The Tavistock and Portman NHS
NHS Foundation Trust

Board of Governors Meeting

Notes from a meeting held on Wednesday 29th November at 4.30
in the Lecture Theatre

Present
Dr Robin Anderson (RA), Public: Rest of London
Ms Jennifer Bird (JB), Public: Camden
Mr Robin Bonner (RB), Staff: Trades' Unionists
Mr John Carrier (JC), Primary Care Trusts
Ms Caroline Garland (CG), Public: Camden
Ms Simone Hensby (SH), Non-Statutory Sector
Dr Aulay Mackenzie (AM), University of Essex
Professor Susan Price (SP), University of East London
Councillor Kirsty Roberts (CR), Local Authorities
Mr Michael Whiteley (MW), Public: Camden
Mr John Wilkes (JW), Public: Rest of London
Mrs Amanda Hawke (AH), Staff: Administrative & Technical
Lou James (LJ), Public: Camden
Angela Kenny (AK), Public: Rest of London
Chrissie Kimmons (CK), Public: Rest of England and Wales
Dr Caroline Lindsey (CL), Public: Rest of London

Chair
Mr Nicholas Selbie (NS)

In attendance
Mr Simon Young (SY), Director of Finance
Dr Nick Temple (NT), Chief Executive
Dr Sally Hodges (SHo), PPI Lead / Consultant Clinical Psychologist
Ms Deirdre Moylan DM), Clinical Director, Adolescent Department
Mr Jonathan McKee (JM), Acting Secretary / Foundation Trust Project Manager

In addition, 11 members attended to observe.

1 – Welcome and Chair's opening Remarks

NS welcomed members, guests, and presenters to the first meeting. NS pointed out this approach to discharging governance in this way is not only new to the trust, it is new to the world.

NS noted some trusts had called their board a council, but added that the trust has chosen to call the group the Board of Governors as to do otherwise would denigrate the importance of individuals and the group.

2 – Apologies for Absence

Ms Alison Armstrong (AM), Specialist Commissioning
Mrs Amanda Hawke (AH), Staff: Administrative & Technical (will be late)
Lou James (LJ), Public: Camden (will leave early)
Angela Kenny (AK), Public: Rest of London (will leave early)
Chrissie Kimmons (CK), Public: Rest of England and Wales (will arrive late),
Dr Caroline Lindsey (CL), Public: Rest of London (will leave the meeting for a short period due to previous commitment)

3 – Role of Governors

JM had circulated a paper, summarising the responses Governors had given to the questionnaire. This will be a live record and can be updated as and when new information becomes available.

The first section gives information on experience and interests of governors for the record.

The second section helps the chair structure future debates, having had an indication of governors' current interests.

The third section indicates what needs to be included in the forthcoming training and support programme, according to the identified needs of governors. There was a strong indication to understand more about the trust's work and philosophy. The trust sought two governors to join staff in thinking the programme through outside the meeting. It was also hoped governors could give some steer to those governors who will be helping with the programme.

Governors felt it was too soon to identify individuals who might be able to provide assistance in this area. CG suggested that a one-off meeting be held that would include all the Governors to explore this and other issues in relation to establishing an effective working group. Which staff are to be involved and whether the Chair will also attend as an observer will be established through e-mail correspondence prior to the meeting. CG kindly offered to co-ordinate the meeting. All governors agreed that their personal details could be shared with all other governors for this purpose. Facilities would be provided at the Tavistock for this purpose.

- JM to collate a list and forward to Caroline, who will find a suitable date as is practicable.

4 – Chief Executive's report on the Integrated Business Plan

NT had circulated a paper. NT thanked SY and JM for their hard work and contribution to the successful outcome. NT explained that planning on a five-yearly approach was new for the trust; much detail was included, and this had been helpful to the organisation as it helped staff visualise ambitious but realistic expansion. There will be challenges, especially with clinical contracts as mid-way through the application process, cuts had been imposed to both clinical and training contracts. A new method of funding research has been put in place in the NHS. Finally, the trust needs to generate a surplus in order to invest in new infrastructure and new developments. NT was pleased to report that plans for a new base for education and training in the north (Leeds) were in progress, and that the trust had been invited to tender for Tier 2 CAMHS services in Camden.

JC pointed out that he had a conflict of interests as he was the Chair of Camden PCT (this is the trust's lead commissioner). JC explained that it had been a difficult year for PCTs as, for example, Camden had had £10 million cut from its budget mid-year, and these cuts had to be passed on to provider organisations. JC asked whether there was any degree of cross-subsidy between cost centres. NT explained that due to the complex integrated nature of service delivery, costs were not always as transparent as might be considered ideal; for example, the cut in the training contracts necessitated cuts across the organisation as all departments provide education and training. A costing exercise is underway, which will provide a much better allocation of costs to different areas of activity.

JW noted comparison on graphs with different horizontal and vertical axis scales is difficult.

JW also added that he was not comfortable with the proposed restructuring of consultancy services. JW felt restructuring seemed an all too common process throughout the public sector which often achieved very little. NT assured the restructuring was on a small scale, and was with a view to delivering the planned growth, and was not being undertaken for its own sake.

MW asked how investment decisions were made. NT explained that the clinical strategy group leads on this for clinical activity, and that the four clinical directors provide valuable support to the process.

CG sought reassurance that any relationship with the private sector would not undermine the trust's NHS status. NT explained that discussions were at a

very early stage, and he would report progress when more information is available.

AM commended the plans, but noted there was a vast array of outcomes at various levels in various departments; how was the trust planning for this wide range of possibilities, eg for accommodation needs? NT explained that plans were made as a result of careful and detailed work and were realistic. The Board was keen to address estates strategy and will do so at a forthcoming meeting.

LJ was passionate about the potential and hoped that the trust would do more to market itself effectively. The trust was not exploiting potential markets and new markets effectively. NT agreed and noted that the lack of communication and marketing resources was an issue that needed to be addressed if the IBP was to be realised. CJ pointed out that other trusts, for example, Great Ormond Street and Moorfields had established themselves within other NHS centres and this model should be explored by the trust. NT confirmed that the trust had already been considering this model especially in discussion with Commissioners and felt it was one that the trust could successfully exploit.

MW added that he worked in the marketing field and was excited about the Tavistock's prospects. CG asked whether it was appropriate that an NHS organisation should be 'selling' services to prospective patients. NT felt that the trust must not risk failing to get its message about quality services out to potentially interested parties, but that it must do this in such a way that was consistent with its philosophy; the consensus was that trust cannot sit back and expect money to flow in without having demonstrated to commissioners, referrers and patients that the trust had something worthwhile to offer.

5 – Current Financial Position 2006 / 7

SY had circulated a paper. SY explained that pay costs were proportionately higher than in other trusts high as the trust had no expensive equipment to operate or medication to prescribe due to the nature of its services. SY noted that there had been significant growth of services in locations other than 120 Belsize Lane, though our name was not necessarily displayed prominently at these locations.

SY noted that the mid-year cut imposed by the SHA came at a particularly difficult time; however, he expected that the projected surplus would be delivered.

SY noted felt that as a Foundation Trust, we now have more freedom to approve capital expenditure when it has a good business case. Cash flow will

need careful monitoring as the trust will need to pay the bills, and cannot expect support externally, other than that agreed with the commercial banks.

Next year the trust will continue to face financial pressures. Financial risks are being managed well. Clinical contracts are likely to yield similar income with the addition of an increase for inflation. There is potential for research funds to be considerably more than previously, although this would depend on the outcome of several bids now being considered externally.

SH asked about the possibility of compulsory competitive tendering for the training contract. SY had heard of no suggestion that this might happen.

SH asked about the RAB [Resource Accounting and Budget] entry. SY explained this was an exceptional non-recurrent item without which we would have been in deficit.

SH asked about the scale of the further cost savings that might be needed next year. SY explained that these were expected to be in the region of £2-300 000.

RB asked how the trust was performing on training income. SY confirmed that the forecast was 15.6 percent increase, which was in line with the IBP.

RB asked about the increase in the expenditure on pay, and whether this was due to meeting increased pay costs, or due to the increased establishment. SY explained that half the increase was due to each factor.

RB asked about the dividend payable to the Department of Health. SY explained that this was due to the Department having bought the land and buildings on behalf of the nation, in a sense this was the "equity", which the Department still owned, and that this payment would be due in perpetuity. The amount paid is based on the value of the assets in their current use, and this is reviewed every five years by the district valuer.

RB was puzzled by the apparent increases that were being given to the NHS by the Department of Health, and yet PCTs were cutting funding to providers. RB also felt that the resources going to mental health rather than the acute sectors was not in line with that needed by users. SY explained that it was his understanding that PCTs were expected to top-slice budgets in order to help the London position overall.

The introduction of PBR (payment by results) had introduced further pressures to the system with some acute trusts aggressively pursuing this approach in order to maximise their income. Inevitably, such an approach reduces that available to other providers in a given health economy. JC added that London has some very expert, apparently expensive, centres of excellence, and that this was one of the difficulties the London health economy faces.

JC also noted that PCTs were being encouraged to release their provider functions, and this was amongst a long list of tasks that PCTs had to undertake currently.

RA asked whether the trust was doing the research it wanted to do, or was it doing the research that other people wanted us to do. SY felt that the current proposals were exactly what we wanted to do and that the new system provided an opportunity to secure funds that may avoid some of the historic biases and prejudices against previous applications. LJ suggested we might use the Leeds base for future bids in order to attract any funds that might be diverted away from London. CK suggested that there was a wealth of charitable funds that the trust had not explored and kindly offered assistance in doing so.

CK also added that the NHS R&D and the MRC budgets are being combined; this will give a total of £1.3 billion! It is likely that the focus of research will be more on epidemiological and outcome measures rather than pure research for its own sake, as has been in the past. AM noted that universities have a great history and much experience in this area and that key to their success had been highly active and expert management, and investment in this area was a prerequisite. SY noted that the current director of research is working along these lines. AM kindly offered his expertise, as did CK.

SY summarised by pointing out that:-

1. we have broken even every year since the trust's formation in 1994 (this is quite unusual for NHS trusts)

2. that, in addition to his duties as finance director

NT added that SY had also been the project director for the Foundation Trust application, which was a considerable piece of work due to the financial focus of the Monitor assessment process.

6 – Appointment of Chair, Non-Executive Directors, Auditors

Paper Nov06/6a&b. NS had circulated a paper for parts A and B. NS pointed out that the 2003 Act made clear that Governors had to accept the recommendations as outlined in the papers, though this might seem to be undermining the authority of the governors. JW felt this was quite odd, and noted that he was uncomfortable with this approach. It was noted that this would be a one-off occasion and in future governors would be able to

exercise their powers fully. SP moved that the motion now be put[1]; this was seconded by CK. Agreed: the paper was adopted.

Paper Nov06/6c. SY presented a paper on behalf of the Audit Committee. He explained that the appointment of the auditors was previously under the remit of the Audit Commission and recommended that no changes are made to the current audit arrangements at present, but the Governors were invited to undertake a review in due course. All the recommendations in this paper were agreed.

7 – External Partner Stakeholders' Event

JM had circulated a paper and DM attended for this item. DM explained that meetings held during the consultation and application process had been useful and that there was a strong desire to continue this dialogue with stakeholders in the future. The planned date for this meeting is the afternoon of the 15th February 2007. The purpose of this meeting will be to discuss with external stakeholders joint goals and common interests, as well as thanking them for their contributions to date.

DM asked the Governors how much input they wanted into the planning of the next event, whether they would like to authorise us to do it in the Trust, or do it themselves, or send a representative to input to the planning. The Governors said they would consider these options and let us know.

JC noted that the previous events had been very good and that it seemed logical that the Governors should increase their input to the planning of the annual event in due course. It was suggested that there should be a Governor at each table at the forthcoming meeting. RA asked for more information on who was to be invited.

- JM to circulate a list of potential invitees

- Governors to make suggestions on the invitation list and forward to Jonathan.

The paper was agreed.

8 – PPI Review

SHo attended for this item. SHo explained that PPI stood for patient and public involvement and that she was the lead of the trust. A recent

[1] BDSO 2.15: "that the motion now be put"

development as a result of patient feedback was to replace the clocks that were no longer telling the right time.

MW pointed out that the trust could only realistically engage with the public or patients on topics that interested them.

LJ commended the recent PPI conference, and noted that it was very difficult to involve service users. LJ suggested focus groups were more effective and cheaper to run than questionnaires.

CK expressed anxiety over how she was expected to access / represent the views of everyone in England and Wales outside London! Nevertheless, giving patients more influence was prominent on the current NHS agenda as this was a political imperative. Marketing will need to be developed if the trust is to realise its IBP objectives. MW agreed, and noted that pharmaceutical companies are very powerful because they invest a lot of time and resources into sales.

9 Notice of future meetings

JM had circulated a paper; this was adopted with a change in the January meeting time to 4pm-6pm.

NS highlighted a discussion for the January meeting during which governors would need to agree whom would serve on the committees; a briefing paper was circulated. JM pointed out all the sub-committees listed were required under the constitution; other committee are up for debate.

- JM to propose full terms of reference for each committee
- Governors to consider whom they would like to select

Date of Next Meeting Tuesday 9th January 2007, 4pm – 6pm, 5th floor lecture theatre, Tavistock Centre.

The meeting closed at 6:30 and the chair invited all present to stay for a celebratory drink