AMHPs continues to be a most important facet of the multi-disciplinary team, and these staff members must be given adequate space to concentrate on this particular responsibility. It is not something that should be considered an adjunct to the care co-ordination role, but as absolute core team business.
Promoting the profession
It is important that social work is positively promoted, both inside and outside the organisation. This is particularly necessary when working in a health environment in which there is a potentially dominant medical model, where developments in the world of social work that may impact directly on mental health social workers are not always fully appreciated or understood.

The Trust and local authorities should encourage their social workers to become affiliated to TCSW to help increase knowledge and connect social workers to the wider social work network and profession. Connecting social workers through other social media can also provide a positive forum for the exchange of information, ideas and knowledge.

It must be clearly communicated that Trust values its social workers, and it must be seen to support social work at all levels, from the board to the frontline. Furthermore, it is important that, as a profession, steps are taken to promote positive stories about mental health social work, addressing the stigma that negatively impacts on mental health service users. The promotion of the profession as a whole must be actively encouraged to combat negative media scrutiny.
10. Conclusion

It has become clear throughout the process of developing this strategy paper that there is consensus among the many managers and frontline professionals consulted that integration continues to be a powerful driver both in health and social care. What integration looks like might change, but it is widely recognised that multi-disciplinary working means fewer points of access across the system, less assessments, and greater efficiency – an overall approach that clearly benefits both staff and more importantly service users.

Social workers, nurses and other professionals have made the multi-disciplinary team the bedrock of mental health services, and there is much to applaud in this model.

However, as financial constraints bite, there is an increasing focus on the “What Works” approach to assessing and measuring outcomes from all disciplines. The introduction of payment by results (PbR) into the NHS means that all activity must be captured, and this has led to some concern by partners that social care, which is more difficult to clearly define may be lost.

It is essential that personalisation works with PbR, so that social care in mental health services provides a momentum for positive changes. Social workers have much to offer as champions and leaders in the areas of personalisation, safeguarding, and understanding the forces that shape and drive communities. Social workers are able to utilise those skills to achieve good outcomes for service users as citizens of communities who share a common interest with, and responsibility to, the place in which they live.

In assessing how integrated services need to change and be enhanced to meet current and future challenges, six priority areas have been identified, and these are addressed in detail in the Strategic Priorities Action Plan (see below) that forms the core of this document. The priority areas, in précis, are:

1. **Workforce development** – enhancing skills and confidence, and developing clear career development plans and working within the professional capabilities framework.

2. **Leading the profession and managing practice** – clarifying lines of accountability, improving practice, ensuring that high standards are maintained, and becoming leaders in social care audit and research.

3. **Delivering outcomes** – effective measurement of social work interventions, with the focus on engagement, empowerment and personalisation, and using technological advances to improve outcomes.

4. **Leading on personalisation** – building the skills and confidence needed to lead on implementing a whole systems approach to personalisation.

5. **Promoting and embedding safeguarding and managing risk** – continuous professional development and training to ensure that skilled, confident
practitioners assess and manage risk, manage complex safeguarding situations, and can lead investigations.

6. **Promoting the profession** – developing the skills and tools to challenge and reverse negative perceptions of social work in the media and in the general public.

This strategy will serve not only as a tool to consolidate and strengthen the position of social work within the Trust, but will ensure that the board and managers of the Trust are aware of the wider context for social workers. NHS organisations can be “closed worlds”, particularly in the area of mental health, and it is vital that social workers are supported to enhance their skills and can look outwards, benefiting from and being conversant with national developments taking place elsewhere.

Most importantly, this strategy aims to develop the workforce into leaders and champions of social care. For service users, this will mean that social workers will continue to be in the vanguard of the human rights agenda.
## 11. Strategic Priorities Action Plan Year 1

### Strategic Priority 1: Workforce development

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
<th>Owner</th>
<th>Deadline</th>
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</thead>
<tbody>
<tr>
<td>1. All Trust managers to abide by Local Government Association Standards for Employers and Supervision Framework. This will ensure a clear set of expectations of managers from frontline staff.</td>
<td>Trust managers are aware of standards and apply them, achieving uniformity across the Trust.</td>
<td>Head of Social Work and Social Care</td>
<td>September 2014</td>
</tr>
<tr>
<td>2. An efficiency review to be undertaken by the Trust, with due consideration given to reducing bureaucracy for social workers. Explore extending the current meridian work in teams to focus on social workers.</td>
<td>Staff enabled staff to re-focus energies on the priority areas.</td>
<td>Chief Operating Officer</td>
<td>March 2015</td>
</tr>
<tr>
<td>3. Monitor the supervision, appraisal and cpd arrangements for social workers, ensuring that all receive appropriate levels of support and training.</td>
<td>All staff have access to, and benefit from, professional supervision once a month. Improved practice and clear career development plans for social workers. Staff are clear about professional role.</td>
<td>Service Managers Head of Social Work and Social Care</td>
<td>September 2014</td>
</tr>
<tr>
<td>4. Principle social worker role to link closely with mental health social workers and Head of Social Work and Social Care</td>
<td>Improved practice and access to new developments &amp; responsibilities, for doing work in the designing of audit and research programme.</td>
<td>Adult Social Care Directors Head of Social Work and Social Care</td>
<td>September 2014</td>
</tr>
<tr>
<td>5. Workshops for managers on the professional capabilities framework. This will ensure consistent standards to be applied Trust wide.</td>
<td>Local authority managers have joined up approach to implementation of the professional capabilities framework.</td>
<td>Adult Social Care Directors</td>
<td>September 2014</td>
</tr>
<tr>
<td>6. Joint workshops between ASC &amp; MH service managers to consider workforce issues and developments across systems.</td>
<td>Local authority managers have joined up approach to the priorities of the local authority.</td>
<td>Head of Social Work and Social Care</td>
<td>on going</td>
</tr>
<tr>
<td>7. Identify current gaps in the workforce &amp; consider succession planning due to demographic profile of social work workforce.</td>
<td>Clarity on the levels of staff required to ensure healthy, thriving workforce.</td>
<td>Borough HR Depts</td>
<td>September 2014</td>
</tr>
<tr>
<td>8. Review current arrangements for approved mental health professional's numbers and any gaps; consider succession planning.</td>
<td>Assurance that there will be sufficient AMHPs to cover all Mental Health Act work</td>
<td>Head of Social Work and Social Care</td>
<td>May 2014</td>
</tr>
<tr>
<td>9. Establish regular forums for SW staff, with local authority presence.</td>
<td>Confident workforce with clear identity and clear</td>
<td>Head of Social Work and Social Care</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Review career pathways to ensure that experienced social workers are valued and kept at the frontline</td>
<td>Clear career development pathways for all SW staff, from newly-qualified up to managers. Use professional capability framework with all social workers.</td>
<td>Divisional Managers</td>
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<tr>
<td>11.</td>
<td>Training in audit and research methodology for SW staff. Review current leadership programs for social work staff</td>
<td>Confidence to lead in the area of audit and Research, and increase in number of social workers taking part in Trust clinical audit program.</td>
<td>Head of Social Work and Social Care &amp; Principal social worker</td>
</tr>
<tr>
<td>11.</td>
<td>Work closely with Nursing/OT to ensure clarity &amp; co-operation between professional groups on the aims of the strategy.</td>
<td>Collaborative approaches maintained.</td>
<td>L&amp;D Training Leads and Heads of professions</td>
</tr>
<tr>
<td>12.</td>
<td>Ensure all newly qualified social workers joining the trust are properly supported under the Assessed Supported First Year in Employment</td>
<td>Ensure we are following the professional capabilities framework</td>
<td>Service Managers</td>
</tr>
</tbody>
</table>
## Strategic Priority 2: Leading the profession/managing practice in each division

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
<th>Owner</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Social care leads to be appointed in each division.</td>
<td>Clear line of accountability for social care performance and leadership.</td>
<td>Chief Operating Officer</td>
<td>December 2014</td>
</tr>
<tr>
<td>2. Systems review on performance, and define key areas of responsibility for workers. Consider balance score cards and their relationship with social care indicators.</td>
<td>Clarity on the responsibilities of staff in reporting on key performance measures.</td>
<td>Service Managers</td>
<td>December 2014</td>
</tr>
<tr>
<td>3. Professional supervision to be embedded for every social worker.</td>
<td>Improved practice, and ensured maintenance of standards.</td>
<td>Divisional managers</td>
<td>September 2014</td>
</tr>
<tr>
<td>4. Identify system to ensure 100% of social workers have an up-to-date appraisal and a learning and development plan.</td>
<td>Social workers feel clear and confident in identifying learning needs, and in moving forward with clear goals and ambitions.</td>
<td>Human resource Departments/Head of Social Care</td>
<td>September 2014</td>
</tr>
<tr>
<td>5. Establish an audit program for social care, led by SW staff. Ensure this is clearly linked into Trust program</td>
<td>Social workers establish themselves as leaders in audit for social care.</td>
<td>Head of Social Work and Social Care &amp; Principle social worker</td>
<td>September 2014</td>
</tr>
<tr>
<td>6. Support staff to be the best they can, but also address and challenge poor performance. Regular HR reports from the boroughs to monthly performance meetings.</td>
<td>Standards and performance rise. Quality is maintained and improved.</td>
<td>Service Managers/LA HR Departments</td>
<td>October 2014</td>
</tr>
<tr>
<td>7. Review quality of care plans ensuring an agreed set of standards and ensure standards are maintained.</td>
<td>Excellent care plans that stand up to scrutiny and can be demonstrated in a personalised way.</td>
<td>Head of Social Work and Social Care</td>
<td>September 2014</td>
</tr>
<tr>
<td>8. Review the allocation of casework in teams, working with managers to consider ways of ensuring the right skills are matched to service user needs.</td>
<td>Social workers undertake case work relevant to their training and experience.</td>
<td>Service Managers</td>
<td>July 2014</td>
</tr>
<tr>
<td>9. Establish clear induction for new social workers joining the Trust.</td>
<td>New social workers are clear and focused on their roles and responsibilities, and of their place within a MH Trust.</td>
<td>Head of Social Work and Social Care &amp; L&amp;D Team</td>
<td>September 2014</td>
</tr>
<tr>
<td>10. Review the balance of social workers across the teams against delivery of social care outcomes</td>
<td>Ensure the optimal skill mix across all divisions</td>
<td>Chief Operating Officer</td>
<td>January 2015</td>
</tr>
<tr>
<td>Action</td>
<td>Outcome</td>
<td>Owner</td>
<td>Deadline</td>
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</tr>
<tr>
<td>1. Work closely with adult social care in incorporating the ASC social care outcomes framework into the Trusts performance framework so we can better identify the contribution and outcome achieved by Trust social workers.</td>
<td>Ability to measure the difference made by a social worker’s interventions in divisional performance.</td>
<td>Head of Social Work and Social Care</td>
<td>Jan 2015</td>
</tr>
<tr>
<td>2. Work with social work staff and principal social worker to develop an audit program focusing on outcomes.</td>
<td>Ability to measure what worked well in SW intervention, and what needs to change.</td>
<td>Head of Social Work and Social Care &amp;Principal Social Worker</td>
<td>December 2014</td>
</tr>
<tr>
<td>3. Appoint champions in each division for service user involvement and participation and peer support models.</td>
<td>Role of social workers focused on engagement, empowerment and personalisation.</td>
<td>Chief Operating Officer</td>
<td>December 2014</td>
</tr>
<tr>
<td>4. Measure outcomes from service user involvement forums in each division which relate to social care.</td>
<td>Ability to measure, from service user involvement, the effectiveness of outcomes delivered.</td>
<td>Head of Social Work and Social Care</td>
<td>May 2014</td>
</tr>
<tr>
<td>5. Encourage and market the use of technology to communicate through social media forums for workforce and for people using services to help improve outcomes.</td>
<td>Ability to communicate more effectively and widely increasing knowledge, using social media.</td>
<td>Heads of IT FT&amp; Boroughs</td>
<td>September 2014</td>
</tr>
<tr>
<td>6. Consider linking panel, reviews to development of an outcomes framework and reported outcome measures. Develop a mental health tool to support this for all staff.</td>
<td>Ensure outcomes are prioritized and staff understand how to measure outcomes. Outcomes are also reported to justify decisions on social care spend.</td>
<td>Head of Social Work and Social Care &amp;Commissioners</td>
<td>January 2015</td>
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</tbody>
</table>
**Strategic Priority 4: Leading on personalisation**

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
<th>Owner</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Champions for personalisation/choice and control to be appointed in each division. Sign up to Making It Real TLAP Campaign</td>
<td>Necessary personalisation leadership provided to begin fully implementing personalised services across the FT.</td>
<td>Divisional Managers</td>
<td>July 2014</td>
</tr>
<tr>
<td>2. Each division to develop a steering group to drive personalisation forward this should feed into Local authority governance structure.</td>
<td>The champion role is supported by steering group with responsibility for personalisation.</td>
<td>Divisional Managers</td>
<td>July 2014</td>
</tr>
<tr>
<td>3. Each steering group to be represented at borough lead groups on personalisation.</td>
<td>Whole systems approach to personalisation.</td>
<td>Divisional Managers</td>
<td>February 2014</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>Divisional Managers</td>
<td>February 2014</td>
</tr>
<tr>
<td>5. Issue guidance to all SW staff on how and when a personal budget should be used, and what is or isn’t appropriate.</td>
<td>Ensure all SW staff are clear about standards, expectations around personalisation.</td>
<td>Head of Social Work and Social Care</td>
<td>September 2014</td>
</tr>
<tr>
<td>6. Review quality for support planning for service users; identify through the steering groups</td>
<td>Social workers take the lead on raising the quality of support plans, with the steering group advising/monitoring.</td>
<td>Head of Social Work and Social Care</td>
<td>December 2014</td>
</tr>
<tr>
<td>7. Ensure staff attend and present all cases to panel so that practice and purpose can be discussed and learning can be facilitated.</td>
<td>Building of skills and confidence to lead on personalisation, and developing excellent quality of practice.</td>
<td>Service Managers</td>
<td>July 2014</td>
</tr>
<tr>
<td>8. Equality and ADP champion with each division to work closely with Trust equality leads.</td>
<td>Working group created to steer the equality and ADP agenda.</td>
<td>Engagement and Equality Lead.</td>
<td>July 2014</td>
</tr>
<tr>
<td>9. Issue guidance on community resources that aid understanding of the market place to promote choice and control/better care choices.</td>
<td>Understanding of personalisation in relation to the communities in which people live.</td>
<td>Borough leads</td>
<td>September 2014</td>
</tr>
<tr>
<td>10. Sign up to Think Local Act Personal Making It Real campaign</td>
<td>Personalisation is refocused on relationships and partnership/co-producing.</td>
<td>Head of Social Work and Social Care &amp; Borough personalization leads.</td>
<td>September 2014</td>
</tr>
</tbody>
</table>
## Strategic Priority 5: Promoting/embedding safeguarding and managing risk

<table>
<thead>
<tr>
<th>Action</th>
<th>Outcome</th>
<th>Owner</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review the training provided on risk management and identify</td>
<td>Confident, skilled practitioners in risk management, assessing and managing risk.</td>
<td>L&amp;D Team</td>
<td>September 2014</td>
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<tr>
<td>appropriate risk management training for all social work staff.</td>
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<td></td>
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<tr>
<td>2. Level 3 training for all SW staff in safeguarding.</td>
<td>SW staff highly trained, skilled and confident in managing complex safeguarding situations, and leading investigations.</td>
<td>Safeguarding Manager &amp; Head of Social Work and Social Care</td>
<td>March 2015</td>
</tr>
<tr>
<td>3. Joint managers meeting with children’s social care and mental health to continue.</td>
<td>Whole systems approach to safeguarding and sharing skills and knowledge across services.</td>
<td>Safeguarding Manager &amp; Head of Social Work and Social Care</td>
<td>Ongoing for both LBI and LBC</td>
</tr>
<tr>
<td>4. Disseminate and promote the Think Family Protocol to all staff.</td>
<td>All social workers are aware of, and use, the Think Family Protocol.</td>
<td>Safeguarding Manager &amp; Head of Social Work and Social Care</td>
<td>March 2014</td>
</tr>
<tr>
<td>5. Encourage observations, on a rotation basis, of the Kidstime Model in action.</td>
<td>Social workers’ awareness of the Kidstime Model, and the benefits to be gained, is developed. Increased knowledge of the impact of mental illness on children.</td>
<td>Safeguarding Manager &amp; Head of Social Work and Social Care</td>
<td>March 2015</td>
</tr>
<tr>
<td>6. Identify social workers in each division with particular responsibilities for disseminating learning from serious untoward incidents and serious case reviews and complaints</td>
<td>Social work leads ensure that lessons from SUIs and SCRs are disseminated, discussed and learning embedded at frontline.</td>
<td>Divisional Managers</td>
<td>September 2014</td>
</tr>
<tr>
<td>7. Review the performance management of safeguarding, following its inclusion on all performance meetings by divisions and achieve all safeguarding performance expectations as per the balanced scorecards.</td>
<td>Clear awareness of safeguarding performance, looking specifically at quality and professional input to raise standards.</td>
<td>Head of Performance &amp; Safeguarding Manager</td>
<td>November 2014</td>
</tr>
</tbody>
</table>
## Strategic Priority 6: Promoting the profession

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<tr>
<th>Action</th>
<th>Outcome</th>
<th>Owner</th>
<th>Deadline</th>
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</thead>
<tbody>
<tr>
<td>1. Increase the number of social workers affiliated to TCSW.</td>
<td>A workforce united under a social work college.</td>
<td>Head of Social Work and Social Care</td>
<td>September 2014</td>
</tr>
<tr>
<td>2. Increase the number of social workers undertaking media training.</td>
<td>Confident skilled practitioners who understand how to engage in intelligent and sensitive dialogue with the media.</td>
<td>Learning and Development Team</td>
<td>March 2015</td>
</tr>
<tr>
<td>3. Develop robust links with TCSW to promote mental health social work.</td>
<td>Social worker affiliated to a body with the political clout to affect change in a wider context.</td>
<td>Head of Social Work and Social Care &amp; Principal Social Workers</td>
<td>September 2014</td>
</tr>
<tr>
<td>4. Increase number of social workers who are spokespersons and who can promote stories that are of media interest.</td>
<td>Trained pool of social work staff who can communicate confidently with the media.</td>
<td>Head of Social Work and Social Care</td>
<td>January 2015</td>
</tr>
<tr>
<td>5. Promote good practice areas and encourage a more open view on media interest, including news stories, television and radio opportunities.</td>
<td>Positive image presented of the profession, public educated on the role of social work, with all its challenges, rewards and complexities.</td>
<td>Head of Social Work and Social Care &amp; Principal Social Workers</td>
<td>September 2014</td>
</tr>
<tr>
<td>6. Increase the use of social media to encourage better communication and raise the profile of SW issues and stories.</td>
<td>Information exchanged is enhanced and new skill used in communication.</td>
<td>Head of Social Work and Social Care &amp; Principal Social Workers</td>
<td>March 2015</td>
</tr>
<tr>
<td>7. Develop research and clinical audit programme that highlights social care, and publish findings.</td>
<td>Published research and audit findings increase understanding of social work and social care and the impact on families.</td>
<td>Head of Social Work and Social Care &amp; Principal Social Worker and Director of Nursing and People</td>
<td>March 2015</td>
</tr>
</tbody>
</table>
Appendices

Appendix 1

I would like to thank the following individuals for their input and involvement into the strategy:

Victoria Hart, Social Worker in Services for Ageing and Mental Health
Maggie Fuller, Service Manager Islington R&R Service
Claire Barcham The College of Social Work
Carolyn Deacon, South Islington R&R Service
Mike Odonoghue, Camden Emergency Duty Service, London Borough of Camden
Jackie Goosens, London Borough of Camden Learning and Development
Moira Matthews, Camden Assertive Outreach Team
Carolyn Godleman, London Borough of Camden
Chris Lee Service Manager Camden Rehabilitation and Recovery Service

Presentations of the social work strategy have also been given at the following:

- Senior Management Team Meeting London Borough of Islington.
- Social Work Forums Islington and Camden.
- Social Care Reference Group
- Operational Managers Meeting
- Workforce Development Meeting London Borough of Camden.

Natasha Sloman
Head of Social Work and Social Care
Appendices
Appendix 2

Statutory Duties

National Assistance Act 1948 (c29) Sections 21-27: Provision of residential accommodation for the aged, infirm, needy, etc. Sections 29 & 30: Welfare of people who are blind, deaf, dumb or otherwise handicapped or are suffering from mental disorder; use of voluntary organisations for administration of welfare schemes, Section 48: Temporary protection of property belonging to persons in hospital or accommodation provided under Part III of the Act.

Mental Health Act 1959 (c72) [section 8]: Welfare and accommodation of mentally disordered offenders.

Chronically sick and Disabled Persons Act 1970 (c44) Section 2 – Provision of certain welfare services.


Mental Capacity Act 2005 (as amended by the MHA 2007) Part 1 – Section 4 – Best Interests Assessments. Mental Capacity Act (as amended by the MHA 2007) Part 1 – Section 4 – Best Interests Assessments. Part 1 – Section 5 – Assessment of Capacity by using the Test outlined in Section 2 and described more fully in the Code of Practice. Part 1 – Section 39 – instruct and consult independent mental capacity advocates in the provision of accommodation for individuals who lacks capacity to agree to the arrangements in accordance with the requirements of this section of the Act.

National Health Service and Community Care Act 1990 (c19) Section 47 – Assessment of needs for community care services.

Carers (Recognition and Services) Act 1995 (c12) Section 1 – Assessment of ability of carers to provide care.

Community Care (Direct Payments) Act 1996 – Functions in connection with the making of payments to persons in respect of their securing the provision of community care services [or services under the Carers and Disabled Children Act 2000]

Children's Act 1989 and 2004

Non-statutory duties

Safeguarding adults at risk and children

Employment and income maximisation

Accommodation.
Executive Summary
The Chief Executive has a duty to keep the Board informed on all matters relating to the health of the organisation and provide a status and progress report on the use of the Trust seal, key strategic developments and significant events since the last Board meeting. This report includes updates supplied by members of the Foundation Trust Executive and the Trust Secretary.

Board members attention is drawn to the continued call to action for bold strategic change in the NHS, and the Monitor, NHS England and TDA report is a further enticement for Trusts and commissioners to take forward new models of care. This report is timed to coincide with the 5 year planning work all NHS organisations are involved with and the encouragement for these to be ‘big and bold’. The focus on the NHS’s capacity to change and adapt is also taken up as a key theme in Monitor’s Strategy which proposes their assessment of Trusts focuses more on the leadership ability to adapt and lead changes.

Recommendations to the Board
The Board of Directors is requested to:

- note the contents of this report; and
- approve the use of the Trust Seal.
Trust Strategic Priorities Supported by this Paper

**Excellence**

**E1** Continually improve the quality and safety of service delivery, service user experience and improving outcomes.

**E2** Delivering the highest level of quality and financial performance.

**Innovation**

**I1** Rapidly adopt best practice and maintain a culture of innovation in service development.

**Growth**

**G1** Pursue organic and inorganic growth opportunities through strategic partnerships and research and development.

**Risk Implications**

The paper covers developments in areas already identified within the risk register.

**Legal and Compliance Implications**

The report includes a summary of national developments which will affect the Trust’s compliance requirements.

**Finance Implications**

The financial assumptions within the planning guidance will form a key part of the Trust’s planning processes.

**Single Equalities Impact Assessment**

As this report summarised the external environment and internal issues it does not of itself require a SEIA, although elements within the report may and would be conducted as part of their separate governance processes.

**Requirement of External Assessor/Regulator**

Monitor is responsible for ensuring that foundation trusts are well governed. Best practice guidance concerning board governance includes an expectation that the Board is kept fully appraised about the external environment, the strategic implications for the Trust and internal matters. This report contributes to this requirement.
CHIEF EXECUTIVE’S REPORT

1. NATIONAL STRATEGIC ENVIRONMENT

1.1 National policy update

Monitor publish: A Call to Action: transformative ideas for the future of the NHS

Monitor have published a report with NHS England and the TDA, illustrative the type of bold and transformative ideas health leaders need to grapple with the increased pressures on the NHS in a resourced constrained environment. The report has 6 visions of future scenarios, these are:

- Segmentation of patients with a community based doctor who enables ‘wrap around’ services no matter what the setting.
- Innovation diffused through the NHS through new entrants into the market
- Technology and disruption – looked at 10 technologies which could transform care at home.
- New models of out of hospital care – particularly the introduction of capitation budgets for high risk cohorts of patients.
- Excellence through specialisation – extending the model of focused planned provision, as exemplified by planned surgery centres.
- Consultant/ senior led seven day-week provision.

The publication is designed to influence the content of Trusts and commissioners 5 year plans.

Monitor Strategy 2014-16

Monitor has published a new strategy, within the strategy Monitor have announced that they will shift their focus in the assessment of FTs and their monitoring to be less driven by "the numbers" in trusts' financial plans and more on their capability to deal with change. This shift is due to huge uncertainties facing NHS providers. The new strategy, says they will focus more on organisations capabilities, including strengths in areas that “drive long term performance”, including individual leadership, strategic planning and operational performance improvement. Monitor will also have to be more flexible in allowing FTs and aspirant FTs to move to new business models.

In an interview about their strategy with the HSJ, David Bennett, Monitor Chief Executive said that he believed that a leadership more focused on the above qualities should play a significant role in accelerating the changes required in the NHS. Mr Bennett also said he can see “advantages” to Alan Milburn’s suggestion at the FTN’s annual lecture earlier this month, that the NHS Trust Development Authority should be scrapped and Monitor given responsibility for regulating all NHS providers.

LONDON DEVELOPMENTS

1.2 North Central London

The Barnet and Chase/ Royal Free merger is moving progressively ahead, with a recent Monitor Board to Board on the business case and a Council of Governors meeting to decide on the merger due shortly. Should these hurdles be passed then I believe the acquisition will happen quickly, with the newly merged Trust ‘live’ from sometime in the summer.
**Whittington Health**

Following the recent departure of the Chief Executive of Whittington Health at the beginning of April, Simon Pleydall has begun as an interim CEO whilst they recruit a permanent replacement. The Medical Director and Director of Nursing have also recently left or announced they were leaving. The interim CEO is concentrating on rebuilding a stable Executive team.

1.3 **Local Authorities**

On 28 March the Trust had a regular partnership meeting with Islington Council. These meetings are held approximately 3 times per year between the Executive member for adult social care, senior staff from the council and myself, the chair and the Director of Integrated Care. The meetings cover areas of joint interest and future changes required of each organisation, such as the funding cuts required from local government.

2. **SERVICE DEVELOPMENTS & OPERATIONS**

2.1 **Acute bed pressures**

Pressures on our acute beds are continuing, last month we reported that pressure had been on PICU beds, but this has now transferred back to adult acute care wards, with 12 people in the independent sector on the day of writing this report. The number is variable; however we are now entering the season when traditionally we experience increased demand. Some of the pressure is accounted for by higher than usual use of beds by overseas visitors.

3. **REGULATION & LEGISLATION**

3.1 **Care Quality Commission**

As the Board is aware, the Trust has been selected by the Care Quality Commission (CQC) as part of the second wave of Mental Health Trusts to undergo an inspection under the commission’s new model, and the CQC has confirmed that the Trust’s inspection will commence on Tuesday May 27, lasting approximately a week.

Preparation for the inspection is well underway with Trust staff working closely with CQC leads to ensure that all the pre inspection information is provided as requested. As the Board is aware, the CQC will commence the inspection on 27 May and this will involve a meeting with the Board at a time to be confirmed on the afternoon of the 27 May 2014.

At the beginning of April the Care Quality Commission issued a consultation on their new inspection regime. They are consulting on the details of the inspection regime for specialist mental health services; this is contained in a provider handbook. The consultation is due to finish in the last week of June.

4. **EXTERNAL PROFILE**

4.1 **A nurse from Stacey Street has won the Islington Dignity in Care Award 2014**

Congratulations to Vilma Toledo, a staff nurse from Stacey Street, who has won the overall award for the Dignity in Care Award.

An extract of what the nominee says of Vilma:

“She visits our residents who had been admitted in hospital to familiarise hospital staff about the best ways of supporting such residents in ways that show recognition and preservation of their dignity.”

Vilma will now be put forward for the Regional Award.
4.2 Service Manager honoured with the Freedom of the City of London

Peter Kane, C&I’s senior service manager for substance misuse services, received London’s oldest award the Freedom of the City of London at a private ceremony at the Guildhall in the city on 14 March. Peter received this award in recognition of his work with drug and alcohol users over the last 30 years. The C&I Communications Team contacted Peter’s home town newspaper, The Argus in Dundalk, Ireland and they subsequently ran the story.

Peter’s first job as a counsellor began at City Roads Crisis Intervention. This was an emergency 24 service which admitted people whose lives had become out of control they were unable to cope any longer. This refuge provided food, shelter, counselling, detoxification and advice about future options. Many went on to rehabilitation and are now still drug free. After 12 years he moved to Positively Irish Action on Aids. This organisation which helped Irish people in London who were diagnosed with HIV or AIDS sorting out benefits, housing problems and linking them in with doctors and hospitals.

In 1996 he became deputy manager of C&I’s Response, North Camden Drug’s Service. Staffed with doctors, nurses, counsellors, psychiatrists and psychologists it provides a full range of programmes for drug users who want to move away from street drugs and begin to address their recovery. Currently Peter is a senior manager at C&I managing five drugs and alcohol services across the London boroughs of Camden and Islington which treat approximately 1800 people at any one time.

4.3 Tile House Team has been shortlisted for Support/Care Team of the Year

The Tile House team has been shortlisted for support/care team of the year in this year’s Housing Heroes awards.

Tile House takes a ground-breaking new approach for housing and care for people with complex mental health issues, delivered through a UK-first partnership between C&I and One Housing Group. Working together, we are providing multi-disciplinary support teams in good quality homes in the heart of King’s Cross. Our staff team is central to the project’s success and it is wonderful to see their contribution recognised.

4.4 C&I involved in research published in the Lancet

C&I was one of 12 NHS drug treatment services across the UK to take part in a study showing that small financial incentives, totalling as little as £30, can dramatically increase the likelihood of people who inject drugs completing a course of hepatitis B virus (HBV) vaccination. This research was published in The Lancet and was picked up by a number of national and local news outlets across the country, such as the Daily Telegraph.

The researchers found that people undergoing treatment for heroin addiction who received a maximum total of £30 supermarket vouchers in equal or graduated instalments in return for full compliance with a regimen of three HBV vaccine injections were at least 12 times as likely to complete the course within 28 days compared to those not receiving a financial incentive (45% for equal payment instalments and 49% for graduated payment instalments vs 9% for no payment incentive).

The study was led by Professor John Strang from the National Addiction Centre at King’s College London, UK, working in collaboration with senior colleagues at Imperial College London and University College London (UCL).
4.5 Clinical secondment to lead mental health commissioning programmes in education and training

The HE NECL has appointed a clinical secondment to lead its Mental Health commissioning programmes in education and training across the sector for non-medical staff. We are delighted that two staff from the Trust have been appointed: Ian Clift, Deputy Director of Nursing; and Neil Ralph, a senior clinical psychologist and researcher at UCL. We are delighted to have Ian and Neil in this new role working alongside the NECL in this new venture, which will enable the clinical voice to support programmes of professional education for trainees/students as well as post qualifying courses, with a strong focus on learning to support care pathways and transformation of services.

5. INTERNAL EVENTS

5.1 C&I gains re-accreditation for first line manager programme

Since September 2012 C&I has been accredited by the Chartered Management Institute to deliver the Level 3 First Line Manager certificate, which is a qualification in management and leadership. In that time 46 staff have successfully achieved the award. Around 20 colleagues are still studying. Early in 2014 we were re-assessed for our accreditation and were successful. C&I is therefore able to continue to deliver this professional management qualification. The First Line Manager programme has been a significant investment in ward and team managers and the completion of C&I-based projects as part of the programme have brought service improvements in our services.

5.2 The cleaning, refurbishment and restoration of the Margarete Centre

The Capital Project's external cleaning, refurbishment and restoration of The Margarete Centre, 108 Hampstead Road, which was managed by Estates and Facilities, has been recently completed. The comprehensive work included cleaning of brickwork and stonework and roof repairs.
5.3 Launch of “Quality Every Day” Clinical leadership event 28th March

The Trust launched “Quality every day”, a Trust-wide programme to support First Line Manager Programme Alumni and other service leaders. We were delighted that Dr Tim Swanwick, Dean of Postgraduate Medical Education, was able to launch the programme with a lecture on clinical leadership which aimed to make sense of health care in light of the Francis, Berwick and Keogh reports. Dr Swanwick is responsible for around 4500 doctors in postgraduate training, at Health Education North Central & East London, our local Education and Training Board.

6. COUNCIL OF GOVERNORS

6.1 Governor Developments

As the Board is aware, we had a joint meeting with the Council of Governors on 27 March to discuss our forward planning objectives, as well as the forthcoming CQC inspection. This was yet again a very productive meeting with excellent engagement and contributions from the Council.

The next general meeting of the Council follows on the 13 May 2014.

7. STAFF CHANGES

I am pleased to welcome Dr Josephine Morgan who is a newly appointed Consultant in Islington Primary Care Liaison.

8. SERVICE VISITS

Since my last report at the end of March 2014, I have visited the following services:

- South Islington R&R Team; and
- Islington Accommodation Team.

9. FTE and SENIOR LEADERSHIP MEETINGS (26 March to 16 April 2014)

The following table gives a brief summary of the areas covered in the weekly Foundation Trust Executive meeting.

<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six month communications plan</td>
<td>Considered and approved an approach to communications over the next 6 months</td>
</tr>
<tr>
<td>2yr Operational Plan</td>
<td>Overseen the final edits post Board leading to submission of the plan on 3 April</td>
</tr>
<tr>
<td>Proposals regarding models of care for Services for Aging Mental Health Division</td>
<td>Approved the progression of work relating to new models of home treatment for older people.</td>
</tr>
<tr>
<td>Occupational Therapy Strategy and the Social Work Strategy</td>
<td>Considered drafts of these documents</td>
</tr>
<tr>
<td>Anti-Ligature programme</td>
<td>Received an update on the progress of this programme</td>
</tr>
<tr>
<td>Procurement of electronic rostering system</td>
<td>The current Rosterpro contract runs out in summer 2014, the executive agreed a procurement process and desired characteristics for the contracted system.</td>
</tr>
<tr>
<td>Board paper preparation</td>
<td>Reviewed progress of Board papers</td>
</tr>
<tr>
<td>Financial reports</td>
<td>Received monthly financial reports</td>
</tr>
</tbody>
</table>
10. **USE OF TRUST SEAL**

The Trust has been used on four occasions since my last report to the Board:

<table>
<thead>
<tr>
<th>#</th>
<th>Date</th>
<th>Description</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>31 March 2014</td>
<td>C&amp;I FT and At Medics Limited UNDERLEASE of ground floor, GP surgery, 211 Kings Cross road, London WC1X 9DN</td>
<td>Contract</td>
</tr>
<tr>
<td>71</td>
<td>31 March 2014</td>
<td>C&amp;I FT and Solutions 4 Health Limited lease of premises forming part of West Wing, St Pancras Hospital, 4 St Pancras Way, NW1 0PE</td>
<td>Contract</td>
</tr>
<tr>
<td>72</td>
<td>31 March 2014</td>
<td>C&amp;I FT and Family Mosaic Housing Services Limited DEED OF SURRENDEER relating to 148 Hornsey Lane N6</td>
<td></td>
</tr>
<tr>
<td>73</td>
<td>31 March 2014</td>
<td>C&amp;I FT and Family Mosaic Housing Services Limited LEASE OF WHOLE relating to 148 Hornsey Lane N6</td>
<td></td>
</tr>
</tbody>
</table>
Executive Summary
This paper presents the arrangements for safe nurse staffing, as required by NHS England, and provides the structure and process for implementing these requirements. This guidance pertains to in-patient areas initially, although community service safer staffing guidance is expected shortly. The requirements set out the Board and organisational responsibilities to ensure that safer nurse staffing is continually and dynamically reviewed and actions taken to ensure that these remain safe at all times.

Recommendation to the Board
The Board of Directors is requested to:
- note the requirements and actions in this paper;
- and sign the document off for publication and dissemination.

Trust Strategic Priorities Supported by this Paper

**Excellence**

**E1** Continually improve the quality and safety of service delivery, service user experience and improving outcomes.

**E2** Delivering the highest level of quality and financial performance.

**Innovation**

**I1** Rapidly adopt best practice and maintain a culture of innovation in service development.
Risk Implications
If not effectively implemented risks are possible in relation to the quality of direct patient care by nursing.
Failure by the Trust to implement systems for safer nursing staff levels could also give to significant reputational risk and harm.

Legal and Compliance Implications
None.

Finance Implications
Following the completion of the establishment review there may be financial implications. The details concerning this review will be highlighted within the safe staffing report for the Board for the June 2014 Board meeting.

Single Equalities Impact Assessment
N/A

Requirement of External Assessor/Regulator
None.

Patient Involvement
The Service User Experience and Staff Experience Committee has been briefly made aware of the work underway with regard to safe staffing. The Board is required to undertake a monthly publication of its safe staffing levels and therefore service users will have access to this information. Another requirement of safe staffing is to publish daily figures of the ward teams on the wards themselves. This information will be freely available within a public area of the ward for patients to consume and discuss with staff.

Consultation
A meeting with senior staff has taken place to discuss the implications and plan to implement these requirements
1. Introduction

This paper summarises the guidance issued by NHS England (Hard Truths 2014) and Jane Cummings, Chief Nurse for England (A guide to nursing, midwifery and care staffing capacity and capability 2013) on reporting and publishing staffing data for nurses and care staff, and the Trust’s response.

In summary the guidance sets out that the Board:

- receives a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool, includes the key points set out in the Cummings guidance and reflects a realistic expectation of the impact of staffing on a range of factors;
- receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis;
- is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap;
- evaluates risks associated with staffing issues;
- seeks assurances regarding contingency planning, mitigating actions and incident reporting;
- ensures that the Executive Team is supported to take decisive action to protect patient safety and experience; and
- publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly ‘safe staffing’ area on a Trust website).

2. Background

Jane Cummings through the National Quality Board (NQB) issued guidance in November 2013 to optimise nursing, midwifery and care staffing capacity and capability, and in 2014 the Government made a commitment to making information more publically available in ‘Hard Truths: The Journey to Putting Patients First’.

Following on from this CEOs of Trusts and Foundation Trusts with inpatient areas have now been issued with an implementation letter outlining how they will be expected to deliver on the Hard Truths commitments, by publishing staffing data regarding nursing, midwifery and care staff.
### Implementation Plan

The letter the Trust received on 31st March 2014 included the following timeline of actions:

<table>
<thead>
<tr>
<th>Action Required by Trusts</th>
<th>By When</th>
<th>Responsibility</th>
<th>Periodicity</th>
<th>National Quality Board Expectation</th>
<th>Further Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>June 2014</td>
<td>Director of Nursing</td>
<td>Every six months</td>
<td>1,3 and 7</td>
<td>NQB pages 12, 18-22 and 42</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>From April and by June at the latest</td>
<td>Deputy Director of Nursing</td>
<td>Each shift</td>
<td>8</td>
<td>NQB pages 48 – 51</td>
</tr>
</tbody>
</table>

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This report:
- draws on expert professional opinion and insight into local clinical need and context;
- makes recommendations to the Board which are considered and discussed;
- is presented to and discussed at the public Board meeting;
- prompts agreement of actions which are recorded and followed up on; and
- is posted on the Trust’s public website along with all the other public Board papers.

To summarise, the displays should:
- be in an area within the clinical area that is accessible to patients, their families and carers;
- explain the planned and
|   | actual numbers of staff for each shift (registered and non-registered);  
|   | • detail who is in charge of the shift;  
|   | • describe what each member of the team’s role is; and  
|   | • be accurate.  
| C | The Board:  
|   | • receives an update containing details and summary of planned and actual staffing on a shift-by-shift basis;  
|   | • is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap;  
|   | • evaluates risks associated with staffing issues;  
|   | • seeks assurances regarding contingency planning, mitigating actions and incident reporting;  
|   | • ensures that the Executive Team is supported to take decisive action to protect patient safety and experience; and  
|   | • publishes the report in a form accessible to patients and the public on their Trust website (which could be supplemented by a dedicated patient friendly ‘safe staffing’ area on a Trust website).  
|   | From April and by June 2014 at the latest  
|   | Director of Nursing  
|   | Monthly  
|   | 1 and 7  
|   | NQB pages 12, 13 and 45  
| D | The Trust will ensure that the published monthly update report specified in Row C [i.e. the Board paper on expected and actual staffing] is available to the public via not only the Trust’s website but also the relevant hospital(s) profiles on NHS Choices.  
|   | The latter can be achieved either by placing a link to the report that is hosted on the Trust website on the relevant hospital(s)’ newsfeed on their NHS Choices webpage or by uploading the relevant document to the relevant hospital(s)’ NHS Choices newsfeed. For Trusts with multiple hospital sites that have their own NHS Choices  
|   | By June 2014  
|   | Head of Communications  
|   | Monthly  
|   | 1 and 7
webpages, this will require the separate posting of the Trust Board report to each hospital newsfeed. However, this is likely to reach more patients given that patients tend to review hospital, not Trust, NHS Choices webpages. This approach will also allow you to highlight hospital-specific plans and achievements, which may be of particular interest to a public audience.

Given these requirements, the update reports should be written in a form that is accessible and understandable to patients and the public. This is likely to include ensuring that the information on staffing is not embedded within hundreds of pages of other Board papers.

<table>
<thead>
<tr>
<th>E</th>
<th>The Trust:</th>
<th>Immediate</th>
<th>Deputy Director of Nursing working with Chief Operating Officer and Divisional Managers</th>
<th>Each shift</th>
<th>2</th>
<th>NQB pages 16 and 17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• reviews the actual versus planned staffing on a shift by shift basis;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• responds to address gaps or shortages where these are identified; and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• uses systems and processes such as e-rostering and escalation and contingency plans to make the most of resources and optimise care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. **Roles and responsibilities** In order to aid clarity and responsibility for the actions necessary throughout the organisation, the following responsibilities are assigned.

| Ward Managers / Team Managers | • Complete the log on a daily/weekly basis. | | | | |
| | • Display on the ward whiteboard the staffing levels for the day: shift planned vs actual in the format of the provided template (Appendix A). | | | | |
| | • Escalate any staffing issues on a shift to the matron/service manager. | | | | |

| Matron / Service Manager | • Responsible for ensuring data is collected and displayed on the wards. | | | | |
| | • Discuss any staffing issues with the ward manager and escalate to the Divisional Manager, Deputy Director of Nursing, Chief Operating Officer or Director of Nursing as appropriate. | | | | |

| Deputy Director of Nursing | • Compile the monthly and 6 monthly report on behalf of the Director of Nursing. | | | | |
| | • Facilitate and lead monthly monitoring quality review of data concerning safe staffing with Divisional Management Meeting on a monthly basis. | | | | |
| | • The above data will complement the perspective gained from the Divisional Management Team’s monthly review of staffing incidents currently recorded on Datix. | | | | |
5. **Current Status**

The Human Resources Department, working with the Deputy Director of Nursing, are currently analysing March 2014 data from RosterPro and NHS Professionals to assess staffing levels on each shift and each day for the period which will be cross referenced against the requirements for any variances.

The Western Australia tool Nurse Staffing tool will also be used to assess staffing levels and acuity on the wards. Currently there is paucity of mental health nursing workforce tools and therefore a very limited choice to select from. The guidance (Cummings 2013) is clear that an evidenced based nurse staffing tool must be chosen and used. This tool is recommended in this guidance. It is envisaged that when the national mental health tool is eventually developed the Trust will then move to this option when the work on this is completed.

To ensure we are able to accurately capture the data and report to the Board, Ward Managers are required to fill in the following table and return it to HR on a daily/weekly basis.

This is a temporary measure whilst the Trust determines the new e-rostering provider. It is expected that the new rostering system will have the capability to report on NHSP and rostering data so that establishment information can be reported from the system. It is hoped that technology will enable each ward to publish daily data and for this to go directly into an e-rostering solution chosen by the Trust.

This process has been discussed and agreed with the Nursing Executive, Divisional Managers and Ward Managers.

6. **Conclusions & Recommendations**

It is anticipated that the aforementioned process will enable the Trust to successfully implement safer staffing process as described by NHS England.

1) The Trust Board are asked to note and agree the structure and process for reporting and reviewing safe nurse staffing levels as outlined in this paper.

2) The Board should note the importance of the effective governance of these arrangements and the continued focus it must have in ongoing Board process.
Safe Staffing – reporting nursing numbers on the white board

The following is suggested as a template for a white board displayed on the ward:

XXX Ward Staffing Board

<table>
<thead>
<tr>
<th></th>
<th>This morning the ward should have:</th>
<th>This afternoon the ward should have:</th>
<th>Tonight the ward should have:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse in charge:</td>
<td>□ Registered Nurses</td>
<td>□ Registered Nurses</td>
<td>□ Registered Nurses</td>
</tr>
<tr>
<td>Number of patients on the ward:</td>
<td>□ Health Care Assistants</td>
<td>□ Health Care Assistants</td>
<td>□ Health Care Assistants</td>
</tr>
</tbody>
</table>

This morning the ward has:  
- □ Registered Nurses  
- □ Health Care Assistants

This afternoon the ward has:  
- □ Registered Nurses  
- □ Health Care Assistants

Tonight the ward has:  
- □ Registered Nurses  
- □ Health Care Assistants

The planned staffing numbers should be filled in at the start of each day. The actual number of staff present for each shift should be filled in at the start of each shift.

If you do not have a white board which you are able to use for this you will need to order one. If you have any queries please contact zoe.peel@candi.nhs.uk
Executive Summary
Choice and mental health was extended on the 1 April 2014 to patients to choose, with the support of their GP, any clinically appropriate provider. It supplements the existing ability for patients with mental health conditions who have been referred for a first outpatient appointment to choose which team, led by a named healthcare professional, delivers their care and treatment.

The extension of choice in mental health also gives the trust an opportunity to review the wider issues raised for example the marketing information to both GP’s and service users.

Recommendation to the Board
The Board of Directors is requested to:

- Note the information in this paper and provide comments.

Trust Strategic Priorities Supported by this Paper

Growth
G1 Pursue organic and inorganic growth opportunities through strategic partnerships and research and development.
**Risk Implications**
There is a risk that C&I will fail to seize opportunities to promote services through being slow to implement patient choice initiatives. There are also risks that income to the Trust from commissioners may fall as a result of patient choice, although patient flows in relation to this change are expected to be low in the short term.

**Legal and Compliance Implications**
The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013 amended the 2012 Regulations, removing - with effect from 1 April 2014 - mental health service exemptions from certain of the obligations that previously existed in relation to choice.

**Finance Implications**
The implication of patient choice will have an impact on the future income of the trust which will be assessed during the five year planning cycle including work being undertaken in relation to competitor analysis.

**Single Equalities Impact Assessment**
N/A

**Requirement of External Assessor/Regulator**
The introduction of choice is part of the policy framework for choice issued by the Department of Health, and will be backed through guidance issued by NHS England.
1 Introduction

From 1 April 2014 there is a new legal right for patients to choose any clinically appropriate provider of mental health services upon referral for a patient’s first outpatient appointment. This brings mental health services into parity with physical health services. It supplements the existing ability for patients with mental health conditions who have been referred for a first outpatient appointment\(^1\) to choose which team, led by a named healthcare professional, delivers their care and treatment.

The introduction of increased choice in mental health services also brings an opportunity for the Trust to consider how choice might impact in a wider sense on the delivery and promotion of its services. An example would be how the Trust promotes itself as a preferred provider both with local GP’s, as well as service users.

The Trust has seen draft guidance from NHS England regarding choice in mental health, but the final version of this has yet to be issued. At a local level, the NCL Commissioning Support Unit will be organising a sector level meeting to discuss the issues raised by extending mental health choice, including the issues raised around the ‘choose and book’ system.

2 Revised Regulations regarding choice of Provider

From 1 April 2014, patients have the right to choose their provider of mental health services in relation to an elective referral to any clinically appropriate mental health service provider that has a contract with any CCG or with NHS England for the service required. The patients’ right to choose will be exercised at the point of referral to the provider, including where the patient’s first contact with that provider is with a clinical assessment service. Exemptions from this are listed below:

- **high secure psychiatric services**;
- if the patient is *detained* under the Mental Health Act 1983;
- if the patient is detained in prison or ‘other prescribed accommodation’, or is on temporary release from prison;
- if the patient is serving as a *member of the armed forces* and members of their family who are registered with Defence Medical Services (DMS) GP practices;
- if a patient is *already receiving* mental health care as an outpatient. However, where a mental health consultant or healthcare professional makes an assessment and diagnosis subsequent to the outpatient referral that is different to the assessment and diagnosis for which the patient was referred, under the terms of the NHS Standard Contract the provider may contact the patient’s GP and, with the GP’s approval, refer the patient to an appropriate provider for treatment. A patient’s legal rights to choice do not extend beyond the first outpatient appointment\(^2\). However, the GP or provider should act with the best interests of patients in mind. They would be expected to support the patient to consider the options for ensuring that the patient’s clinical needs are met, including where this might mean offering the patient the opportunity to attend a different outpatient provider, where treatment more appropriate to their needs is available;
- to *drug and alcohol misuse services commissioned or provided by local authorities*; or
- where it is necessary to provide *urgent care or treatment*, in the same way that choice of provider does not apply with a physical health care emergency, such as a heart attack or stroke.

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\(^1\) ‘Outpatient appointment’ refers to any appointment where a patient does not stay overnight (NHS Choice Framework 2014/15)

\(^2\) The right to treatment within 18 weeks from referral that exists for physical health does not currently apply to mental health services. The Department of Health is leading a mental health waiting times steering group with NHS England and other system partners, which is considering the relevant issues.
Patients should be involved in decisions about their care, as set out in *No decision about me, without me* (December 2012). However, any referral must be to a clinically appropriate service. Patients must be supported by referrers in making the decision about their care and treatment, including patients with mental impairment.

Further guidance is necessary on the issue of whether consideration of a clinically appropriate service should also include whether integration with social care services is required, an essential element of care of many mental health service users.

3 **NHS Choice Framework**

In addition to the choice of clinically appropriate provider, from April 2013, people with mental health conditions have had a right to choose who treats them within the organisation providing their health and care. This means having a right to choose which team, led by a named healthcare professional, delivers their care and treatment. The choice must be ‘clinically appropriate’, and patients can only choose a team which offers the right care and condition for their condition.

This raises issues regarding the information and support that patients and GP referrers have regarding the Trust’s services. The Trust is improving the level of information on the Trust’s website in relation to services, so that patients and GP’s can refer to the most appropriate service. In addition, the trust is reviewing its existing offers in relation to choice at an operational level, for example requests to change key worker/consultant, in order to maximise the level of choice for service users beyond that suggested by national guidance.

Services in the Trust that are able to take direct, non-urgent, referrals at present include the Assessment and Advice Team, IAPT, and Memory services.

4 **Choose and Book**

The guidance on choosing a clinically appropriate provider makes specific reference to use of the NHS ‘Choose and Book’ system. Choose and Book allows GP’s to support their patients in choosing a clinically appropriate provider for their mental health services, and provides a web based system to send referral information electronically to the chosen provider, to enable the patient to be booked into an appointment slot.

The Trust’s RiO system does not allow direct booking from Choose and Book, and the trust will need to use an indirect booking system to use Choose and Book following a referral being placed on the system, by contact with the GP or service user.

Discussions have been held with Camden and Islington commissioners and GP leads on the use of choose and book and there has been a mixed response, with some GP leads stating a preference to maintain the current system for referrals. A seminar has been proposed between commissioners and providers organised by NCL CSU to provide more clarity on the issue.

The trust is able to enter services onto choose and book for indirect referral even if local commissioners/ CCG decide not to use it as a referral system. The presence of Trust services on choose and book will allow GP’s outside C&I to refer to the Trust’s services, and will enhance awareness of those services outside our local area.

5 **Integration with Social Care**

The guidance does not refer to integrated health and social care services such as those operated by the Trust. There is no indication whether or not the term ‘clinically appropriate’ only refers to the health aspect of the service or where an integrated service with social care is required. Without this clarification there will be significant confusion.

The Trust has argued strongly that for those with complex needs, an integrated approach with social care is an essential part of the care pathway. To take on the treatment of those with complex needs from other areas without strong arrangements with the respective local authorities would create the potential for poor organisation, coordination and delayed delivery of services. Changes to this approach, to move away from locality based approaches would need thorough planning and consideration.
6 Contracts and Pricing
Mental Health services do not currently operate with nationally mandated tariff prices. Any additional activity generated by the Trust will be either covered by the existing contract arrangements with C&I or the Associate Commissioners. Referrals from outside these areas will be charged at non-contract activity prices. Changes in terms of income for the trust in 2014/15 are likely to be neutral or positive. However, with the introduction of the Mental Health Tariff in 2015/16, and the introduction of cap and collar financial arrangements, there will be downside risks in relation to loss of activity due to patient choice. This can be mitigated through a number of actions outlined in this report, including marketing initiatives to GPs and service users.

7 Competition and Marketing
The extension of patient choice gives the trust an opportunity to market its services to other areas. Work has begun to market trust services through improving its website, use of the 111 Directory of Services, NHS Choices, and Choose and Book. Direct marketing to GP’s will need further consideration and be informed by the national guidance to be released by NHS England in order to target marketing messages effectively.

In terms of competition, there is little activity from mental health trusts, private or other organisations at a London-wide or national level to compete at this level on any of the platforms identified, including Choose and Book. This is likely to be because of the practical issues identified earlier in this report, and the small changes in patient flows that are anticipated at the initial phase. However, this is expected to change, and actions to identify marketing mechanisms are being taken to put the Trust in a good position to take up new opportunities. As an example of one of those opportunities, discussion has taken place on the potential for increased demand for IAPT services for commuters accessing Kings Cross services. Service leads are scoping this and preparing business plans to maximise the opportunity presented by the central location of IAPT services in Kings Cross.

8 Competition Analysis
The Trust is carrying out further analysis on the competition impact of the introduction of choice. Specifically, we will explore the following areas:

- Identification of the services where competition for patients is likely to occur.
- Development of specific patient choice models for each service, demonstrating which factors are pertinent in making patient choice decisions.
- Identification of potential market competitors for patients in each of the services.
- For C&I services delivered from Camden and Islington, identification of the value of income at risk and opportunity to develop new income for each service.

This work is anticipated to be completed in approximately 6-8 weeks time.

9 Progress to Date and Next Steps
The choice and mental health working group has representatives from business development, information team, services and performance. The group has met twice and has focussed so far on the following:

- Local arrangements for referrals from GP’s, including use of the ‘docman’ system for communicating with GP’s.
- Choose and Book operational issues, including system compatibility, services to include, and GP views.
- Risks and opportunities.
- Analysis of border flows of patients from existing information sources.
- Pricing and tariff issues.
- Existing choice options for C&I patients.
- Discussion of the implications of the draft NHS England guidance.
Actions to be completed -

Operational actions:
1. Review existing operational policies at service level to clarify choice offer. Service level lead to be appointed to review policies and propose amendments where necessary. Clarify definition of choice at 'first patient appointment' as it applies to the trust.
2. Assess the option to use the Choose and Book system to market C&I, and to offer indirect booking functions. An assessment is underway and will be complete end of April 2014.
3. Create a system for monitoring changes in activity in relation to choice, including commissioner level activity where available. Existing data sources will be collated and examined for this purpose, by end of April 2014.

Wider strategic and business development actions:
1. Respond to the release of further guidance from NHS England. Clarification on essential issues are being sought, for example through lobbying via the NHS confederation.
2. Review competition and marketing actions in relation to the introduction of choice, including improvement of the trust’s website in order to provide greater information to both GPs and service users on the Trust's offer. An approach to this is being explored by the Trust's communication lead.
3. Undertake and complete the analysis of the competition elements of the introduction of choice. A first draft of this analysis will be available in 12 weeks.
4. Engage local commissioners and attend and contribute to the NCL seminar on the implementation of choice in mental health. This seminar is expected to take place within 8 weeks.

10 Monitoring and Governance
The mental health and choice working group was established by FTE to consider the issues of choice posed by the extension of choice in mental health to any clinically appropriate provider. The group will have two reporting routes.
1. The group will report to FTE in relation to the actions in relation to the service related issues involving service related actions such as implementation of choice at operational levels, and the service issues in relation to Choose and Book.
2. The work in relation to choice at a business development and strategic level will report to the Finance and Estates Committee, as part of the FEC terms of reference covering business development.
MINUTES OF THE SERVICE USER EXPERIENCE AND STAFF EXPERIENCE COMMITTEE MEETING
Held on Tuesday 7 January 2014 at 2.30pm
Conference Room 4, 1st Floor, East Wing,
St Pancras Hospital

PRESENT:
- Ms Sarah Charles (Chair) Senior Independent Director
- Dr Sue Goss Non-Executive Director
- Ms Claire Johnston Director of Nursing & People
- Ms Wendy Wallace Chief Executive
- Dr Sylvia Tang Deputy Chief Executive & Medical Director
- Mr Paul Calaminus Chief Operating Officer

Ex-officio member
- Ms Wendy Wallace Chief Executive

IN ATTENDANCE:
- Ms Leisha Fullick Trust Chair
- Mr Ian Griffiths Divisional Manager, R&R
- Ms Aisling Clifford Interim Divisional Manager, Acute
- Ms Alison Martin Head of Risk & Patient Safety
- Ms Cheryce Mullings Performance & Regulation Compliance Manager
- Dr Mark Cole Head of Learning & Development
- Mr Karl Heidel Head of Communications
- Ms Anne Prouse Executive Personal Assistant (minutes)

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<th>INTRODUCTORY ITEMS</th>
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<td>1. Welcome, Apologies and Quoracy</td>
<td>Ms Sloman</td>
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<td>The Chair welcomed those in attendance. There were apologies from Ms Acosia Nyanin, Head of Governance &amp; Performance; Ms Lincia Tuitt, Service User Representative; Ms Lucy McLean, Staff Governor; and Ms Natasha Sloman, Staff Governor. Ms Charles advised the committee that Mr Tony Fisher had resigned from the Committee. Ms Charles would now ask Ms Sloman to address the matter of service user representation on the Committee. Ms Charles thanked Mr Fisher in his absence for his involvement and his assistance on service user programmes in the Trust. The meeting was quorate.</td>
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2. **Minutes of the Service User Experience and Staff Experience Committee held on 19 November 2013**

The minutes of the meeting held on 19 November 2013 were agreed as a correct record.

For item 5 (Update/work plan for Service User Involvement and Service User Alliance), Mr Calaminus clarified that a general survey for services would be rolled out across the trust. Dr Tang cautioned against having too many surveys running in services. Ms Mullings stressed the importance of having a global understanding of service user experience across the Trust and advised that the trust was looking at investing in the necessary technology.

3. **Matters Arising from the Service User Experience and Staff Experience Committee held on 19 November 2013**

The schedule of matters arising from the Service User and Staff Experience Committee meeting on 19 November 2013 was reviewed, and verbal updates were provided.

3.1 **IBUG survey of service user experiences of the transition and care review**

Ms Charles advised that Mr Fisher had queried whether CBUG might be approached to carry out a survey as IBUG had done. Mr Calaminus clarified that this had been an Islington CCG initiative and Ms Wallace cautioned that now was not an appropriate time. Mr Calaminus agreed to let Camden CCG know.

3.2 **Membership concerns from service user representatives**

Dr Goss stressed that the committee needed to be vigilant about the atmosphere of the meeting not being intimidating for service users. Ms Charles agreed.

3.3 **Patient Experience Aggregated Implementation Plan and Briefing**

The Committee discussed this matter and Ms Johnston advised that once the aggregated performance work had been completed, the work to link themes to trust values could be planned. Ms Mullings confirmed that a 12 week roll out programme of the plan would take place at the end of March. The analysis of performance data and gap analysis would be done as the experience tool was implemented. Dr Goss stressed that a creative plan was needed now and could not wait until the technology was in place. Ms Johnston reassured the Committee that plans were in place and she would discuss with Ms Sloman prior to the next meeting.

Mr Calaminus agreed to bring the surveys which had come to the divisional performance meetings to the Committee for comparison.

3.4 **Human Resources and Workforce Update**

Dr Cole updated on the Band 2-4 vocational development programme, where he was trying to balance competency and progression. Ms Johnston advised the committee that the 40% decrease in funding from the LETB for professional development would constrain such programmes.

4. **BUSINESS ITEMS**

4.1 **Revised Draft Terms of Reference**

Ms Charles advised the Committee that the planned appendix (reports and workplan) to the Terms of Reference was not yet completed. Ms Prouse highlighted the new format of the document, which had been applied to all Committee Terms of Reference.
Ms Charles queried the inclusion of listening exercises (In Our Shoes and In Your Shoes) and Ms Johnston advised that listening exercises were taking place in the Nursing Directorate.

The Committee discussed its role as champion in several areas and what that meant in practice. Mr Calaminus highlighted the importance of benchmarking environmental changes e.g. benefits reform and their cumulative effect on vulnerable residents.

Ms Wallace, Ms Charles and Ms Johnston agreed to meet to discuss the number and make up of staff governor representation on the Committee.

The Committee APPROVED its draft ToR with a number of amendments.

5 STAFF EXPERIENCE

5.1 Acute Division Service User and Staff Experience Update

Ms Clifford presented the results of an audit of inpatient staff perceptions of impact of service reconfiguration coordinated in early 2013 by Fiona Nolan, Deputy Director of Nursing, who was currently on sabbatical, and Roger Evans, Divisional Manager, Acute Division. The audit covered 17 inpatient wards. Ms Clifford provided an update on current plans in the Acute division in relation to the areas evaluated in the interim report. These included: patient safety (incident rates); staff sickness and absence; staff and patient experience; length of stay and throughput; and readmission rates.

Ms Clifford highlighted the significant changes that had been made to the Trust recruitment process, using assessment centres and more service user involvement, and outlined the work currently being done around fitness of staff to carry out Therapeutic Management of Violence and Aggression. Ms Clifford explained the ‘Safewards’ initiative, the return to short nursing shifts, formalising flexible working patterns and the development of meaningful crisis plans.

Ms Charles thanked Ms Clifford for her very useful update. Dr Goss was pleased with the management actions which had been taken and asked whether the work being done around readmissions would be ongoing. Ms Clifford confirmed that this was preferred and advised that the number of psychologists in the crisis team was being doubled in order to work particularly with those service users who were being readmitted. Dr Goss asked what the committee needed to do in order to facilitate the development of meaningful crisis and contingency plans and Ms Clifford advised that a work group was being set up to look at this.

Dr Tang voiced concern about the evidence base supporting primary nursing and short shifts. Ms Clifford was unable to comment on this as she had not been involved in that piece of work. Dr Tang stressed the need for evidence on the impact of primary nursing on patient care. Ms Clifford said the evidence was only anecdotal. Ms Johnston confirmed that there was no national evidence about the value of shorter shifts but that the Trust had adopted the existing guidance, for example that of the Royal College of Nursing. She advised that mental health trusts who had piloted primary nursing had generally reverted to another model. Ms Johnston pointed out that this piece of work had been poorly responded to by ward managers and that the burnout rate was highlighted in studies which had looked at 12 hour shift working.

Dr Tang asked for evidence to support shorter shifts, and Ms Johnston stated that there was insufficient work done in this field, but that a conjoint piece of work had been completed by Directors of Nursing in London. She advised the Committee that primary nursing was the most common method for delivering nursing care and suggested that the trust could adapt the methodology rather
than discarding the model. Ms Johnston agreed that further discussion was needed if consultants had concerns.

Ms Fullick advised that it was useful to have the information on staff experience from the audit in the context of visiting wards and asked how visitors (including Non Executive Directors and service users) could help. Ms Clifford stated that service users were already heavily involved. Ms Clifford welcomed feedback on an advertisement which sought to make the Acute division an attractive employer to applicants, and Ms Fullick said she would be happy to discuss this matter.

Mr Heidel noted that, in previous trusts he had worked for, higher rates of sickness absence had been seen for staff working 12 hour shifts, due to their completing other work in their spare time. This was not so apparent for staff on shorter shifts. Ms Wallace urged caution when looking at ward manager versus staff perspectives, and pointed out that the audit had been done six months following the changes and that it took time for teams to bed down. She said the work pointed to many questions which needed further digging, and the Trust needed to hear service user views in order to better understand this. Ms Charles agreed and suggested that an update of the audit would be useful.

Dr Goss asked that bed occupancy be added as a theme in the complaints and incidents themed report.

The Committee NOTED the Acute Division Service User and Staff Experience Update presented by Ms Clifford.

5.2 Staff Survey Action Plan 2012
Dr Cole presented the Staff Survey Action Plan. He advised that the embargoed results from the staff survey exercise for 2012 had been shared with Trusts and the Foundation Trust Executive had recently received a verbal update of the headlines from those results. Once the embargo was lifted, the Staff Survey Action Group would be convened to agree the action plan from this year’s exercise. The initial cut of the 2012 data showed an improvement on the previous year, particularly around appraisal and objectives.

Dr Goss asked whether there was a plan to hold trust listening events in the near future. Dr Cole explained that there was currently no strategic overview of how this work was being taken forward. Ms Wallace stressed that staff needed to be trained in the listening event methodology and that the current accountability for this work was primarily with Human Resources but the responsibility should be organisation wide. Ms Charles suggested ownership by services may be beneficial. Dr Goss asked that the results of listening exercises came to this Committee.

Dr Cole confirmed a more sophisticated appraisal system would be in place by April, and stressed that the paperwork of an appraisal should be incidental to the conversation a manager had with staff.

The Committee NOTED the Staff Survey Action Plan paper provided by Dr Cole and AGREED to take an update at the April meeting.

5.3 Duty of Candour
This report was held over to the meeting on 8 April.
6  SERVICE USER EXPERIENCE

6.1 Substance Misuse Service User Survey 2013
Mr Griffiths made a presentation on the highlights of the Substance Misuse Service User Survey 2013. He pointed out the absence of questions regarding environment, which would be included in the next survey. The Division was currently working on a forward plan for service, building on this work.  
Ms Charles thanked Mr Griffiths for his presentation and commented that this had been a very valuable exercise. Ms Fullick and Dr Goss echoed the Chair’s thanks.  
Ms Charles asked whether, as in SMS services, all services were taking care plans into supervision sessions. Mr Calaminus advised that this was the case, but that SMS were also piloting using recordings of patient interactions in supervision. Mr Griffiths also explained the role playing exercises currently taking place in SMS services. Dr Tang asked whether training was provided for supervisors and supervisees. Dr Cole advised that the trust provided some clinical supervisor training, and his department was working with a practice development nurse to develop a package for supervisors and supervisees. The supervision practice framework was due for review and would be consulted on widely.  
Ms Johnston commented that nurses wanted the time and tools to be effectively supervised and to understand reflective practice. It was crucial that external standards (nursing revalidation and CQC) were met. 

The Committee NOTED the presentation on the Substance Misuse Service User Survey 2013.

6.2 Quality Health/CQC Inpatient Service User 2013 Summary
This report was held over to the committee meeting on 8 April. Dr Goss advised the Committee that she would place this item on the Quality Committee agenda for 21 January.

7  SUB GROUPS’ MINUTES, REPORTS AND ITEMS

7.1 Carers Minutes July and October 2013
The Committee RECEIVED the minutes of the Carers meetings for July and October 2013.

7.2 Minutes of the Service User Alliance June 2013
The Committee RECEIVED the minutes of the Service User Alliance of June 2013.

7.3 Minutes of the Wellbeing Group
Not applicable.
### ANY OTHER BUSINESS

#### 8.1 Any Other Business

The Mystery Shopper report, originally scheduled for this meeting, would be held over to the April meeting due to the absence of service user representatives.
No other items were noted.

**Ms Nyanin**

#### 8.2 New risks identified during the meeting, referred to/from other Committees

No new risks were identified or referred during the meeting.

#### 8.3 Date of Next Meeting

2.30-5pm, Tuesday 8 April 2014
Conference Room 4, 1st Floor, West Wing, St Pancras Hospital.

### 9 CLOSE

The Chair closed the meeting at 5.10pm

I certify that these are fair and accurate minutes of the stated meeting.

………………………………………………
(Service User Experience& Staff Experience Committee Chair)  (Date)
## PUBLIC BOARD MEETINGS - EXPECTED DOCUMENTS 2014/15

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**MORE FREQUENT REPORTS:**

| Chief Executive’s Update (Incl. Use of Trust Seal)                         | WW    | √    | √    | √     | √     | √    | √    | √    |
| Monitor Finance Declaration                                                | DW    | Q4   | Q1   | Q2    | Q3    |
| Monitor Governance Declaration                                             | CJ    | Q4   | Q1   | Q2    | Q3    |
| QIPP Indicator Report                                                       | CJ    | Q4   | Q1   | Q2    | Q3    |
| Board Performance Report (Frequency going forward may change. Supporting  | CJ    | Q4   | Q1   | Q2    | Q3    |
|   detail behind Board Quality Dashboard)                                   |
| Human Resources & Workforce Performance Report                             | CJ    | Q4   | Q1   | Q2    | Q3    |
| Nursing Establishment Report                                               | CJ    |      |      |       |       |      |
| Finance Position                                                            | DW    | M12  | M3   | M5    | M6    | M7   | M9   | M11  |
| QIPP Position (Removed for 2014/15 as now to FTE)                          | DW    |      |      |       |       |      |

**2013/14 SPECIFIC REPORTS:**

<p>| St Pancras Acquisition / Forward Planning Report (Acquisition in April,    | DW    | √    |      |
| forward plan dates to be advised)                                         |
| Integrated Business Plan                                                   | CPI   |      | √    |</p>
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