The Tavistock and Portman
NHS Foundation Trust

Quality Account 2022-23

Contents

Part 1: Statement on quality from our Chief Executive Officer

It is my pleasure to introduce the Tavistock & Portman NHS Foundation Trust's Quality Account 2022/23. This Account is an important and valuable way in which the Trust sets out its commitment to delivering high quality services to our local communities and stakeholders – both in the improvements we have made during the year, and those we want to focus on in the year to come.

The Tavistock and Portman has remained under the System Oversight Framework (SOF) Level 3 during 2022/23, as per the instruction of NHS England (NHSE). This is defined as "co-ordinated support package and enhanced oversight required" and was based on improvements that needed to be made to our quality, governance, leadership, finance and the estates arrangements. We have made significant progress in a number of the areas that were identified to improve as part of the framework rating and we remain committed to working collaboratively with NHSE and the Integrated Care Board (ICB) to define and meet the exit criteria from the Level 3 status.

During the early part of the year, a Quality Improvement Plan, based on thirteen key areas, was developed in order to address some of the areas of work where our quality assurance processes needing strengthening. This work was also a key requirement of our SOF 3 programme of work. There has been significant progress in many areas to date, including:

- the establishment of a robust and accountable Quality Committee, a sub-committee of the Board of Directors
- the development and embedding of a new Quality Report and dashboard which sets out our performance against key quality indicators, identifying key risks, issues and actions
- reviewing and improving how the patient voice is currently heard by the organisation through the valuable work of our Patient and Public Involvement (PPI) team
- strengthening our processes around learning from deaths, including the way in which we report and audit them

The newly established Quality Committee has been instrumental in supporting our quality improvement journey, working with our non-executive directors, commissioners and patients to fully assure the quality of services that we provide.

We will continue to progress the improvement actions identified in the plan to further embed our commitment to improving our quality processes. This will include a review of our Complaints process and the implementation of the Patient Safety Incident Response Framework (PSIRF), which is an exciting and transformative approach to how we examine and, most importantly, learn from our incidents.

Following a further publication from the Cass Review into gender services for children, NHS England announced a new regional model for gender care for children and young people. Our Gender Identity Development Service (GIDS) will be closing as part of this new model. While the loss of this valued, caring and resilient staff group will be felt across the Trust, the new model, once fully operational, should increase capacity and improve access to care. This remains a significant programme of work for the Trust, ensuring that our patients and staff are supported through the transition to the new model safely and sensitively.

Throughout the year, the GIDS clinical and operational teams have undertaken a significant amount of transformational work into strengthening a number of the clinical governance and operational processes in place. In respect of quality, highlights have been improving the documentation and process for supervision, a focus on resolving complaints, aligning the clinical audit calendar to regulatory requirements and initiatives to support staff wellbeing.

During Quarter 3, we implemented the final stages of our Strategic Review, which was a key piece of work to support the Trust in its long term financial and operational sustainability and ensuring its better alignment with services across the Integrated Care System (ICS) in North Central London. The results of our 2022/23 NHS Staff Survey have highlighted that some staff have been impacted by the changes in a way that we would not have hoped for. It is clear that we have a lot of work to do with the outputs of the staff survey, including improving staff morale and engagement, and this is a key area of focus for us in 2023/24.

You will find more details in the next section and throughout the Account about our progress towards the Quality Priorities we set ourselves for 2022/23, as well as updates relating to our wider quality programme. Some of the information is, of necessity, in rather complex technical form, but I hope the glossary will make it more accessible.

Looking forward to 2023/24, the quality priorities we have set ourselves are a combination of continuing progress made to date for some areas, and new areas we need to focus on. The priority topics for 2023/24 were developed following discussions with service users via our Trust-wide Forum, non-executive directors, staff, management and commissioners. In addition, we considered current service challenges, key performance issues and quality data reviewed and presented to Board over the past year. Our Quality Committee also held a seminar for its members to speak through the proposed priorities and agree the areas of focus. A number of these identified quality priorities are long-term objectives and we are clear as an organisation that enduring success and impact will take time.

Our patient record system, Carenotes, was affected by a national outage in August and was inaccessible until November. This followed a cyber security incident, which affected multiple NHS Trusts nationwide, however, it was confirmed by our suppliers shortly after the outage, and again in November by third-party auditors, that there was no compromise or loss of patient data from the system. NHS England and the system provider were working hard to rectify this, but inevitably the incident caused severe backlogs with our data including, being able to report our performance in an accurate and meaningful way. Maintaining the security and accuracy of patient data was, and continues to be, our top priority during this process.

Our performance against the Quality Priorities we had set ourselves for the year were also affected in terms of both being able to collect and articulate an accurate picture of progress. Our staff worked incredibly hard and were dedicated to restore the system as quickly and safely as possible, and our robust business continuity processes ensured that we were able to continue to provide our services where it was safe to do so. We appreciate the patience that patients and staff have shown during this incident and the subsequent recovery time.

During the later months of 2022/23, a series of industrial action days were called by national nursing, medical and non-medical unions. A majority vote in favour of participating in the industrial action amongst our staff that voted was reached. I am pleased to report that we maintained a safe and equitable service during the strike periods, with as little disruption to our patients as possible. Our Board are wholeheartedly in support of fair and equitable pay for all NHS staff and we will continue to work with the wider system to support a resolution to the challenges.

Waiting times to first and second appointments continue to be longer than we would wish in some areas of the Trust. As part of this continuing quality priority, we will seek to recommend, formalise and implement ways of improving waitlist management. Whilst it is not always simple to broadly ‘improve’ waiting times due to a number of contributing factors, how we support patients whilst they are waiting, and how any measurable clinical harm as a result of extended waiting times can be assessed, is important and will be key objectives in this quality priority for the coming year.

In order to support our younger patients who do experience longer waits for appointments than we would like, we created the NCL Waiting Room, an online platform to support children, young people, and their families, to develop self-care strategies to manage their mental health while they wait for their first session. The platform also helps clinicians gather information about the child’s mental health before their first appointment to help offer more tailored support.

The Board of Directors is ultimately responsible for, and committed to, ensuring that we continue to deliver a high-quality service for our patients. I confirm that I have read this Quality Account, which has been prepared on my behalf. I have ensured that, whenever possible, the Account contains data that has been verified and/or previously published in the form of reports to the Board of Directors and confirm that, to the best of my knowledge, within the data constraints outlined, the information contained in this Account is accurate.

Michael Holland
Chief Executive Officer
June 2023

Part 2: Priorities for improvement and statements of assurance from the board

In this section the Trust updates on progress of delivering our quality priorities that we had set ourselves for improvement for 2022/23, our agreed quality priorities for the coming year, along with statements of assurance from our Board of Directors and other mandated sections for the Quality Account.

2.1 Progress against priorities from 2022/23

The progress we have made in delivering our four quality priorities for last year are set out in the following tables.

Following the loss of access to internal information systems from August 2022 to January 2023, it has been challenging to both collect and articulate an accurate picture of progress. A number of the actions we set ourselves to support achievement of the Quality Priorities were paused in light of this.

Clinical Effectiveness and Patient Safety

Our Quality Priority	What success will look like	How did we do in 22/23?	Future actions for 23/24
Waiting Times	***Review waiting list initiatives currently being implemented across different service lines to ensure that best-practice is adhered to and embedded across the Trust***	***We achieved this*** The Clinical Operations Director, supported by the General Managers and Commercial Director are currently finalising a programme plan, the aim of which is to ensure a cohesive Trust wide delivery framework and approach. This work is split into the following High Impact Action workstreams and will deliver appropriate assurance to QIPR: PTL and Activity Management, Booking System, Key Performance Outcomes and Measurement (including Trust Wide PROMS and PREMs), Monitoring of KPI's not on the Dashboard - (Monitoring and Management of ESR KPI's), Pathway Mapping and QIPR	***This action was completed and therefore will not need to continue into 23/24.*** ***Waiting Times is also a key strategic objective for the Trust and so the operational aspects of improvement will be covered via that process going forward.***
	Develop and implement a Trust-wide framework for managing waiting time performance across the Trust and agree an access policy to formalise waiting list management including use of patient tracking lists & meetings (PTL's), DNA's, cancellations and non-responders	***We partially achieved this*** A patient tracking list (PTL) policy has been drafted and is being reviewed by the general managers. It will be finalised early in Q1 of 2023/24. Waiting lists are largely managed outside of Carenotes using excel and or word with oversight by clinical managers. Tweaks to reports are being requested to ensure pending referrals and waits for assessment can also be managed via Carenotes. New Carenotes forms have been created to manage waiting lists for interventions can be managed via Carenotes. Trails to implement the intervention waiting list forms are scheduled for Q1 2023/24.	***As above, Waiting Times is a key strategic objective for the Trust and so the operational aspects of improvement will be covered via that process going forward.***
	Building on the clinical harm SOP, develop and implement a harm review policy to identify harm in long-waiting patients, recognising learning and any preventative actions	***We partially achieved this*** A Trust harm review policy has been written but has not yet been operationalised in Complex Mental Health or Community & Integrated service lines.	***This will continue into 23/24***
	Improve communications and supportive advice with patients who are on a long waiting list, including further developing digital support	***We achieved this*** 2022/23 saw various developments in the way that service lines communicate with patients on waiting lists – through the development of local processes for telephone, mail & electronic communication, alongside the creation of online platforms to support patients whilst they wait to be seen	***Although we achieved this objective last year, we will again keep this as part of the quality priority to ensure that we're supporting long waiting patients in the right ways.***

Patient Experience

Our Quality Priority	What success will look like	How did we do 22/23?	Future actions for 23/24
Equalities	***Improve Accessible Information Standards (AIS) data recording by 25% compared to 21/22 data***	***We did not achieve this*** We have not been able to achieve this in 2022/23. As a result of the Carenotes outage for much of Q2 and Q3, and the recovery process continuing through Q4, we have not had accurate data. We will continue to work on improving our data recording for AIS and hope this can continue to be a QP in 23/24.	***This has been refocussed for 23/24***
	Use data collected via Experience of Service Questionnaire (ESQ) by protected characteristics (list to be defined in line with what is collected) to understand how experiences of services differ, and then devise a plan to address areas identified improvement	***We partially achieved this*** By the end of the year, we were able to look at this data for patient ethnicity for one service line as part of a pilot idea. We are making plans to review this and make suggestions for improvement across all our outcome monitoring and patient feedback.	***Reworded in line with 23/24 Core20Plus5 CQUIN***
	In collaboration with Quality Improvement, seek to understand barriers within the local community to accessing treatment and develop a Quality Improvement project that will seek to address these barriers.	***We did not achieve this*** We have not been able to progress this due to the Carenotes outage meaning that the above data was only available in the last couple of weeks of 2022/23.	***This will continue into 23/24***
	Develop guidance regarding the standard processes for ensuring timely and accurate data capture across all clinical services, including a system for their review (Q3/Q4)	***We partially achieved this*** Processes have been developed however this was impacted by the access to Carenotes issue. We have developed a plan for how we will recover the large volume of data that is missing following the Carenotes outage. We are also revising our intake process to increase the amount of AIS and other data we receive before assessment.	***This will continue into 23/24***
	Implement guidance and report again across the directorates to monitor adherence and make adjustments where needed (Q3/Q4)	***We did not achieve this*** See previous comment.	***Once the guidance has been implemented we will build this audit process into our Clinical Audit programme***

Clinical Effectiveness and Patient Safety

Our Quality Priority	What success will look like	How did we do in 22/23?	Future actions for 23/24
Outcome Measures	***To increase OM returns across all services by 25% above baseline by year-end***	***We did not achieve this*** There was a 41% reduction in outcome measure collection compared to the previous year (in which it had increased by 34%). Collection this year was severely impacted by Carenotes not being available from July to December and the recovery work that has been undertaken since. Qualtrics was unable to be used and this meant clinicians could not be sent regular reminders on what was due.	***This has been refocussed for 23/24***

	Develop an agreed logic for sending & counting Outcome Measure and ESQ forms (which may differ by individual clinical and service lines) to enable a true reflection of the patient voice	***We achieved this*** The logic for the frequency of sending CORE and the Trauma OMs have been agreed and implemented. The ESQ logic has been agreed for mental health and informatics are working to update Carenotes.	***N/A***
	Roll-out of Qualtrics to other service user completed Outcome Measures across the Trust including all ESQ (12+, Patient/Carer and 9-11's), RCADS and SDQ forms	***We partially achieved this*** Qualtrics has been used to distribute CORE 34 & ESQ 12+ in all our over-18 mental health services although it was not used from August 22 to February 23 due to the Carenotes outage. PCPCS hasn't started again since Carenotes returned as it is in the process of change to CORE 10, which is expected to take place from early Q1 2023/24. Qualtrics was starting to be used for CAMHS services to distribute ESQ 12+ & Parent/Carer pre-Carenotes outage and is scheduled to start up again from April 2023. RCADS and SDQ have now been built in Qualtrics and the rollout will take place in Q1 2023/24.	***This has been refocussed for 23/24***

Clinical Effectiveness, Patient Experience, Patient Safety

Our Quality Priority	What success will look like	How did we do?	Future actions
Gender	***To implement and embed recommendations from the CQC inspection of GIDS service***	Implementation of the CQC recommendation has been part of *business-as-usual* work in the GIDS team throughout the year. The Clinical Safety Governance Practice weekly meeting review progress against the CQC must-do and should-do actions to ensure that GIDS remains compliant. Where gaps are highlighted or areas of concerns raised, actions are put in place to address these. There are also clear processes for dissemination, learning and feedback through our clinical governance processes. Key areas of quality improvement throughout the year include; • Audit calendar in place in line with CQC regulations • Streamlined approach to supervision and monitoring with benefits to service users of - more robust and streamlined frameworks to the endocrinology pathway; - improved and consistent approach to clinical documentation and communication to patients; - embedding feedback from PPI to improve service delivery	***This has been refocussed for 23/24***

2.2 Our quality priorities for 2023/24

Our priorities for 2023/4 as set out in this Quality Account, have been arranged under the three broad headings which, when put together, provide the national definition of quality in NHS services: patient safety, patient experience and clinical effectiveness. Progress on achievement of these priorities will be monitored during the year and reported in next year's Quality Accounts.

Each of the quality priorities is assigned to a member of the Trust's senior management team to ensure senior leadership, accountability and embedding throughout each of the areas. Progress against the priorities will be monitored though various forums including our internal Quality Report and Quality Committee.

As outlined in section 2.1 above, some of our headline quality priorities from 202/23 will be carried forward into the coming year with an additional two areas added in.

Clinical Effectiveness / Patient Experience		
Priority 1	Equalities	*Builds on Quality Priority from last year*
Clinical Effectiveness / Patient Safety		
Priority 2	Waiting Times	*Builds on Quality Priority from last year*
Clinical Effectiveness		
Priority 3	Outcome Measures	*Builds on Quality Priority from last year*
Clinical Effectiveness, Patient Experience, Patient Safety		
Priority 4	Quality in Gender	*Adapted Quality Priority*
Clinical Effectiveness / Patient Safety		
Priority 5	Endings	*New Quality Priority*
Clinical Effectiveness, Patient Experience, Patient Safety		
Priority 6	Learning	*New Quality Priority*

How we chose our priorities and our targets for success

The priority topics for 203/24 were developed following discussions with our service users and our people, as well as our governors, the Board and our commissioners. In addition we considered current Trust Quality Priorities, service challenges, key performance issues and quality data reviewed and presented to the Board over the past year. Our Quality Committee also held a seminar for its members to debate the proposed priorities and agree the areas of focus.

A number of these identified quality priorities are long-term objectives and we are clear as an organisation that enduring success and impact will take time. There are several sub-projects that will underpin each of these quality priorities and areas of focus may also ultimately change based on the learning from these sub-projects. All such decisions will be subject to internal governance processes.

As some of the objectives are broad it is not possible to disaggregate milestones for improvement throughout the year, however, progress and likelihood of a year-end achievement will be monitored through our Quality Report.

Clinical Effectiveness and Patient Experience

Priority 1: Equalities

The target of this priority is to improve both the collection and processing of data related to protected characteristics but also, more importantly, how we address any identified areas for improvement as a result of that data to ensure we represent the populations we serve in an equitable manner. The actions underpinning this target have been devised building on progress made in previous years and also in line with the expected direction of travel for commissioners CQUIN objectives.

In previous years we have stipulated a specific percentage improvement by which we want to improve the capture of AIS information across the Trust. However, due to the Carenotes outage, the baseline data for 22/23 is not an accurate representation of our performance in Accessible Information Standards (AIS) collection and therefore unstable to base a future percentage improvement on. Instead, we want to make sure that, firstly, our processes to capture AIS information are robust and that our internal systems support staff to do that. This will then support increasing performance for data capture in future years.

Quality Priority 1: Equalities

Targets for 2023/24

- Improve the process by which Accessible Information Standards (AIS) data is captured and recorded

- Use data collected via Experience of Service Questionnaire (ESQ) by protected characteristics *(list to be defined in line with what is collected)* to understand how experiences of services differ, and devise a plan to address any areas identified for improvement
- In collaboration with Quality Improvement, seek to understand barriers within the local community to accessing treatment and develop a quality improvement project that will seek to address these barriers. We will first pilot this is one area to focus efforts and increase impact and learning.

Clinical Effectiveness and Patient Safety

Priority 2: Waiting Times

Waiting times to first and second appointments are a concern which we are fully cogniscent of, across a number of the Trust's clinical services. We understand the impact this can have on patient care, experience and safety; on staff well-being; on the Trust's contractual and financial position; and on its reputation.

This has been a quality priority for the last two years, and progress has been noted as above, however it is also a key Trust strategic objective and so we are now re-focusing this priority to focus on the quality areas. Whilst it is not always simple to broadly 'improve' waiting times due to a number of contributing factors, how we support patients whilst they are waiting, and how any measurable clinical harm as a result of extended waiting times can be assessed, is important and this has been an important area of our focus.

Quality Priority 2: Waiting Times
Targets for 2023/24
• Building on the clinical harm SOP, develop and implement a harm review policy to identify harm in long-waiting patients, recognising learning and any preventative actions
• Improve communications and supportive advice with patients who are on a long waiting list, including further developing digital support

Clinical Effectiveness

Priority 3: Outcome Measures

Building on the developments in the last two years, we are looking to further develop the consistent use and analysis of Outcome Measures (OM) across the Trust in parallel with continuing our use of semi-automated data collection software. Outcome Measures have a number of possible uses including the systematic evaluation of clinical progress, as a means of eliciting self-reported feedback on an individual's mental health state and providing data separately to clinical observations or opinion.

In 2022/23, we focussed on improving consistent, logical collection of OM and having clearly defined mechanisms and accountability for all teams. We also further rolled out the digital provision of the data collection.

We understand that progress in this area is a constantly evolving situation and, as such, we are proposing that Outcome Measures continues to be an area of quality priority focus for the next two years. In the first year, we will work to embed and establish a meaningful data set for outcome measures, that can support us to articulate a measurable improvement for our service users.

Quality Priority 3: Outcome Measures
Targets for 2023/24
• To increase OM returns across all services by 25% above baseline by year end
• Embed and establish a meaningful data set and process for outcome measures, that can support us to articulate a measurable improvement for our service users

- Continue to develop the use of electronic support such as of Qualtrics to other service user completed Outcome Measures across the Trust

Clinical Effectiveness, Patient Experience & Patient Safety

Priority 4: Quality in Gender services

A vast amount of work in relation to improving the quality and safety of the GIDS service has been undertaken since the CQC inspection as outlined above. In recognition of the upcoming transfer of the case load to the new regional hub model, we will continue to ensure that our service users are supported along their pathway.

Quality Priority 4: Quality in Gender Services
Targets for 2023/24
• Continue to support our children and young people in GIDS whilst awaiting transfer of care to the new regional hub model

Clinical Effectiveness, Patient Experience, Patient Safety

Priority 5: Endings

This quality priority will look at a sustainable approach to an exit from specialist mental health services and how these are managed. It is based on feedback from service users in our Trust-wide forum that there are currently perceived inconsistencies in approaches across services. We will first start this piece of work in our Mental Health services. The outcomes of this piece of co-produced work will inform what the objectives of Years 2 & 3 will look like and possible roll out to other Trust services.

Other mental health providers across North Central London are also looking at their processes in place for this and there are discussions underway about how these might be aligned across providers. This quality priority will also support our links with cross-sector workforce.

Quality Priority 4: Endings
Target for 2023/24
• Co-designing and co-producing what an ‘Endings’ strategy looks like with patient groups, making sure our processes and approaches around discharge are correct and consistent

Clinical Effectiveness, Patient Experience, Patient Safety

Priority 6: Learning & the implementation of PSIRF

In line with expectations set out as part of the move to the Patient Safety Incident Response Framework (PSIRF) we will seek to put processes in place that will ensure we are an organisation with a clear and accountable framework to articulate learning and triangulation and to enact change.

PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approached to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

Alongside the implementation of PSIRF, and using key principles from the new framework, we will focus on ensuring that our processes to learn and embed preventative actions are robust and accountable. The Trust’s Quality Management System is currently under review and this will be a major factor in addressing this quality priority.

Quality Priority 6: Learning
Targets for 2023/24
• Review current processes in place for sharing of learning and ensure that these are fit for purpose, including triangulation of key quality metrics, meeting structures to support clinical governance and information flow from service to Board
• Working on the outcomes of this review, develop and embed a clear and accountable structure for learning and triangulation throughout the Trust

2.3 Statements of assurance from the Board

This section contains the statutory statements concerning the quality of services provided by the Tavistock and Portman NHS Foundation Trust in the past year. These are common to all Quality Accounts and can be used to compare us with other organisations.

A review of our services

During the reporting period 2022/23 the Tavistock and Portman NHS Foundation Trust provided and/or sub-contracted 210 contracted services, across three Clinical Directorates, covering 116 clinical teams.

The Tavistock and Portman NHS Foundation Trust has reviewed all the data available to it on the quality of care in these contracted services.

The income generated by the relevant health services reviewed in 2022/23 represents approximately (£60.8m) 90% of the total income (£67.3m) generated from the provision of relevant health services by The Tavistock and Portman NHS Foundation Trust for 2022/23.

Participation in clinical audits and national confidential enquiries

National Clinical Audits and National Confidential Inquiries

During 2022/23 there were no National Clinical Audits directly relevant to health services that the Tavistock and Portman NHSFT provide.

During that period, the Tavistock and Portman NHSFT participated in 100% of the national clinical audits and of national confidential inquiries that it was eligible to participate in.

Local clinical audits

There were 21 local clinical audits undertaken during 2022/23 with 2 audits still in progress. The reports of 21 clinical audits were reviewed by the provider in 2022/23 and the Tavistock & Portman NHSFT has taken or intends to take the following actions to improve the quality of healthcare provided;

1. **Audit of Electronic Patient Records**
   Multiple case notes audits have taken place during the year across all directorates focusing particularly on completion of assessment and risk summaries, crisis plans and care plans. Separate audits of trainee cases notes were also undertaken during the year. The context of the audits was significantly related to remote working during the pandemic and ensuring that case notes were completed according to the standards expected. Areas for improvement were identified and re-audits completed. This work will continue in 2023/24.

2. **Prescribing Audit of Controlled Drugs**
   Two prescribing audits were carried out (Q1 & Q4). The purpose of these audits was to review controlled drugs prescribed at the Tavistock and Portman NHS Trust and to ensure adherence to the 'Prescribing & Administration of Medication Procedure'. There were no significant concerns identified.

   The Q4 audit focus was identifying prescription incidents. Two prescription incidents were identified at the time of this audit. They were both escalated and rectified within a timely manner. The main recommendation remains that the Trust should consider adding e-prescribing to the electronic patient records.

3. **Demographics Audits** to review completeness of demographic data recorded on electronic patient record. Services have reviewed their processes for obtaining this information and made changes to support improvement.

4. **Referral Received Date Audits (Quarterly)**
   Audits to monitor the logging of referral dates and accuracy of the process within intake/administration.

5. **Initial Consultation Document Pilot: Ethnicity and Cultural Needs Audit May 2022**
   This audit was to provide assurance that the service provision is open to all ethnic groups and cultural needs are identified. We also audit regular recording of ethnicity and discussion and identification of cultural identity and associated needs is taking place.

6. **GIDS clinical notes audit**
   The audit was completed following a CQC inspection, where a number of areas were identified for improvement in record keeping activities. The CQC noted that these areas were often absent from the clinical record. Since the inspection, work has been undertaken with staff to raise the standards of documentation in these key areas, and they are now part of routine recording. The auditors also checked whether the notes were written and confirmed within three days of appointment with the young person. The auditors then scored the quality of the documentation using the CQC's scoring system.

7. **Case Notes Audit of Clinical Trainees in CYAF**
   All clinical Trainees should follow the guidance on the Health Records Management Procedure when recording patient clinical notes on Carenotes. The Trust undertakes an annual review of case notes to ensure that the highest quality of record keeping is maintained. Each year the audit focusses on a different aspect of record keeping. This 2022/23 audit is focussed on the completeness of case notes by clinical trainees.

   All clinical Trainees should complete an "Assessment Summary Under 18 Years" on Carenotes once assessment with a patient has been completed. The 'Assessment Summary' covers various sections including a risk assessment and Care Plan. The care plan outlines whether treatment plans have been discussed with the patient as well as whether there has been an alternative treatment plan discussion. The risk assessment consists of various categories which can be marked as none, mild, medium and severe. If a patient is marked above two milds or one moderate on any of the categories a crisis plan must be completed.

8. **Initial Consultation Form Pilot: Physical Health Care Audit – Gender Service**
   The Initial Consultation Pilot ran from September 2021 to April 2022. Its aim was to ensure;
   - The requirement of the assessment process within GIDS were clearly described.
   - That assessment information was collected and organised in a consistent and standardised way.
   - To provide assurance that key physical health and wellbeing needs are identified at initial assessment.

<u>Ongoing projects</u>

Psychosocial development of transgender youth accessing a UK gender identity developmental service.

The proposed study will give an insight into the young person's psychosocial wellbeing and social responsiveness, and how this is influenced by clinical engagement with the young person. In this sense this research could provide valid insight into the impact of clinical practice on well-being without medical interventions. The research will look at internalising, externalising, and suicidal behaviour, general well-being, as well as traits related to autism, and social functioning. This project is ongoing and is due for completion in June 2023

Assessment of baseline information prior to starting HRT and monitoring after starting HRT at GIC

As a tertiary specialist gender service, the primary role of the GIC is to assess patients for gender incongruence and dysphoria and, if indicated, to recommend gender-related treatment and interventions. Due to the national reach of our service, and the commissioning arrangements and service specification, we then rely heavily on our GP and other colleagues in primary care to arrange baseline blood tests and investigations, prescribe hormone treatment and monitor treatment with input and support from our specialist service. The aim of this project is to quantify the completeness of the baseline information and blood testing and monitoring of HRT in the first year of treatment and is due for completion in June 2023.

Retrospective audits

The following audits were completed in previous years but due to delay in reporting to the Trustwide system they are being included in this year's report for completeness.

- **Audit of Safeguarding Supervision of Young people on a Child Protection Plan (GIDS)**
  This audit was a CQC priority and was conducted at the request of the GIDS Safeguarding Lead. The aim was to establish whether the 7 young people who were on a CPP (child protection plan) during financial year 2021- 2022 received at least quarterly supervision.
- **Re-Audit of Safeguarding and Risk Assessment GIDS**
  The GIDS Safeguarding Standard Operating Procedure (2019), in use at the time of the November 2021 audit, states that a safeguarding and risk form under 18s on Carenotes must be at least partially completed after the 1st appointment in all cases and updated regularly whenever new risks are identified. This report is a follow up audit of those cases without a safeguarding and risk form under 18 at the time of the November 2021 audit for assurance of completion.
- **GIDS consent audit**
  The audit was carried out between September 2020 and March 2021. This audit was conducted as part of GIDS' audit schedule and adheres to the audit plan as outlined in the GIDS Consent, Capacity and Competency Recording Standard Operating Procedure (SOP) 1.0 (January 2020).
- **Retrospective Audit of Informed Consent for a Referral to the Endocrine Clinic to Consider Treatment with Puberty Blockers (GnRHA) retrospective audit**
  Following a planned inspection of the Gender Identity Development Service for Children and Young people (GIDS) in November 2020 the CQC requested a review of young people attending the endocrine clinics in London and Leeds, who had been referred prior to the implementation of the GIDS consent and competency recording standard operating procedure in January 2020, to ensure the appropriate consent had been documented.
- **GIDS Safeguarding Audit - completion of Safeguarding & risk form and Safeguarding Supervision form**
  Retrospective audit from 2021. This audit was conducted as part of GIDS' regular audit schedule outlined in the GIDS Safeguarding SOP v1.1 (Jan 2020).

Below is a summary of actions taken or due to be taken to improve the quality of care that our Trust provides;

- Re-auditing electronic patient records to ensure completion of sections on risk. Feedback will be provided to relevant service lines. There is an ongoing programme of case notes audits which can be targeted depending on findings.
- Training on clinical audit methodology has increased and will continue to be provided.
- Reviewing Trust wide structures and processes for safeguarding supervision.
- Work is ongoing to integrate clinical audit and Quality Improvement (QI) and to consider how QI and clinical audit work best together at a local level.
- As part of planning for 2023/24 we are considering how clinical audit can be integrated and strengthened within the new Patient Safety Incident Response Framework (PSIRF).
- Continue to use audit methodology as a framework for learning from incidents.
- Enhance processes needed to evidence improvement from audit.
- The Trust's Quality Management System is currently under review with the aim of optimising processes including audit logging and monitoring of action plans.

Participation in clinical research

The Trust is one of the leading mental health Trusts across the country for research, and its performance across key research domains are highlighted below.

Between the beginning of April 2022 and the end of March 2023, 21 participants have been recruited to 1 research study in the Trust. The recruiting study for the Trust during the 2022/23 financial year is detailed below.

Recruiting Study Name	IRAS	Recruitment Numbers
Young People Distressed by Gender-related Dysphoria: a qualitative study exploring the perspectives of young people, parents/carers and care professionals	306023	21

The Tavistock & Portman NHSFT has been successful in securing grant funding to host the following studies which are due to begin recruitment imminently and feed into 2023/24 data.

Study Name	IRAS	Recruitment Target
NIHR Research for Patient Benefit scheme. 'A feasibility trial of remotely delivered Video Interaction Guidance [VIG] for families of children with a learning disability referred to specialist mental health services.'	315829	50
What Works for Children's Social Care. 'Watch me Play: a Randomised Controlled effectiveness Trial of a remotely-delivered intervention to promote mental health resilience versus treatment as usual for children (age 0-8) across UK early years and children's services.'	129095	439
NIHR Programme Grants for Applied Research. 'Personalised Assessment and Intervention Packages for Children with Conduct Problems in Child Mental Health Services'.	268597	246

Recently awarded grants in collaboration with Tavistock and Portman NHS Foundation Trust

- NIHR Invention for Innovation (i4i) scheme. 'OliTool: a 'smart' system to support primary school children develop social and emotional literacy and self-regulation skills for mental health and wellbeing'.
- UKRI ESRC (Economic and Social Research Council). 'Markers of Autism and Gender Incongruence in Children (MAGIC): Cognition in Autistic and Non-autistic Gender-incongruent Children and Their Families.'

Goals agreed with commissioners for 2022/23

The use of the Commissioning for Quality and Innovation (CQUIN) payment framework; Tavistock and Portman NHS FT income in 2022/23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework due to the size of our contracts.

Regulatory compliance – Care Quality Commission (CQC)

The Tavistock and Portman NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is full registration with conditions, for a single regulated activity "treatment of disease, disorder or injury".

The Trust has continued its comprehensive action plans in relation to recommendations issued by the CQC, both in relation to the Trust-wide inspection and other focused inspections to individual services and teams.

A focused inspection was undertaken by the CQC in January 2023 of our community forensic services (Portman Clinic) and community CAMHS services (North and South Camden CAMHS and Camden Adolescent Intensive Support Service (CAISS). Our overall rating remains Good however in the individual domain of Safe, in the community CAMHS service our rating changed from Good to Requires Improvement (specifically related to MAST completion in South Camden CAMHS). Action plans have been put in place with immediate effect to address the must and should do recommendations that were identified.

Positive practice and outcomes were identified in both services that were inspected. This included;

- ***At the Portman Clinic*** – service users felt supported and safe and that all staff treated them with kindness, compassion, and respect; staff knew how to recognise adults and children at risk of harm and worked with other agencies to protect them; the service took account of people's individual needs and made it easy for them to give feedback; people could access the service when they needed it and did not have to wait too long for treatment.

- ***At the community CAMHS services*** – assessments and treatment for crisis were prompt; communications and online support services were age-appropriate and adapted to accessible needs; the premises were accessible for people with physical disabilities.

The full reports for both inspections are available on the CQC website, www.cqc.org.uk .

The CQC's assessment of the overall Trust has remained as Good since November 2018, with the individual domain ratings as below.

Data security and quality

The Tavistock and Portman NHSFT did not submit records during 2022/23 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This is because The Tavistock and Portman NHSFT is not a consultant-led, nor an in-patient service.

The last Data Security & Protection Toolkit submission was made in June 2022. The resulting status following that submission was 'Standards Not Met', with an amended status (on approval of the Data Security Improvement Plan') is 'Approaching Standards'. The next Data Security & Protection Toolkit submission is due in June 2023.

The main reason for the 'approaching standards' categorisation is that the uptake of training for IG & Data Security compliance is underperforming against the target.

The Tavistock and Portman NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23.

Data Quality Maturity Index (DQMI)

The Data Quality Maturity Index (DQMI) is a monthly publication from NHS Digital about data quality in the NHS and is intended to raise the profile and significance of such matters. It is based on the completion of agreed data items which include NHS number, date of birth, gender, postcode, specialty and consultant.

DQMI – Data Quality Maturity Index	Q1 2021/22	Q2 2021/22	Q3 2021/22	January 2022
Tavistock and Portman NHS FT	**97.1%**	**96.9%**	*Not Submitted*	*Not available yet*
National Average	**81.0%**	**81.7%**	*Not submitted*	*Not available yet*

N.B. Due to Carenotes outage, Q3 submission returns still outstanding

The importance of having high quality data on which to base decisions, whether clinical, managerial, or financial, is recognised by the Trust. An ongoing focus on having robust systems, processes, data definitions and systems

of validation helps assure us of our data quality. Whilst the Trust has key processes in place for assuring the quality of data it recognises that further work is required, particularly in respect of timely data submissions by staff, and further improving data validation and completeness.

Trust Developments - Infrastructure and Results

Significant work has been undertaken over the last few years to improve data validation across the Trust. This has included changes to Carenotes forms, the updating of protocols and data collection tools in order to support communication and information requirements of staff and service users. One of the areas of focus during 2021/22 was improving governance processes around the completion of Assessment Summary forms for under 18s. During 2022/23 we extended this review to the Assessment Summary forms for over 18s.

The new monitoring process for flagging up incomplete and missing forms has been reinforced during 2022/23. These consist of a series of simple reports which allow local teams to access and manage their own data with a focus on contemporary cases. However, ingraining the usage of these tools was hindered by the impacts of the CareNotes outage during the year.

Following the CareNotes outage, the Trust established a Data Recovery Project Group. This team has been meeting on a regular basis since the system was restored. The system outage had a clear impact on data quality however there has been an important Trust-wide effort to correct the situation and, as a result of this, the data has been improving on a weekly basis. The project has not yet been fully completed but the progress achieved has been significant.

The initial focus has been on updating appointments activity and outcoming appointments. This work included Clinical Notes and improving the governance around them. The Trust reinforced the training materials and raised awareness of expectations around completeness of Clinical Notes. A new report to monitor clinical notes was also deployed and we hope that this new tool will have a positive and sustained effect on our completion rates and patient safety. As the retrospective activity has been restored, we have started to evaluate clinical assessment forms due for completion and the review of active caseloads.

One of the most significant successes achieved during 2022/23 has been the improvement on Care Plans completion rates for under 18s. The improvements implemented on the Assessment Summary and Review Forms for under 18s are directly linked to the completion of Care Plans. The result is a more robust system supported by new reports and a more efficient administrative process. This then translates into an increase in completion rates on Care Plans - an 11% increase on Initial Care Plans and an 8% increase in Review Care Plans.

	2019/20	2020/21	2021/22	2022/23
Initial Care Plans	**47%**	**52%**	**52%**	**63%**
Review Care Plans	**24%**	**38%**	**25%**	**33%**

Over the year a strategy to improve the completion rates of Crisis Plans has also been developed, which has resulted in significantly improved compliance rates.

In terms of technological developments, we have some exciting projects being developed that are scheduled over the next financial year:

- To continue to develop and improve the Power BI Dashboard. This year we deployed the first phase including monitoring referrals and appointments. Over the next 12 months we plan to encourage use, improve awareness and training. The scope will also be expanded to cover more performance and quality parameters.
- To grow the number of targeted and automated reports that have been set up, to allow teams to have real-time access to their own data on a number of metrics
- To expand usage of Qualtrics, as a tool to improve our Outcome Measures collection rates.
- To continue improving CareNotes forms and interfaces to improve the administration process and data quality.

Quality Assurance Work

- The Quality Assurance Team maintain a presence at Clinical Governance Meetings across the Trust to ensure that data quality and reporting considerations are factored into conversations where appropriate. Key performance and quality reports are presented on a monthly basis, assessing progress achieved or highlighting areas for improvement.
- There are a series of scheduled notifications sharing information on data quality performance with general management and other key staff
- The validation of data and checks on the completeness and accuracy of data as outlined in the Trust's Clinical Data Quality Management Procedure
- The use of standard operating procedures (SOPs) for data collection, validation and reporting to support the quality of data by the Quality Assurance Team and services

Training and Education

- Mandatory training on our electronic patient administration system (Carenotes) and outcome monitoring has been a success and continues with recently updated training materials available to all teams. The new materials on Clinical Notes are essential to ensure good quality data is entered to enable robust reporting.
- An updated set of Outcome Measure training tools designed and incorporated into new starters induction schedules
- The informatics department shares with all Care Notes users 'Top Tips' on how best to use the system on a regular basis.
- Ongoing support of services by the Quality Assurance Team to deliver improvements in relation to CQUINs, KPIs, locally agreed targets and where data quality issues are identified. This includes the provision of monthly team reports on missing data in order to improve data completeness for reporting purposes.

Patient safety incidents resulting in severe harm or death

In respect of patient safety incidents, the Trust does not report enough incidents to be included in the national report. Trust information over time is reported below. The Trust is exempt from the National Patient Experience Survey for community mental health services but undertakes a similar internal survey which is reported below.

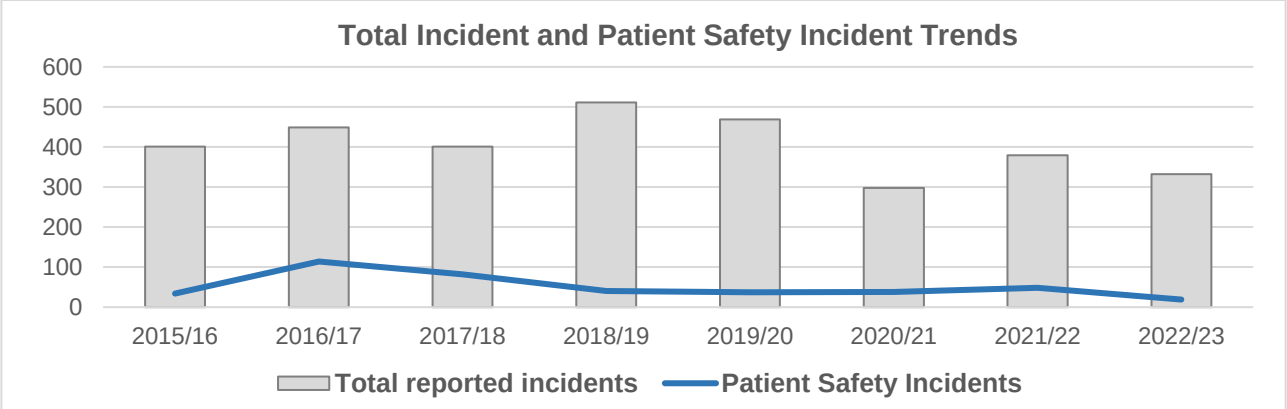
Patient Safety Incidents (PSIs)

The number and rate of patient safety incidents reported within the Trust during 2022/23 are below.

During the past year we submitted 19 incidents to the National Reporting and Learning System (NRLS) from no harm to severe harm or death.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total reported incidents	401	449	401	511	469	298	379	**332**
Patient Safety Incidents	34	114	82	40	37	38	48	**19**

Source: Quality Portal (QP), PSIs reported 1 April 2022 to 31 March 2023



Patient safety incidents are uploaded to the National Reporting and Learning System (NRLS) for further monitoring and inter-Trust comparisons which promote understanding and learning. Currently there is no nationally established and regulated approach to the reporting and categorising of patient safety incidents so different Trusts may choose to apply different approaches and guidance when reporting, categorising and validating these.

The Tavistock and Portman NHSFT considers that this data is as described for the following reasons:

- The organisation provides outpatient psychological therapy services only and no physical interventions
- The majority of patient safety incidents reported resulted in no harm
- All deaths of Gender patients, even if on a waiting list / not yet seen, or not discharged are reviewed
- The importance of incident reporting and learning is promoted across the Trust in order to support the management, monitoring and learning from all types of incidents. Staff are reminded of this at induction and training events and lessons are shared using a variety of methods
- Data for this indicator is derived from the Quality Portal, our internal electronic patient safety software
- All clinical incidents are reviewed, and action taken if required by the Patient Safety Lead (Associate Medical Director
- The Trust's Quality Committee receives information on significant incidents from relevant reporting groups on a quarterly basis
- There is a monthly Incident Panel chaired by the Medical Director where all serious clinical and non-clinical incidents are shared and discussed
- A 'learning lessons' event is convened at least quarterly by the Medical Director and open to all staff.

Learning from Deaths

Policies are in place supporting the Trust response to deaths of patients under the care of the Trust or on waiting lists for Trust services. An incident form is completed for all patient deaths and recorded on the Incidents/Serious Incidents section of the Trust incident reporting system (Quality Portal). When a death has been reported it will be reviewed by the Medical Directorate office and a decision made about the requirement for a mortality review report, a concise report or, if indicated, a serious incident investigation. All deaths are subject to review at the monthly Incident Panel chaired by the Chief Medical Officer.

The Trust also reviews deaths of former patients within six months of discharge. Deaths outside of this time frame may be logged on the Quality Portal for information rather than investigation.

Duty of Candour obligations are fulfilled with careful consideration of the needs of family members, particularly if suicide is the suspected cause of death. The Trust ensures that the deceased person's GP is aware of the death. In addition, the death is reported to other relevant organisations that may have an interest.

Serious Incidents: Serious incidents are investigated according to the Trust Procedure for the Investigation of Serious Incidents and are reported on the Strategic Executive Information System (StEIS, NHSE). This system facilitates the reporting of serious incidents and the monitoring of investigations between NHS providers and commissioners.

Concise reports: These are internal reports required following the unexplained and/or untimely death of a patient. Such reports are also requested for any incident that should be reviewed but where the Trust is not required to lead a serious incident investigation. Concise reports may also be uploaded to the Strategic Executive Information System (StEIS). The report includes details of the most recent risk assessment, any safeguarding concerns, details of the incident if known and of any relevant antecedents. The clinician must give an account of actions taken, any support offered to the family and to staff. Duty of Candour is applied where appropriate. An action plan is completed.

Initial learning from incidents is documented to prompt the team/service line to consider if there are actions that should be applied immediately. It is anticipated that any learning will be augmented through further discussion at the monthly Incident Panel meeting and at any subsequent learning lessons events.

The key questions being addressed in a concise report and in a serious incident investigation are the following:

- Was the death predictable and if so, were any indicators not identified and/or not acted upon?
- Was the clinical care that was delivered appropriate?
- Was the clinical care given by an appropriate person(s)?
- Would the clinical staff have done anything differently as a result of participating in the analysis?
- What lessons have the clinical staff taken from the incident?

Mortality Reviews: These are brief reports, requested when the death of a patient seems likely to be from natural/medical causes not related to care. These reports have basic details about what was known about the patient and seek an opinion from the clinician on preventability and/or predictability.

The Trust works jointly with other health care providers to review the care provided to people who are current or recent past patients.

During 2022/23 the Trust was notified of 47 patients' deaths (patients known/or on waiting list or within 6 months of discharge). This comprised the following number of deaths which occurred in each quarter of the reporting period:		**Numbers of actual deaths within quarter**
Quarter 1	9	6
Quarter 2	13	5
Quarter 3	8	No confirmed data as yet
Quarter 4	17	No confirmed data as yet

The figures in the table above represent the number of patient deaths the Trust came to know about in each Quarter rather than accounting only for the number of deaths that occurred in each quarter. The second column shows the confirmed deaths within quarter. The data is incomplete due to the delay in receiving confirmation of dates of death and causes.

By 31 March 2023, 13 concise reports and 15 mortality reviews were discussed at the incident panel. The number of deaths in each quarter for which a case record review or an investigation was carried out was:	
Quarter 1	6 x concise reports and 3 x mortality review
Quarter 2	3 x concise reports and 6 x mortality reviews and of these 1 x serious incident investigation (StEIS logged)
Quarter 3	3 x concise reports and 3 x mortality reviews and of these 1 x serious incident investigation (StEIS logged)
Quarter 4	1 x concise reports and 3 x mortality reviews

Several reports from Q4 are pending and will come for discussion at Incident Panels during Q1 2023/24. A key issue is determining the likely cause of death in order to complete the most appropriate report. It is often difficult to obtain this information.

Inquests that took place: The Trust may not necessarily be informed that an inquest has taken place and clinicians may not have been requested to provide witness statements to the Coroner.

Trust clinicians have given evidence as witnesses at two inquests during 2022/23.

In Q4, 2022/23, The Trust received a Regulation 28: Report to Prevent Future Deaths in relation to a patient on a waiting list for a Trust service who died in 2021.

An inquest pertaining to a patient known to the Trust, which had been due to take place in late 2022, was adjourned.

No cases during the reporting period are judged more likely than not to have been due to problems in the care provided to the patient.

Actions taken in the reporting period:

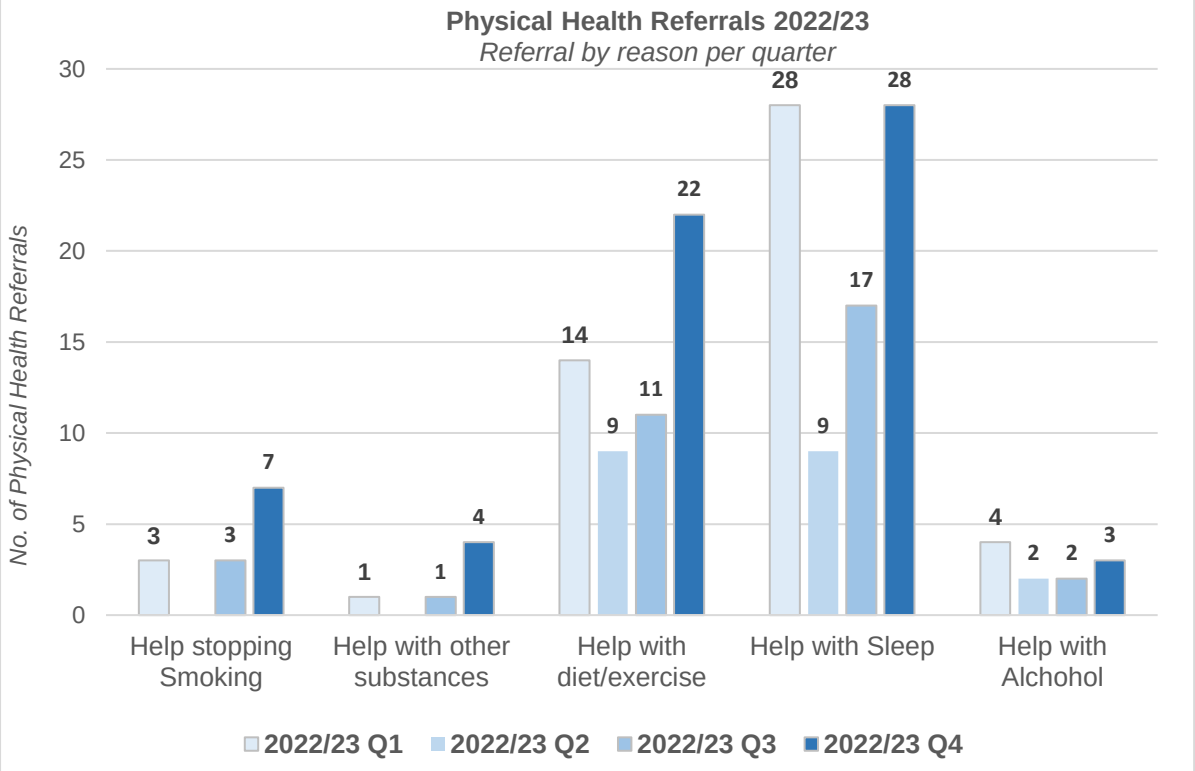
- An incident panel is convened monthly, chaired by the Chief Medical Officer. All deaths are discussed, and any reports reviewed. Action plans are brought back for review and updating.
- There is a programme of learning lessons events during the year, some of which pertain to learning from deaths.
- The Trust's Local Risk Management System (LRMS) will be replaced during 2023/24. Procurement of a new system is scheduled for Q2 2023/24

Improving the physical health of patients

The Living Well Service has provided evidence-based treatment for smoking, drinking, substance use, healthy weight and sleep for all patients aged 13 years and above on an active caseload within our Trust. This programme of work was led by the Physical Health Specialist Practitioner (PHSP) and a Lead Administrator who processes the referrals (through completion of the Physical Health form), offered triage and short term intervention around sleep hygiene and diet and exercise (smoking and drug/alcohol support was referred onto locality specialist services).

The PHSP (filled between May-December 2022) and Lead Administrator role have now been vacant since December 2022 and referral data has not been available since August 2022 when the access to the Carenotes system was affected by the cyber incident. Given the historic challenges with recruitment and retention to the PHSP role and a need for strategic thinking about this service, we have decided to take this opportunity to have a new look at what physical health provision we offer our patients. A co-produced project plan is being put together to actively engage stakeholders to think about What service/provision do we need? What do our patients want? What would this look like? What is realistic? What is best practice? We will work on this project throughout the coming year and aim to have an agreed direction of travel implemented by Q4 23/24.

Over this period signposting advice for available local services is also provided to referring clinicians to pass onto patients on the Intranet.



Reporting against core indicators

We are required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. In respect of patient safety incidents, the Trust does not report enough incidents to be included in the national report for comparison but provides information over time. The Trust is exempt from the National Patient Experience Survey for community mental health services but undertakes a similar internal survey which is reported below.

Patient experience

In 2022/23, 95% of patients reported positive feelings about their experience of care/treatment

	2022/23			
	Q1	Q2	Q3	Q4
Positive responses relating to experience of care/treatment	**97%**	**90%**	**100%**	**96%**

Numerator = 'Good + 'OK' Denominator = 'Good' + 'OK+ 'Not Good' + 'Don't Know'.
Source: Quality Team, Data received and calculated: 06/04/2023

The Tavistock and Portman NHSFT considers this data is as described for the following reasons: the questions included in the Trust Experience of Service Questionnaire (ESQ) are completed by patients seen in the Trust to obtain feedback on their experience of our services. This information cannot be directly compared with the questions derived from the National Patient Experience Survey for community mental health services however, we would score very positively for patient experience when compared to other mental health trusts.

	Yearly Averages								
	2014/15	*2015/16*	*2016/17*	*2017/18*	*2018/19*	*2019/20*	*2020/21*	*2021/22*	*2022/23*
Positive responses relating to experience of care/treatment	**92%**	**94%**	**93%**	**99%**	**98%**	**97%**	**98%**	**95%**	**95%**

Patient & Public Involvement (PPI) Updates

The PPI team is a small team that works collaboratively across our Trust departments and with community colleagues to embed involvement in clinical and educational work and in the business as usual of all departments.

A useful definition of patient and public involvement, and one that we use at the Tavistock and Portman NHS Foundation Trust, is that PPI is work with communities, patients / service users, families, and carers, which specifically refers to their rights and benefits in having a say in their health care.

The PPI team influence service design and development, help support staff recruitment, continuing professional development and training and provide expert consultancy on the development of policies, procedure and practice.

Over the past year there have been significant developments within the PPI team and in the wider Trust.

The Trust has continued to deliver its clinical and education services during the pandemic with services increasingly keen to build PPI work into the 'business as usual' of operations and some of the most significant activities are outlined in this report.

The most significant activity for work of the PPI team over the past year and into 2023 is the strategic review of services which has recently been completed. The strategic review acknowledges the value of the Trust PPI work and further extends our ambitions for it. This work will be strengthened through a slightly amended team structure and the proposed changes in clinical services will ensure that patient involvement work is everyone's business. All clinical, clinical administrative and operational staff will need to ensure they are tending to patient experience as a core aspect of good governance. Managers will need to routinely review how this focus is kept through the PPI resource so that we can make a step change in our ambition and achieve greater co-production with service users

and think creatively about how we might attract people with lived experience into employed roles in the Trust at all levels.

Employing service users on our interview panels has been one of the most successful pieces of work for patient and public involvement to date. This work embodies principles of co-production and the process recognises the value of lived experience within mental health development. We have seen a shift in organizational culture as Trust staff have become more familiar with the benefits and rewards of having service users' input on panels. The training of service users and families is undertaken by the PPI team and experienced service user representatives who have previously been on our interview panels. The training has been updated and co-produced with one of our service users co designing the programme. This work supports employment and educational opportunities for our service users.

Other training opportunities have been in employing visiting lecturers to teach on professional training programmes and this work is being extended this year. The PPI team have a trust repository on Moodle of resources for staff in involvement work which can be accessed and used by our teaching staff to inform educational programmes.

The work of training staff in involvement and co production is ongoing.

The PPI team work alongside clinical colleagues and various projects in clinical services include:

- Update of the Trust website
- The Waiting List app. This has been consulted on and co designed with service users.
- The City and Hackney PPI group
- Turkish Men's Project
- Trauma Panel and Peer Support Workers in Trauma
- Focus Groups in Children and Young Adults services
- GIDS PPI Stakeholders Group and PPI staff team (GIDS clinicians giving some time weekly to PPI)
- GIC forum
- GIC website update group with comms (underway)
- Service user inspectors were involved in a mock CQC inspection in the trust.
- NCL wide co production working group
- Camden Co production Alliance (adults)

System Oversight Framework Indicators

The Trust has a range of NHS England (NHSE) targets on which we report throughout the year and which form part of the System Oversight Framework (SOF), used by NHSE to detect possible governance issues and identify potential support needs. Such information, including Mental Health Services Data Set (MHSDS), and operational performance information is presented quarterly to the Board alongside formal complaints, staff Friends and Family Test (FFT) findings and actions and patient safety incidents.

MHSDS System Oversight Framework Indicators	Target %	Q1	Q2	Q3	Q4
Valid NHS Number	95%	99.33%	99.40%	Carenotes outage	99.42%
Valid Postcode	95%	99.68%	99.66%	Carenotes outage	99.65%
Valid Date of Birth	95%	100%	100%	Carenotes outage	100%
Valid Organisation Code of Commissioner	95%	99.18%	99.23%	Carenotes outage	99.12%
Valid Organisation Code GP Practice	95%	99.08%	98.94%	Carenotes outage	98.95%
Valid Gender	95%	100%	100%	Carenotes outage	99.98%
Ethnicity	95%	91.61%	92.03%	Carenotes outage	87.00%
Employment Status (for adults)	85%	64.81%	65.61%	Carenotes outage	58.57%
Accommodation Status (for adults)	-	64.89%	65.12%	Carenotes outage	57.65%
Primary Reason for Referral	-	100%	100%	Carenotes outage	100%
Ex-British Armed Forces Indicator	-	84%	85%	Carenotes outage	87%

MHSDS Data is published monthly. Quarterly data is represented by April, July, October and January figures.
Q2 – Please note this data is from July Primary. We were not able to run July Refresh data because of the Carenotes Outage
Q3 – Please note we don't have data for October due to the Carenotes Outage

Ethnicity compliance rates has been one of the most challenging MHSDS and DQMI data indicators as the target has increased to 95%. Thanks to the hard work of clinical and support services over 2021/22, the majority of our services improved their ethnicity completion rates. However, during 2022/23 the Carenotes outage affected our ability to collect and input this data. We are expecting to see a gradual improvement over the next few months as the services go back to business as usual.

Part 3: Review of quality performance

Quality of care overview: performance against selected indicators

This section contains information on the quality of services provided by the Tavistock and Portman NHSFT during 2022/23, describing the Trust's progress against indicators selected by the Trust Board in consultation with service users.

This includes an overview of the quality of care offered by the Trust based on our performance in 2022/23 on a number of quality indicators selected by the Board in consultation with internal and external stakeholders. At least three indicators for each of the three quality domains of patient safety, clinical effectiveness and patient experience are included. Where possible, we have included historical data demonstrating how we have performed at different times and also, where available, included benchmark data so we can show how we have performed in relation to other trusts. Indicators include those reported in the past three years.

The Trust Board, the Quality Committee, along with North Central London Integrated Care Board (ICB) and our clinical commissioners from other boroughs have played a key role in monitoring our performance on these key quality indicators during 2022/23. Monitoring has also been undertaken through our divisional quality review monitoring, operational clinical governance and quality improvement processes.

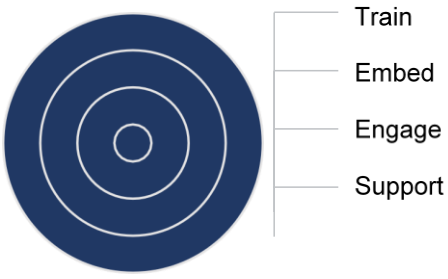
Quality Improvement (QI)

Quality Improvement (QI) at the Trust is focused on improving patient outcomes, system performance and professional development. At the heart of our approach is our strong commitment to improving patient experience and outcomes, and our belief that quality improvement is about both relationships and the effective use of proven methodology. We therefore seek to engage with, and respect the views of, staff and patients, as well as using well evidenced and structured tools and methods. QI support structures are actively in place to enable staff to become actively involved in this approach and for it to become part of everyday work.

The Trust is committed to continually improving the quality and experience of care for patients and staff by fully embedding quality improvement in all its work. We do this by supporting and encouraging teams and clinicians to use QI methodologies to identify improvement needs and address challenges and issues.

Quality Improvement draws on a wide variety of methodologies, approaches and tools but the Trust primarily advocates the use of the IHI Model of Improvement with its Plan, Do, Study, Act (PDSA) approach of small scale testing and change. This approach is supported by the Director of Quality and the QI Operational Group.

In line with the strategy, our QI objectives for 2022/23 continued to be:



- **Train** *Staff and patients are trained in Quality Improvement methodology*

- **Embed** *Quality Improvement is built into Trust Infrastructures*
- **Engage** *Calendar of events keeps everyone aware of QI developments*
- **Support** *Staff have places to take their ongoing development needs*

With an ever-changing health and social care landscape this approach has been helping us to develop high quality clinical services which are tailored to our patients' needs. There have been continuing improvements and growth in delivering quality improvement (QI) across the Trust over the past year. There are a number of active QI projects across the Trust and there are QI forums across the Trust to support these;

- Gender - 3 active projects, including dormant cases and staff wellbeing
- Complex mental health - 6 projects
- Community & Integrated - 11 projects, including psychiatry consultations, equality of access to services, reducing not attended appointments
- Department of Education & Training - 2 projects, including one on academic misconduct

There are Associate QI Leads across areas of the Trust who are supported by Associate Directors for QI. There are QI vacancies in some areas which are all actively being recruited to. While the vacancies have affected the delivery and impact of QI work across the Trust during the year, a fourth QI training event was held in April 2022 and we are aiming to roll out a further event in 2023/24. A total of 116 staff across the Trust have been trained so far.

Patient Safety

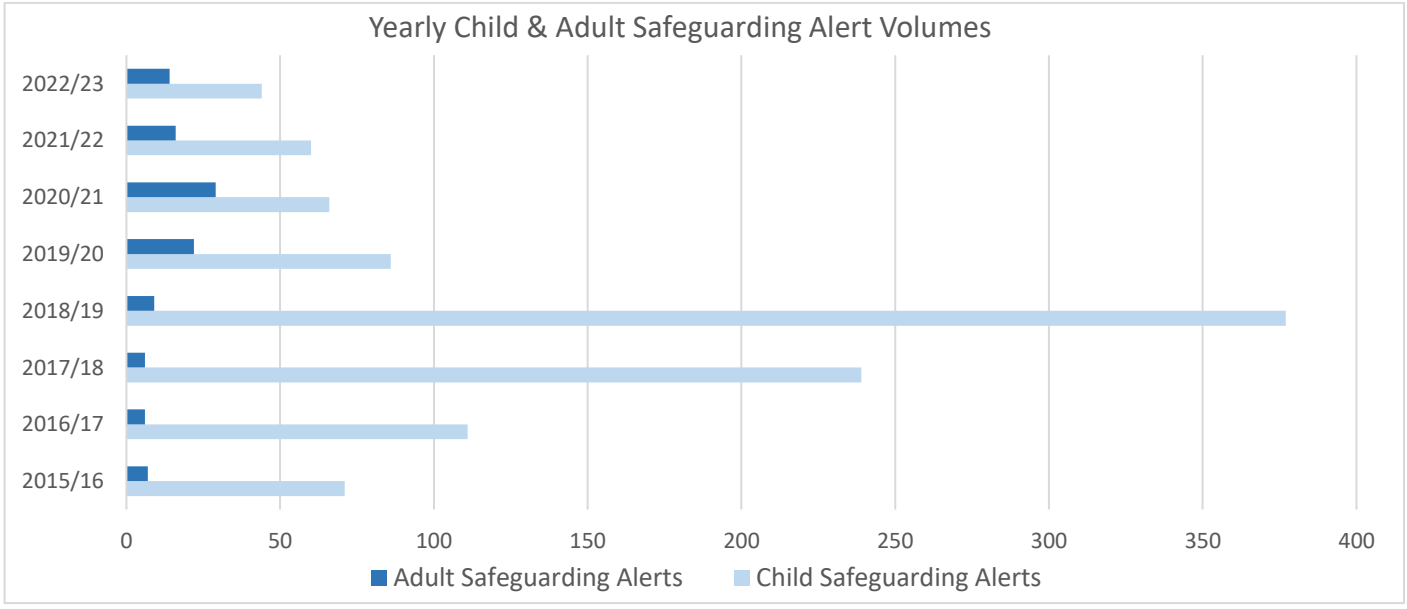
Patient Safety Incidents (PSIs)

This information is included on page 18 of this document.

Safeguarding

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Child Safeguarding Alerts	71	111	239	377	86	66	60	44
Adult Safeguarding Alerts	7	6	6	9	22	29	16	14

Source: Clinical Governance Report



Children safeguarding
The 2022/23 children's safeguarding data shows a further slight drop in referrals compared to 2021/22 and 2020/21. The explanation may relate to the aforementioned issues with accessing Carenotes, but also due to the fact that the threshold for referral has been reviewed. Staff are advised to contact the safeguarding lead for advice before creating an alert.

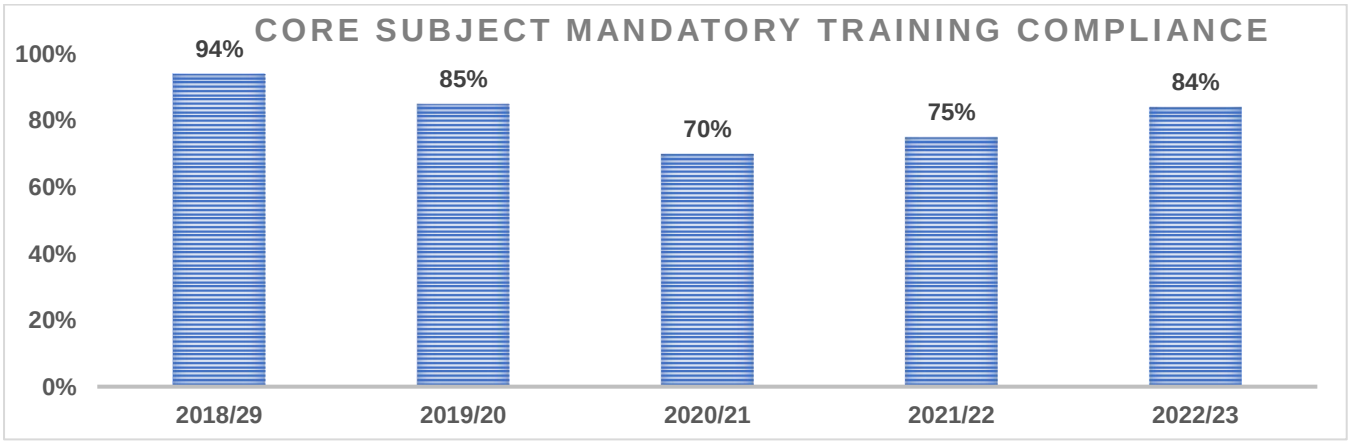
Adult safeguarding
The number of adult safeguarding concerns during 2022/23 is only slightly lower than the previous year 2021/22, which is an achievement given the challenges in recording on Care Notes.

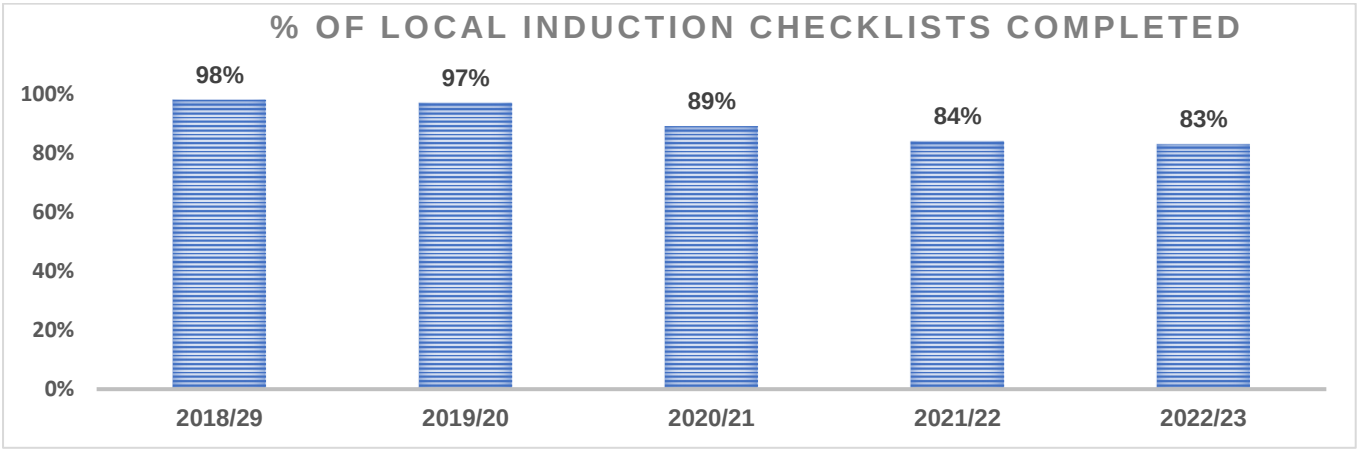
There have been seven sessions of Safeguarding Adults Level 3 training delivered during 2022/23. The work undertaken by the Adult Safeguarding Lead and the Patient Safety Officer to raise awareness on the importance of recording concerns has continued throughout the year.

Mandatory Training 2022/23

	2018/19 Overall Figures	2019/20 Overall Figures	2020/21 Overall Figures	2021/22 Overall Figures	Quarter 1 *(Apr – Jun 22)*	Quarter 2 *(Jul – Sep 22)*	Quarter 3 *(Oct – Dec 22)*	Quarter 4 *(Jan – Mar 23)*	2022/23 Overall Figures
Core Subject Mandatory Training Compliance	94%	85%	70%	75%	*86%*	*84%*	*85%*	*81%*	**84%**
Local Induction Checklists Completed	98%	97%	89%	84%	*82%*	*83%*	*86%*	*82%*	**83%**

Source: Electronic Staff Record





Every member of staff employed by the Trust is required to be compliant with a range of mandatory and statutory training requirements. The organisation has a consistent approach and has adopted the requirements and curriculum for each topic area in line with our partner Trusts in North Central London. The Trust has continued to accept training delivered

at other NHS organisations for the purpose of consistency. The Trust, along with many other Trusts, has changed the method of training delivered from face-to-face (classroom based) to online e-learning modules through the Oracle Learning Management (OLM) module of the Electronic Staff Record (ESR). The staff member's personal ESR self-service account also provides data including current compliance rate and completion / expiry dates of modules. This approach has enabled staff members to complete training as and when required at their own pace and within the comfort of their own homes.

Compliance throughout 2022/23 has improved on the previous year, which had been lower than expected due to the pandemic.

Disclosure and Barring Service (DBS) compliance 2022/23

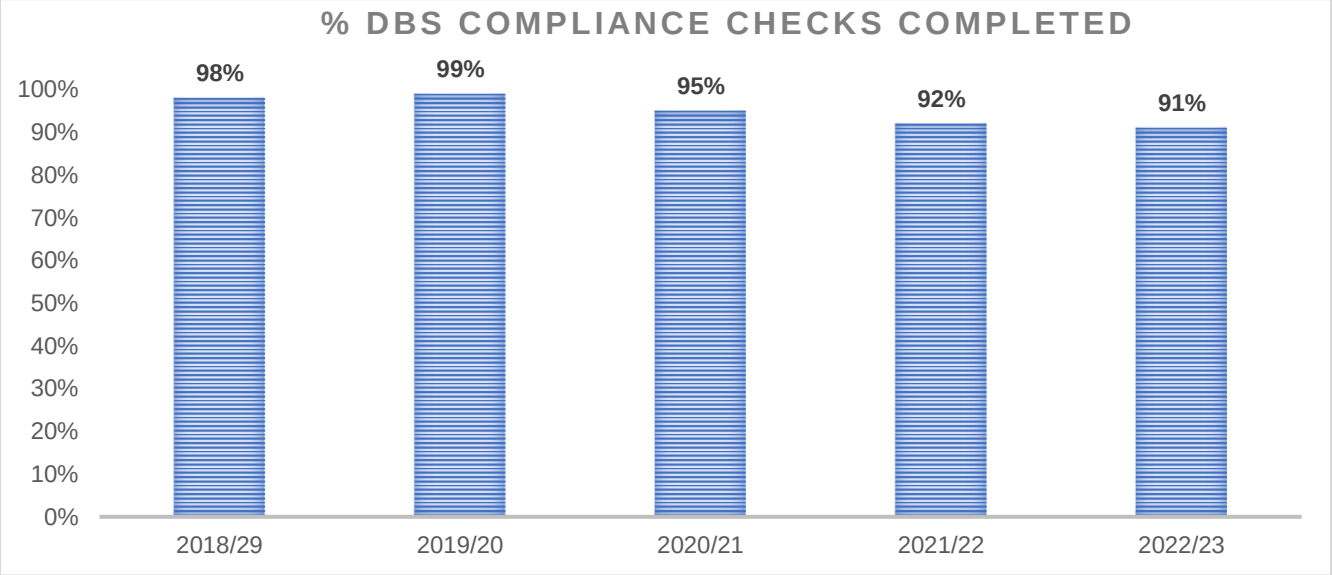
	2018/19 Overall Figures	2019/20 Overall Figures	2020/21 Overall Figures	2021/22 Overall Figures	Quarter 1 *(Apr–Jun 22)*	Quarter 2 *(Jul–Sep 22)*	Quarter 3 *(Oct–Dec 22)*	Quarter 4 *(Jan–Mar 23)*	2022/23 Overall Figures
DBS Compliance Checks Completed	98%	99%	95%	92%	*88.35%*	*92.48%*	*92.56%*	*93.64%*	**91%**

Source: Electronic Staff Record

The Disclosure and Barring Service (DBS) helps employees make safer recruitment decisions. The DBS is an executive non-departmental public body of the Home Office.

The Trust continued to maintain a high level of compliance to the required standards. For the purposes of transparency, staff that are on maternity leave, or a prolonged absence are included in the denominator for this metric.

The Trust's recruitment and selection procedure requires that all staff that conduct regulated activity should undergo a disclosure check before commencing with the organisation. The Trust ensures that all staff are rechecked every three years. The Trust accepts DBS compliance from any staff member or potential candidate who is part of the update service which is an online subscription that allows the staff member to keep their certificate up to date on an annual basis. We have also taken the necessary precautions by implementing ESR notifications as part of our internal messaging / workflow systems within ESR. The workflow notifications relating to DBS compliance enables the team to respond and act on this information. Role-based notifications support internal processes and helps maintain the ESR system and its data.



Patient Experience

Formal complaints received

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Formal Complaints Received	43	184	180	166	116	144	103

Source: Quality Portal 04/2023

A formal complaint is defined as any written complaint received from a patient or a representative of the patient. A verbal complaint may be treated as a formal complaint if the complainant wishes their concerns to be treated formally; in these cases a written record must be made by the recipient of the complaint and sent to the complainant with an invitation for it to be signed for accuracy and returned to the Complaints Manager. The Trust has a Complaints Policy and Procedure in place that meets the requirements of the Local Authority and NHS Complaints (England) 2009 Regulations.

The amount of complaints received had risen during the years following the transfer of Gender services into the Trust but has seen a steady downward trend since. Gender services continue to account for the highest number of complaints received. Waiting times, access to services and the delay in sending out clinical letters due to Carenotes access issues during August-December 2022 were some of the trends seen in the complaints received during the year.

Complaint Categories 2022/23	No. of Complaints
Communications	**28**
Waiting Times	**21**
Other	**19**
Access to Treatment or Drugs	**14**
Clinical	**13**
Trust Administration	**2**
Values & Behaviours	**2**
Appointments	**2**
Information Governance	**2**

Since the pandemic and the Trust's internal restructure of portfolios of work, the response times to complaints has increased. A review of the complaints process is being undertaken by the CNO, who has now assumed responsibility for this function. Team managers are being involved in the review process and training in effective complaints management is expected to improve the timeliness of responses.

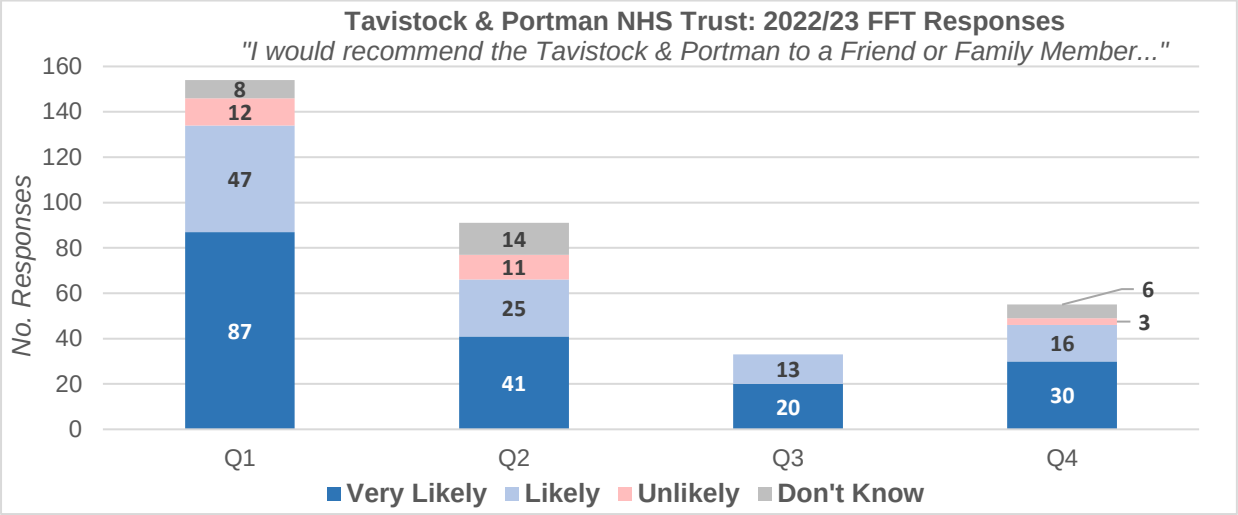
We endeavour to learn from each and every complaint, regardless of whether it is upheld or not. In particular, each complaint gives us some better understanding of the experience of our services for service users, to ensure that improvements to our services are made we have instigated a more robust system of actions plans following upheld complaints. Actions following complaints are reported to the Quality Committee and reports are provided to service leads to share within their clinical governance structures.

Experience of survey questionnaire: friends and family test

The Trust takes part in the Friends and Family Test and reports as part of our Key Performance Indicator schedule on a quarterly basis. This allows us to see how many of our patients would recommend our service to a friend or family member if they required similar treatment.

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
% of patients who would recommend the Tavistock and Portman to a friend or family member if they required similar treatment	**94%**	**93%**	**98%**	**97%**	**94%**	**91%**	**88%**	**84%**

Breakdown of 2022/23 Responses



Source: Quality Team, Data received and calculated: 06/04/2023

The Trust received a reliably positive response to the FFT questions over the course of 2022/23, with 84% of patients answering 'Very Likely or 'Likely to the FFT prompt and only 26 negative responses returned over the course of the year. Increasing the amount of survey responses that we receive, as part of the wider ESQ form, has continued to be a focus area of work in 22/23.

Clinical Effectiveness

Outcome monitoring data

Goal-Based Measure (GBM) outcome data for Child and Adolescent Mental Health Services (CAMHS)

For our Child and Adolescent Mental Health Services (CAMHS), we use the Goal-Based Measure (GBM) to enable us to know what the service user wants to achieve (their goal or aim) and to focus on what is important to them. The Goal-Based Measure tool is a way of evaluating progress towards goals in clinical work with children, young people, and their families and carers. This helps us to make adjustments to the way we work with the individual.

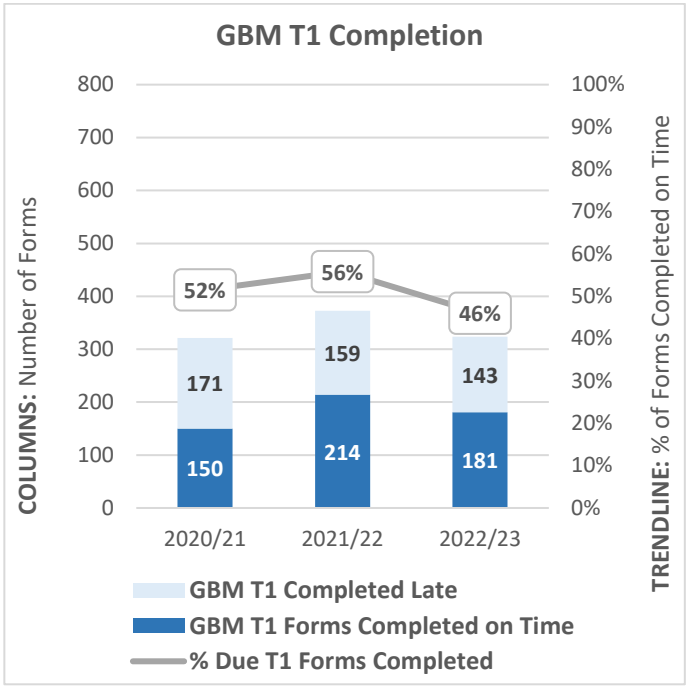
Time 1 (T1) refers to the first time the patient agrees goals with their clinician. This is expected to be completed within one month of the patients second attended appointment. The GBM goals are agreed jointly between the clinician and the patient and are reviewed after three months, or earlier if clinically appropriate. This review is known as Time 2 (T2) and is expected to be completed three months after T1 but is deemed as completed 'on time' if recorded within four months of T1.

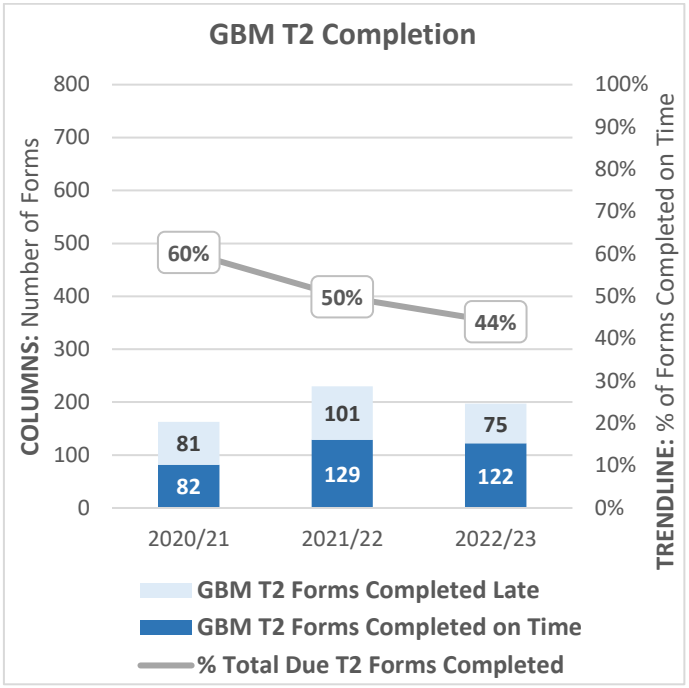
The CareNotes outage the Trust experienced from August 2022 to December 2022 has affected the progress achieved earlier in the year. During the outage we were not able to run reports or supply notifications to teams. As the Trust returns to business as usual the performance in this area is starting to improve.

Below we show the completion rates for open patients with a due GBM T1 and T2:

TIME 1	2020/21	2021/22	2022/23
Time 1 Forms Due	623	668	712
Time 1 Forms Completed	321	373	324
% Due Forms Completed	**52%**	**56%**	**46%**
Forms Completed on Time	150	214	181
Forms Completed Late	171	159	143
% Due Forms Completed on Time	**24%**	**32%**	**25%**

TIME 2	2020/21	2021/22	2022/23
Time 2 Forms Due	270	461	451
Time 2 Forms Completed	163	230	197
% Due Forms Completed	**60%**	**50%**	**44%**
Forms Completed on Time	82	129	122
Forms Completed Late	81	101	75
% Due Forms Completed on Time	**30%**	**28%**	**27%**





Despite the technical challenge we faced this year we have completed a higher number of forms compared to 2020/21 both for T1 and T2s. We find this is an encouraging sign that the Trust has improved the process around outcome measures.

Targeted work will be undertaken during the 2023/24 financial year to strengthen our reminder system for missing forms, not only for T1 and T2 but also for subsequent missing forms.

Improvement rates	2020/21	2021/22	2022/23
% Qualifying Camden CAMHS patients who reported an improvement in their GBM scores from first to last completed form	**36.6%**	**50.0%**	**60%**

The improvement rates are taken from the first form (T1) to the last completed form (TL) on qualifying discharged patients during 2022/23 - this allows us to evaluate the whole patient's pathway. We can then determine if there has been an improvement in score based on the following definition:

- Positive change in goal progress -> +2.45 or more
- No change in goal progress -> -2.44 to +2.44
- Negative change in goal progress -> -2.45 or less

Adult services: Clinical Outcomes for Routine Evaluation (CORE) outcome monitoring for adult services

The main outcome measure used across all adult services (patients over 18 years old) is the CORE. CORE (Clinical Outcomes in Routine Evaluation) is a session-by-session monitoring tool with items covering anxiety, depression, trauma, physical problems, functioning and risk to self. This is designed to provide a routine outcome measuring system for psychological therapies covering four dimensions: subjective well-being, problems/symptoms, life functioning and risk/harm.

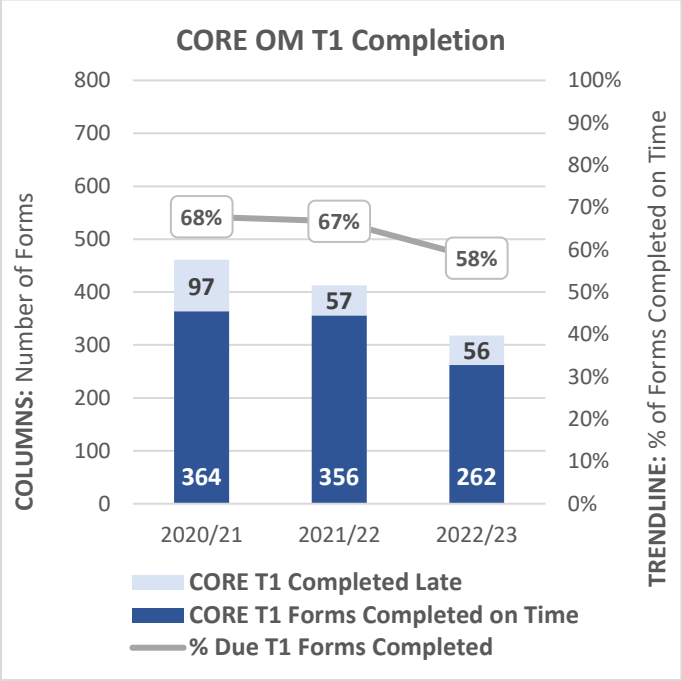
Over the course of 2021/22 we successfully tested an online collection method (Qualtrics). In 2022/23 we started implementing this method in a wider range of services with the idea of increasing the number of patients we can reach and subsequently improving our return rates. Unfortunately, the database outage we experienced from August 2022 to December 2022 hindered the project. This is in the process of being restarted and ingrained in the service's routines.

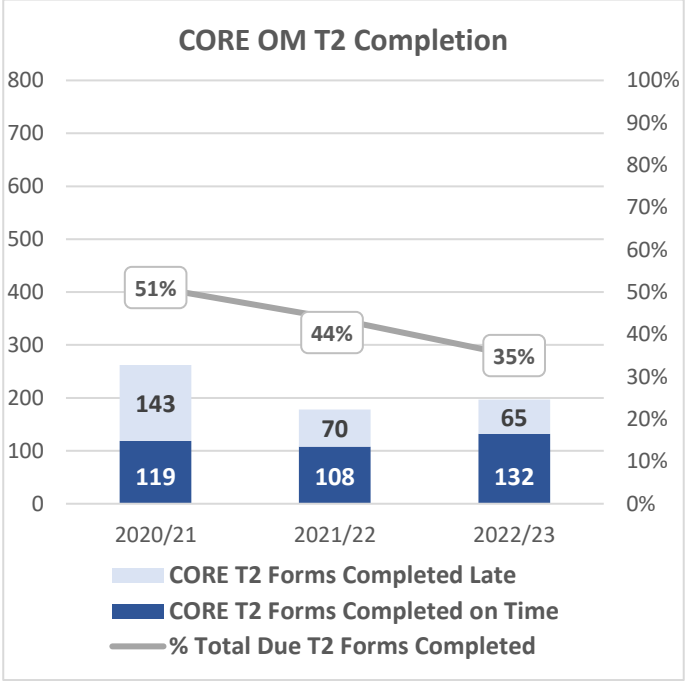
Targeted work will be undertaken during the 2023/24 financial year to strengthen our reminder system for missing forms, not only for T1 and T2 but also for subsequent missing forms.

Below we show the completion rates for open patients with a due CORE T1 and T2:

	2020/21	2021/22	2022/23
Time 1 Forms Due	680	619	544
Time 1 Forms Completed	461	413	318
% Due Forms Completed	**68%**	**67%**	**58%**
Forms Completed on Time	364	356	262
Forms Completed Late	97	57	56
% Due Forms Completed on Time	**54%**	**58%**	**48%**

	2020/21	2021/22	2022/23
Time 2 Forms Due	513	407	565
Time 2 Forms Completed	262	178	197
% Due Forms Completed	**51%**	**44%**	**35%**
Forms Completed on Time	119	108	132
Forms Completed Late	143	70	65
% Due Forms Completed on Time	**23%**	**27%**	**23%**





Despite the technical challenge we faced this year we have completed a higher number of forms compared to 2020/21 for T2s. We expect this number to carry on increasing as services go back to business as usual and Qualtrics is fully reinstated.

Improvement rates	2020/21	2021/22	2022/23
% of Discharged patients who reported an improvement in CORE score from first to last completed form	**69%**	**66%**	**56%**

Having patients complete multiple instances of the same OM form means that we are able to directly compare changes in score between their first and last completed form, which gives us a good insight into the outcome of their treatment. Annual data for 2022/23 showed that 56% of patients who attended at least two appointments, and had at least two CORE OM forms completed at discharge experienced an improvement in their CORE score, we think this drop on improvement dates is due to a lower number of forms collected due to the system outage.

In order to align our working practices with the upcoming CQUIN, we are planning to closely monitor the number of patients discharged with a minimum of two completed CORE OM forms and plan to work closely with teams to ensure that an increasing number of patients have at least two forms completed prior to discharge.

Did not attend (DNA) Rates

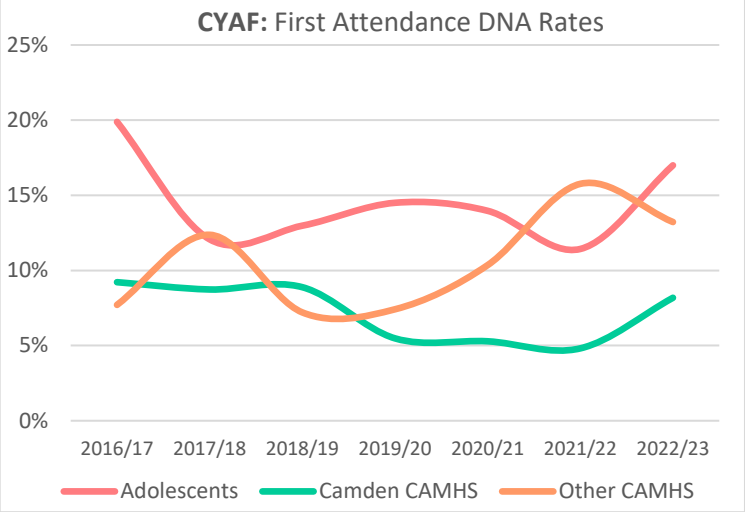
The national target is for DNA rates to be below 10%, with the Trust once again coming in below this for subsequent appointments – which make up the vast majority of the Trusts appointment activity. The DNA rate for first appointments has just breached the 10% target at 10.3% - which, for context, is still the second lowest DNA rate for first appointments in the last 6 financial years.

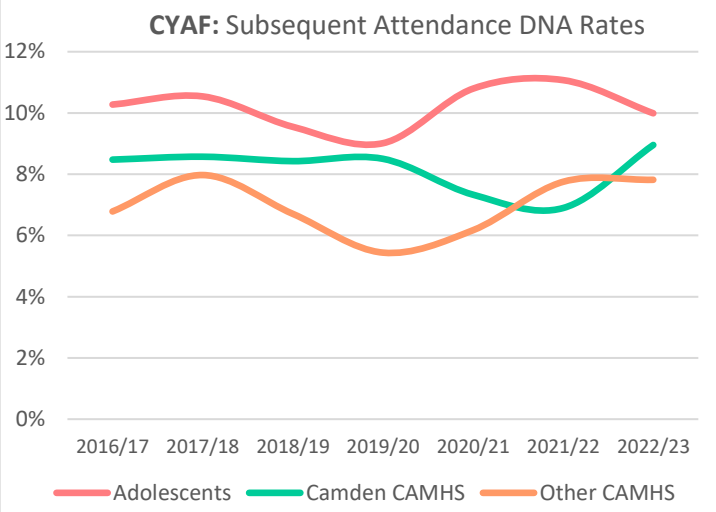
The outcome of all patient appointments is monitored to improve the engagement of patients, and where possible to minimise wasted NHS resources. The Trust continues to offer choice concerning the times and location of appointments; emailing patients and sending them text reminders for their appointment, or phoning patients ahead

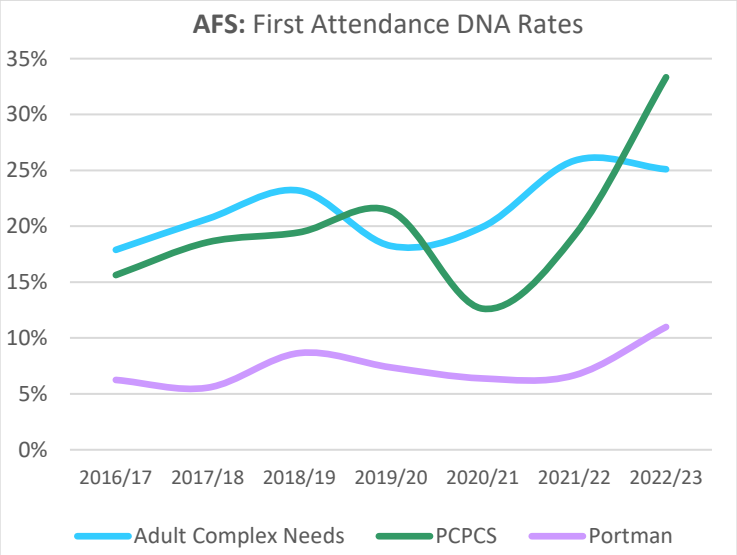
of appointments as required. The Trust continues to work with clinical and administrative teams, support services and Quality Improvement groups to identify methods of further reducing DNAs. Since the start of the pandemic, the Trust mobilised quickly and effectively to offer patients remote video appointments which have enabled patients to access care in situations where a face-to-face appointment isn't possible.

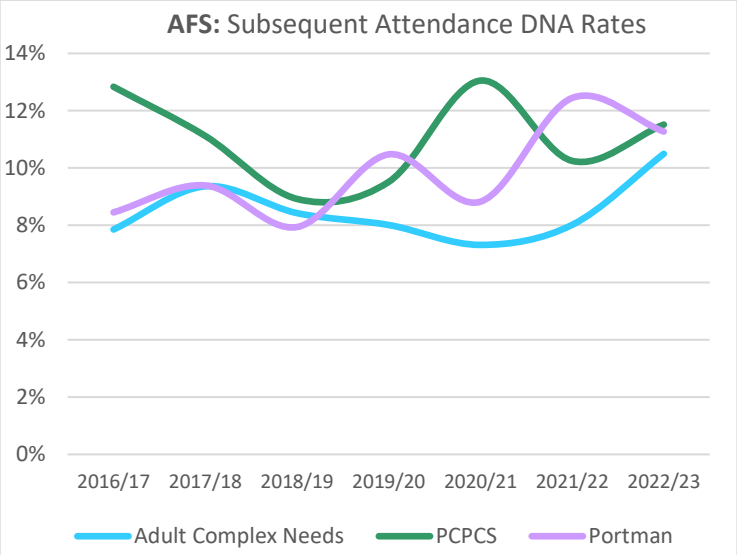
	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Trustwide Total							
First Attendance DNA %	11.5%	12.2%	12.3%	10.3%	8.8%	10.3%	15.7%
Subsequent Appointments DNA %	9.0%	9.7%	8.8%	8.8%	8.5%	8.7%	10.0%
Adolescents & Young Adult							
First Attendance DNA %	19.9%	12.1%	13.0%	14.5%	14.0%	11.4%	17.0%
Subsequent Appointments DNA %	10.3%	10.5%	9.5%	9.0%	10.8%	11.1%	10.0%
Adult Complex Needs							
First Attendance DNA %	17.9%	20.7%	23.2%	18.2%	19.9%	25.9%	25.1%
Subsequent Appointments DNA %	7.9%	9.4%	8.4%	8.0%	7.3%	8.0%	10.5%
Camden Child and Adolescent Mental Health Service (Camden CAMHS)							
First Attendance DNA %	9.2%	8.7%	8.9%	5.5%	5.3%	4.8%	8.2%
Subsequent Appointments DNA %	8.5%	8.6%	8.4%	8.5%	7.3%	6.9%	9.0%
City & Hackney Primary Care Psychological Services (PCPCS)							
First Attendance DNA %	15.6%	18.6%	19.5%	21.3%	12.6%	19.2%	33.3%
Subsequent Appointments DNA %	12.8%	11.1%	8.9%	9.5%	13.1%	10.2%	11.5%
Gender Identity Clinic (GIC)							
First Attendance DNA %	10.0%	12.3%	11.5%	8.3%	11.8%	15.0%	19.6%
Subsequent Appointments DNA %	14.4%	14.7%	12.6%	12.8%	14.3%	11.5%	13.2%
Gender Identity Development Service (GIDS)							
First Attendance DNA %	12.8%	11.5%	13.4%	12.6%	6.2%	6.3%	13.5%
Subsequent Appointments DNA %	8.7%	10.2%	9.8%	10.2%	9.7%	10.0%	10.9%
Other CAMHS							
First Attendance DNA %	7.7%	12.4%	7.2%	7.4%	10.4%	15.8%	13.2%
Subsequent Appointments DNA %	6.8%	8.0%	6.7%	5.4%	6.2%	7.8%	7.8%
Portman							
First Attendance DNA %	6.3%	5.6%	8.7%	7.4%	6.4%	6.7%	11.0%
Subsequent Appointments DNA %	8.5%	9.4%	7.9%	10.5%	8.8%	12.4%	11.3%

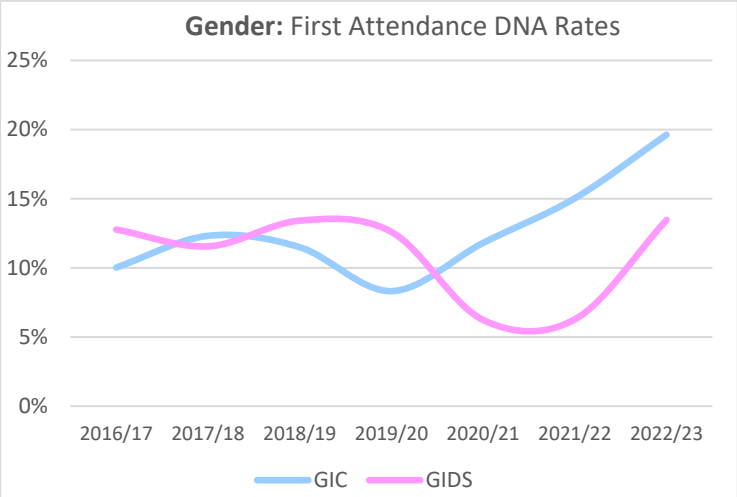
There was a slight decrease in the number of both first and subsequent attended appointments across the Trust during 2022/23, although this should be seen within the context of the Trust experiencing a long-term outage of our Clinical Software. As a result of the aforementioned cyber incident and subsequent access to Carenotes, there is a backlog of appointment data that is being uploaded on an ongoing basis and so the figures shown are, regrettably, not a completely reliable reflection of the clinical activity undertaken this year. The decreased number of appointments came with a corresponding increase in the overall DNA rates.

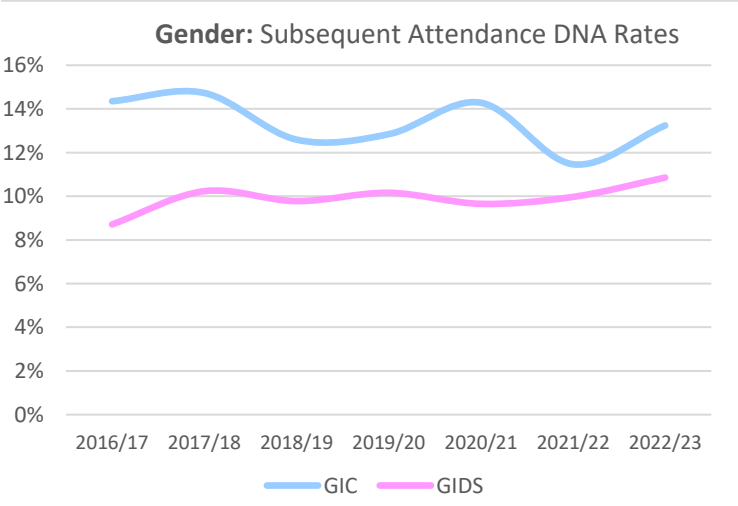












Definitions used for DNA's for percentages are as follows:
1st DNA(%) = Total 1st DNA / (Total First Attended + Total 1st DNA appointments)
Subsequent DNA (%) = Total sub DNA / (Total subsequent attended + Total subsequent DNA appointments

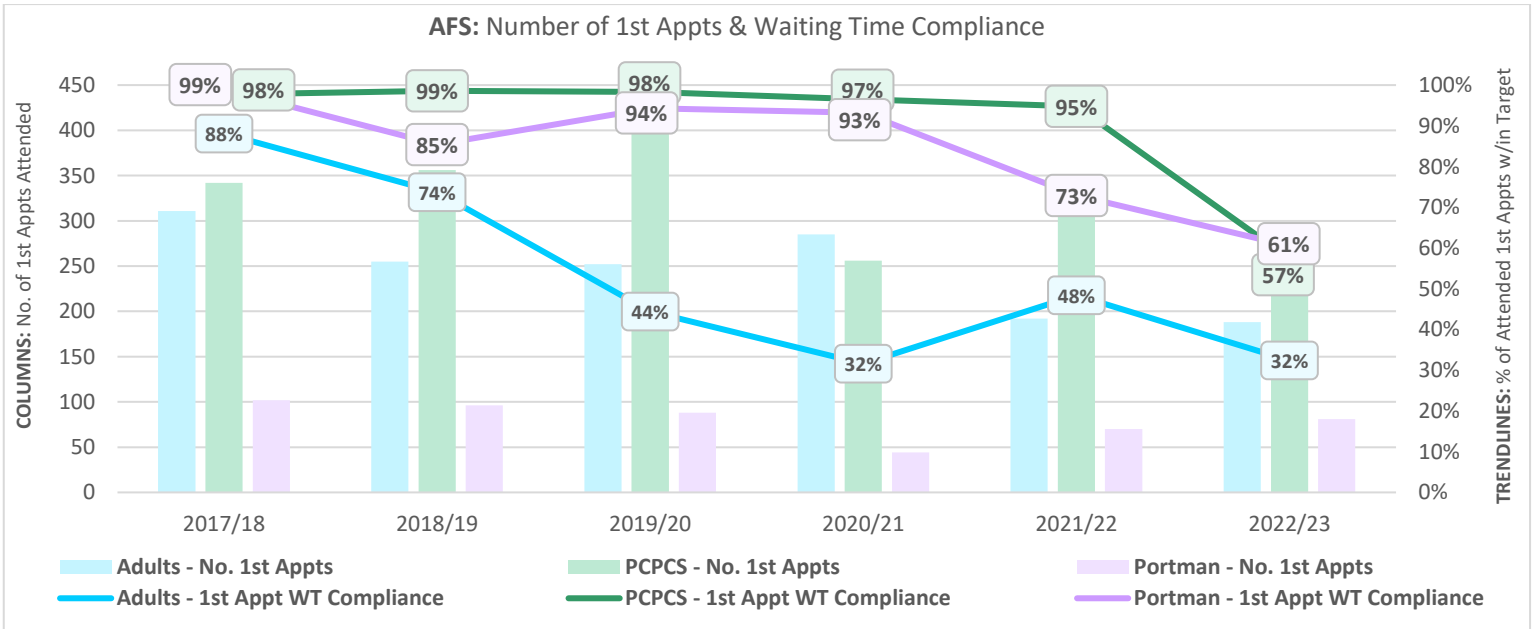
Waiting Times - Compliance with Waiting Time Targets for 1st Appointments

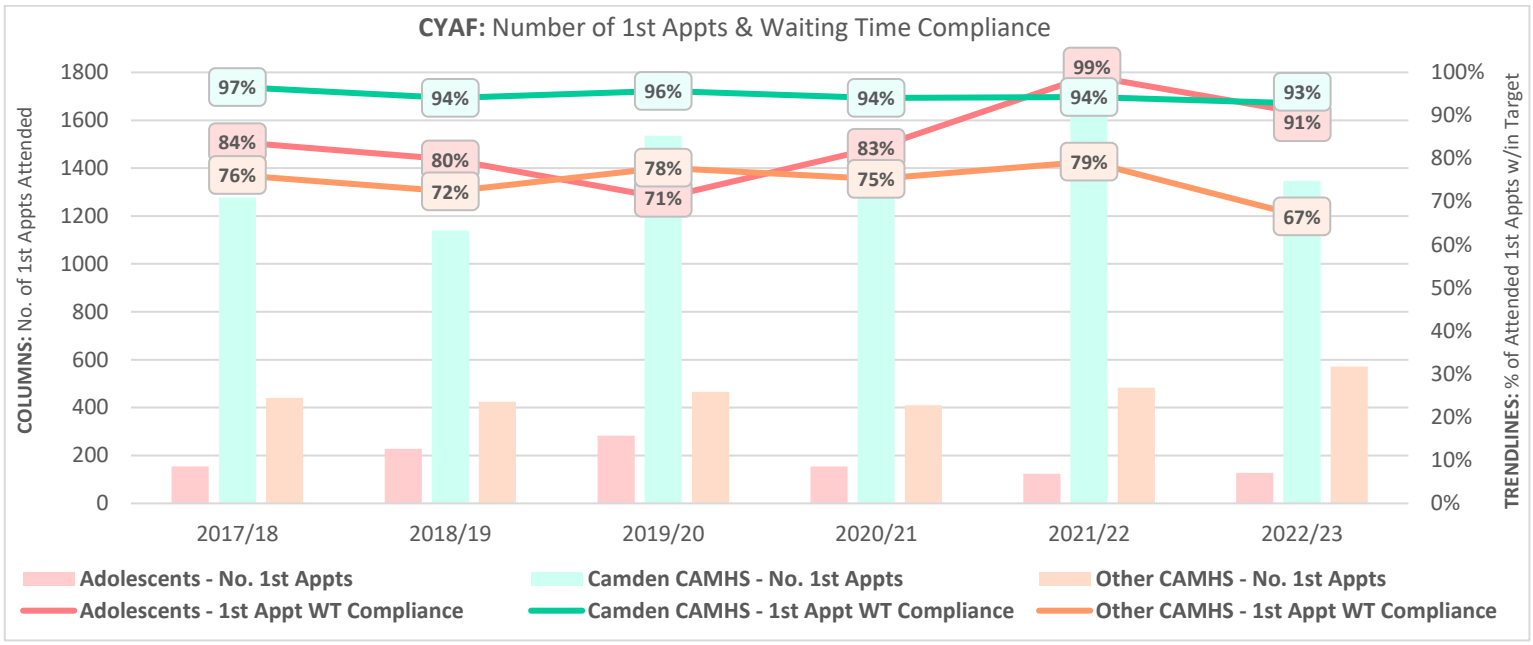
The Trust saw decreases in compliance with waiting time targets for first appointments over the 2022/23 financial year for all but one service-line. The greatest challenges continue to be in our gender services, attributable to the increasing number of referrals being received for GIC.

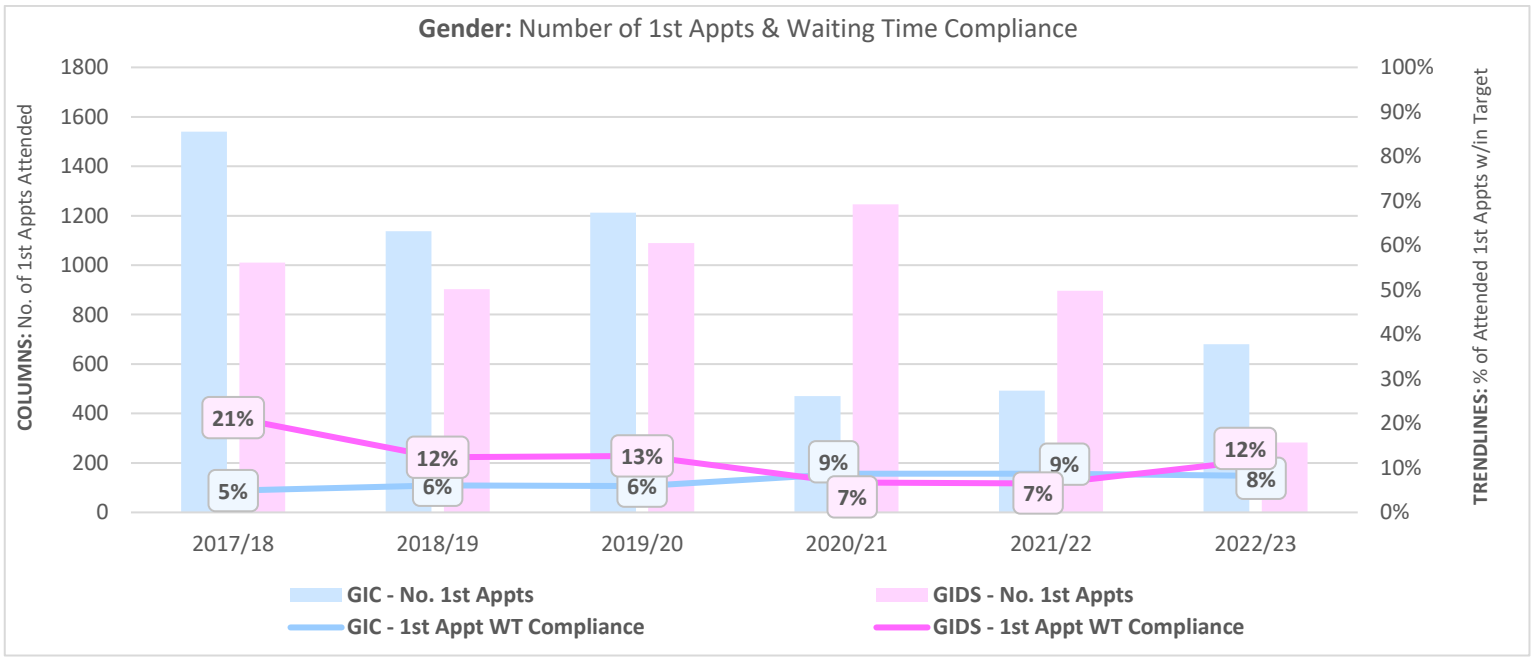
Waiting Times has continued to be a quality priority for the Trust in recent years, and will continue to be a quality priority into 2023/24 (see section 2.1 & 2.2). Waiting Times is also a key strategic objective for the Trust and so the operational aspects of improvement will be covered via that process going forward.

	Waiting Time Target for 1st Appts		2017/18 % Patients Seen for 1st Appt within Target	2018/19 % Patients Seen for 1st Appt within Target	2019/20 % Patients Seen for 1st Appt within Target	2020/21 % Patients Seen for 1st Appt within Target	2021/22 % Patients Seen for 1st Appt within Target	2022/23 % Patients Seen for 1st Appt within Target
Adult Complex Needs	< 11 Weeks	1st Appts	311	255	252	285	192	188
		% On Time	88.1%	73.7%	44.4%	31.6%	48.4%	32.4%
City & Hackney PCPCS	< 18 Weeks	1st Appts	342	356	409	256	347	296
		% On Time	97.7%	98.6%	98.3%	96.5%	94.8%	57.4%
Portman	< 11 Weeks	1st Appts	102	96	88	44	70	81
		% On Time	99.0%	85.4%	94.3%	93.2%	72.9%	60.5%
Adolescents *(Under 18's)*	< 8 Weeks	1st Appts	31	16	36	12	17	20
		% On Time	74.2%	50.0%	52.8%	83.3%	100.0%	80.0%
Adolescents *(Over 18's)*	< 11 Weeks	1st Appts	123	212	246	142	106	107
		% On Time	86.2%	82.1%	73.6%	82.4%	99.1%	92.5%
Adolescents Total		1st Appts	154	228	282	154	123	127
		% On Time	83.8%	79.8%	70.9%	82.5%	99.2%	90.6%
Camden CAMHS	< 8 Weeks	1st Appts	1278	1140	1536	1330	1681	1347
		% On Time	96.6%	94.1%	95.7%	94.1%	94.3%	92.8%
Other CAMHS	< 8 Weeks	1st Appts	441	424	466	409	483	572
		% On Time	76.2%	72.4%	77.9%	75.3%	79.3%	66.6%
GIC	< 18 Weeks	1st Appts	1540	1137	1212	471	493	680
		% On Time	4.9%	6.1%	5.9%	8.7%	8.7%	8.2%
GIDS	< 18 Weeks	1st Appts	1011	903	1089	1246	897	283
		% On Time	21.3%	12.4%	12.7%	6.7%	6.5%	11.7%

Source CareNotes.14/04/2022







Notes on Waiting Time & Waiting List Calculations

Waiting Time Breaches (Trust wide) – Target dependent on service. Number (%) of patients attending a first appointment 4, 6, 8, 11 or 18 weeks after receipt of referral.

The Trust monitors waiting times on an on-going basis, seeking to reduce the length of time that patients have to wait. To calculate the year-end indicator, the numerator and denominator at the end of each quarter, are added together, to arrive at year-end figure. The definition is as follows:

The numerator for the quarterly calculations is the sum of:

- *Number (n) of referred patients who had attended a first appointment more than either 6, 8, 11 or 18 weeks (dependant on service) after referral received.*

The denominator for the quarterly calculations of the indicator is the sum of:

- *Number (n) of patients who attended a first appointment during the quarter.*

Waiting lists are calculated as Number of patients with an accepted referral who have yet to attend an appointment.

National Staff Survey 2022/23

There were 335 questionnaires completed by the Tavistock and Portman staff, a 45% response rate, which is down from the level of participants the previous year (58% in 2021/22).

The national staff survey participation rate has been declining over the past few years. These results further highlight the low morale and the experience of our staff. Our staff survey results reflect the feeling in the organisation and has highlighted the issues that the organisation needs to prioritise and develop initiatives to address staff's concerns.

The table below highlights the key areas where our scores have declined significantly compared to the 2021 survey. These areas are 'we are recognised and rewarded' and 'we are always learning'. The overall combination of feeling at the Trust is also reflected in significantly lower Staff Engagement and Staff Morale factors.

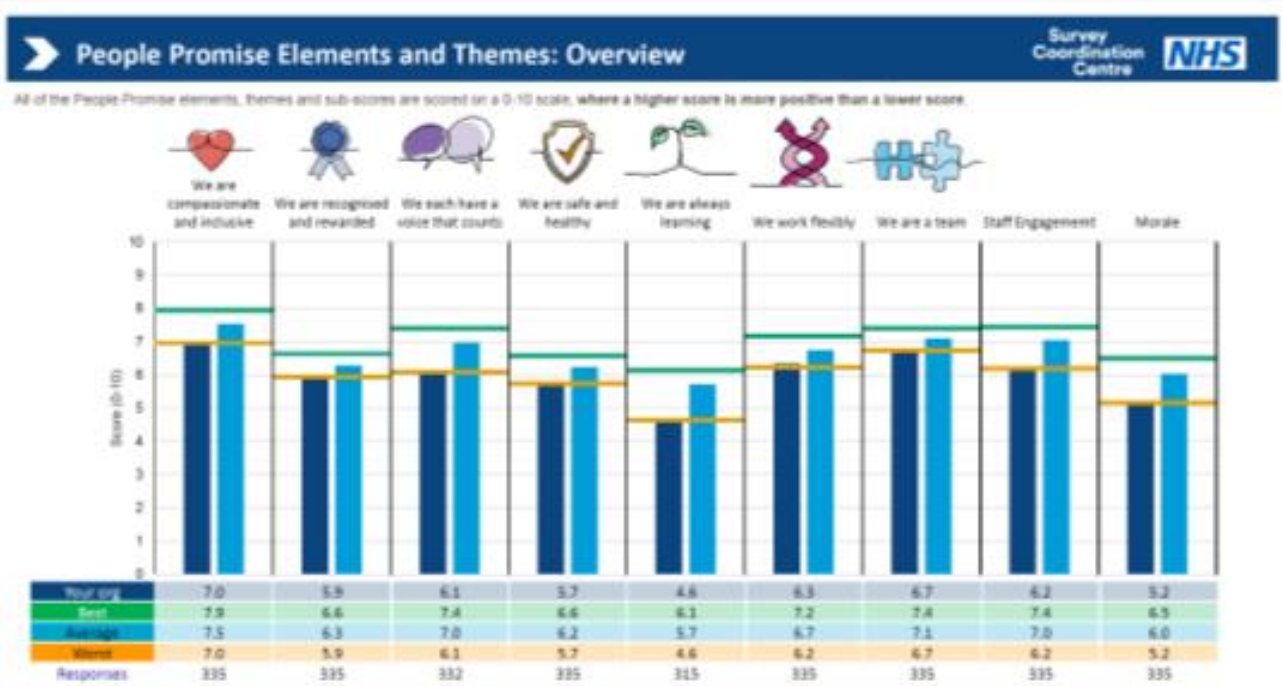
Appendix B: Significance testing – 2021 vs 2022

Survey Coordination Centre NHS

The table below presents the results of significance testing conducted on the theme scores calculated in both 2021 and 2022*.

People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We are compassionate and inclusive	7.2	411	7.0	335	Not significant
We are recognised and rewarded	6.3	419	5.9	335	Significantly lower
We each have a voice that counts	6.4	408	6.1	332	Not significant
We are safe and healthy	5.9	411	5.7	335	Not significant
We are always learning	5.2	397	4.6	315	Significantly lower
We work flexibly	6.5	416	6.3	335	Not significant
We are a team	6.9	414	6.7	335	Not significant
Themes					
Staff Engagement	6.6	420	6.2	335	Significantly lower
Morale	5.5	419	5.2	335	Significantly lower

Whilst not all areas showed statistical significant changes in our results, our overall scores were low across each of the elements.



We have identified that the themed areas we need to focus on are;

- Staff morale and wellbeing
- Discrimination, bullying, abuse (esp. WRES & WDES)
- Career progression (esp. WRES & WDES)
- Reasonable adjustments (WDES)
- Flexible working
- Appraisals
- Management support
- Communications & staff engagement
- Positive response on areas of team working and effectiveness

Some of the work has already commenced as they linked to the results from the last survey so initiatives have already been implemented.

In terms of work that is either in train or already complete following the survey results, this includes;

- Created a reasonable adjustments process which better enables staff to request and receive equipment to help them in their roles. We will also be creating a new policy shortly to ensure transparency and consistency of the process.
- Reviewed staff engagement channels – future direction and leadership forum are two examples, and we will refresh and better publicise routes for engaging.
- Reviewed the Freedom to Speak Up process, providing a clear flowchart and more than one route to escalate concerns. We will further strengthen this over the year.
- Refresh and reset priorities for all our staff networks, including electing chairs.
- Educate people on having difficult conversations and handling difficult situations.
- Implement a no blame culture approach, focusing on just and learning policy base.
- Design and deliver leadership and management training as well as back to basics training.
- Build trust with the people function (HR).
- Be clear about what actions we take and progress we make to improve and communicate the changes.
- Be more visible as leaders and create further spaces for discussion.
- Actively listen and learn.
- Actively encourage and promote meaningful appraisals.

Reported raising of concerns: Whistleblowing

The Trust takes the issue of staff being able to raise concerns by speaking up, or 'whistleblowing', very seriously. The Trust continues to support and promote the Freedom to Speak up (FTSU) Guardian to ensure staff are supported when concerns need to be raised.

Having analysed the NHS Staff Survey for 2022 it is apparent improvements must be made to support staff in raising concerns. From those 334 who responded to the statement 'I would feel secure raising concerns about unsafe clinical practice' the positive response rate for the Trust was 62.5% which is a decrease in comparison to last year's figures of 66.4% albeit not a statistically significant percentage drop. The national average for this question was 71.9%

From the 332 people that responded to the statement 'I am confident that my organisation would address my concern' the figures show a statistically significant drop from 48% (in 2021) to 38.9% in 2022. From 2017 there has been a year-on-year decline in the figures; 2017 being the highest rate at 68.5%. The national average for this question was 56.7%

Further analysis from the NHS staff survey data shows, when staff were asked to comment on the statement 'I feel safe to speak up about anything that concerns me in the organisation', 50.5% of staff agree, which is an increase from 47.7% last year. The national average for this statement was 61.5%

When staff were asked 'if I spoke up about something that concerned me I am confident my organisation would address my concern' only 31.1% agreed (down from 34.2% last year). The national average for this question was 48.7%.

Appendix B: Significance testing – 2021 vs 2022

Survey Coordination Centre NHS

The table below presents the results of significance testing conducted on the theme scores calculated in both 2021 and 2022*.

People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We each have a voice that counts	6.4	408	6.1	332	Not significant

Although not rated as a statistically significant change, the continued low confidence of our people, highlighted by a rating of 6.1 for the 'We each have a voice that counts' theme overall, is a clear indication that FTSU was still a topic of concern at the time of the survey.

We are making positive progress towards addressing this. A new FTSU policy has been ratified, with a revised flowchart to make the process more accessible. Both the policy and flowchart will be regularly reviewed, and updates made where required to ensure their fitness for purpose.

The newly appointed Chief People Officer (CPO) is the nominated Executive Lead for FTSU issues and has begun to meet regularly with the FTSU guardian in addition to regular three-way meetings between the FTSU guardian, the CEO, and the CPO. A FTSU update is also be timetabled for communication to the Audit Committee and the Trust Board.

Furthermore, the Trust is working to update our key employee relations policies, applying a just and learning culture focus, in order to further foster trust in our people to raise issues and concerns, and confidence that those concerns will be appropriately addressed.

Staff Rota Information

The Trust has a dedicated Guardian of Safe Working Hours who supports the safe working of junior doctors including the coordination of collating exception reports and facilitates payments of fines.

The Trust has appointed to all trainee positions and is fully completed therfore there is no vacancies or staff gaps on the Rota.

Part 4: Annexes

Statements from North Central London (NCL) Clinical Commissioning Group (CCG), Camden Healthwatch, Camden Local Authority Health and Adult Social Care Scrutiny Committee and Governors and response from Trust

Statement from our Governors

Quality of services is a key focus for the Trust. In the past year, responding to the Governance Review, the Board oversight of quality of services has been strengthened. Feedback and involvement of representatives of the North Central London commissioners has been positive. This annual report reminds Governors of the past year's priorities and gives a useful overview of progress and work that still needs to be done. I welcome that next year's priorities build on the past year and focus on equalities, waiting times and outcome measures, with clear targets for 22/23.

The Council of Governors and the Board have been working together in new ways. The lead Non Executive Director attends the Council of Governors meetings and is available to answer questions on the Board Quality Committee report which provides key information, an assurance rating and further actions that are being taken. Governors have been invited to learning events, for example on safeguarding.

I welcome the strengthening of policies and procedures, the recovery of Care Notes, Trust-wide learning lessons events, and the recognition of a clinical supervision programme as good practice. Going forward I will be taking a particular interest in the improvements in data and outcome measures, the achievement of consistent practice across the Trust, and how we are learning with other providers.

Kathy Elliott

Lead Governor

7 June 2023

Statement from North Central London (NCL) CCG

NHS
North Central London
Integrated Care Board

19 May 2023

Laycock PDC
Laycock Street
London
N1 1TH
0203 198 9743
northcentrallondon.icb.nhs.uk

NHS North Central London Integrated Care Board Statement for the Tavistock and Portman NHS Foundation Trust 2022/23 Quality Account.

The NHS has continued to face significant challenges during 2022/23 due to the Covid -19 pandemic, and other outbreaks of seasonal illnesses including respiratory viruses, Group A Streptococcus, staff shortages and illness, combined with increased demand for healthcare and industrial action.

North Central London Integrated Care Board (NCL ICB) has worked closely with the Trust throughout 2022/23, taking a pragmatic approach regarding assurance of commissioned services throughout the year, obtained through regular discussions with key staff and attending the Trust's Quality and Safety Committee meetings.

We confirm that we have reviewed the information contained within the draft Quality Account (provided to NCL ICB in May 2023). The document received complies with the required content, as set out by the Department of Health and Social Care. Where the information is not yet available a place holder has been inserted.

A cyber-attack on the software supplier of Electronic Patient Record, 'Carenotes' in August 2022, resulted in several Trusts in England, including the Tavistock and Portman being unable to access key patient records or data. This has had a significant impact on the Trusts ability to capture key data.

The issues surrounding the cyber-attack have been resolved and the Trust have established a Data Recovery Project Group, to oversee data validation across the Trust.

We welcome the approach taken by the Trust to review the complaints process and look forward to seeing an improvement in response time to complaints in the coming year.

NHS England (NHSE) moved the Trust into category 3 in the NHS England System Oversight Framework (SOF) in February 2022, this is defined as "Co-ordinated support package and enhanced oversight required".

NCL ICB along with colleagues at NHSE and the Care Quality Commission (CQC) are working collaboratively with the Trust to support them to understand the SOF3 implications for the trust, namely, improvements to quality, leadership and governance and finance and the estate

North Central London ICB Chair: Mike Cooke
North Central London ICB Chief Executive Officer: Frances O'Callaghan

provision. This work is on-going.

We acknowledge the significant work undertaken by the Gender Identity Development Service (GIDS) through a transformational programme of work developed in response to the CQC, following an inspection of these services in October 2020, where the service was rated as inadequate.

This work included streamlining pathways to reduce waiting times to access the service, enhanced supervision and training for staff working in the service and preparation for transition of the GIDS service to the new regional hub model as set out by NHSE. We continue to work collaboratively with the Trust during this time, recognising the impact of this change in service provision on staff working in GIDS.

The 2022/23 NHS Staff Survey highlighted key areas of focus for the Trust to prioritise and develop initiatives around; staff morale and engagement, recognition, and a culture of learning. The Trust will continue to build on programmes of work in these areas, and with those staff working within GIDS.

We welcome the collaborative work undertaken by mental health providers across North Central London to support a sustainable approach to support people to leave specialist mental health services and are pleased that the trust is engaged in this process.

We support the Trusts quality priorities for 2023/24 and will continue to work closely with the trust to support, coordinate and oversee the programme of improvements in line with these criteria through the coming year.

Frances O'Callaghan
Chief Executive Officer
North Central London ICB

North Central London ICB Chair: Mike Cooke
North Central London ICB Chief Executive Officer: Frances O'Callaghan

Camden Local Authority Health and Adult Social Care Scrutiny Committee

Comments from the Chair of the LB Camden Health and Adult Social Care Scrutiny Committee

Disclaimer: The Health and Adult Social Care (HASC) Scrutiny Committee did not sit between the receipt of the draft quality report and the due date for comments. They could not therefore provide comments on the named quality report. The following statement was provided solely by the Chair of the HASC Scrutiny Committee, Cllr Larraine Revah, and they should not be understood as a response on behalf of the Committee.

The report is well structured, and clearly sets out how the Trust performed against priorities in 2022/23. The report demonstrates the Trust acknowledges areas requiring improvement, and sets out plans to improve areas of concern.

The following observations were made in accordance with a set of core governance principles, which guide the scrutiny of health and social care in Camden.

1) Putting patients at the centre of all you do.

Addressing waiting times was a key priority for the Trust in 2022/23. It is promising that the Trust achieved or partially achieved all aspects of this ambition. It is positive that the trust improved communications and supportive advice with patients who are on the waiting list through the development of local processes for telephone, mail and electronic communication, alongside the creation of online platforms.

It is concerning that the results of the 'friends and family' test have fallen to 84% of patients who would recommend the Trust to friends or family, from 88% the previous year and 91% in 2020/21.

2) Focussing on a common purpose, setting objectives, planning.

The Trust recognises the low morale and difficulties staff are facing, with the staff survey results reflecting this feeling. The Trust have identified several themes to focus on to improve morale and staff wellbeing, and have detailed work that is already underway to address these.

The report clearly sets out priorities for the coming year.

3) Working collaboratively.

The priority for 2023/24 to co-designing and co-producing what an 'Endings' strategy looks like with patient groups, making sure processes and approaches around discharge are correct and consistent, is a fantastic example of working collaboratively with patients.

The section detailing the Trust's Patient and Public Involvement team lists several projects that have utilised collaboration to improve services, in particular employing service users on interview panels demonstrates the value of co-production and lived experience.

4) Acting in an open, transparent and accountable way - using inclusive language, understandable to all - in everything it does

It is unfortunate that the Trust did not achieve ambitions relating to equalities due to the Carenotes outage that led to the Trust not having accurate data. I note the Trust has carried over these ambitions to 2023/23, I look forward to reviewing progress next year, in particular progress to understand and address barriers within local communities to accessing treatment.

The Trust also set out to use data from the Experience of Service Questionnaire (ESQ) by protected characteristics to understand how experiences of services differ, and then plan to address areas identified for improvement. In 2023/24 The Trust applied this to one service line for patient ethnicity, next year I would like to understand the outcome of this work and hope to see the Trust apply this to further service lines.

Kind regards

Councillor Larraine Revah

Chair of Camden Health and Adult Social Care Scrutiny Committee

Statement of directors' responsibilities for the Quality Account

Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum.

Guidance issued to organisations that meet the thresholds above dictates to Boards on the form and content of Quality Accounts. In preparing the Quality Account, directors are required to take steps to satisfy themselves that the content of the Quality Account is not inconsistent with internal and external sources of information including and in respect of:

- Board minutes and papers for the period 1 April 2022 to 31 March 2023
- papers relating to quality reported to the Board, and its sub-committees where appropriate, over the period 1 April 2022 to 31 March 2023
- feedback from external stakeholders with whom the draft Quality Account was shared, as noted in Part 4: Annexes of this Account
- the 2022 national NHS staff survey published for the Tavistock and Portman NHS Foundation Trust
- CQC inspection reports for inspections undertaken during the year 2022/23, and previously were ratings and recommendations remain relevant
- the Quality Account presenting a balanced picture of the Trust's performance over the period covered
- the performance information reported in the Quality Account is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Account has been prepared in accordance with the NHS's annual reporting manual and supporting guidance as well as the standards to support data quality for the preparation of the Quality Account

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board, at the Extraordinary meeting of 28 June 2023.

Michael Holland

Chief Executive Officer

June 2023

Appendix - Glossary of Key Data Items

AFS – Adult and Forensic Services.

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

CAMHS – Child and Adolescent Mental Health Services

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

CareNotes – This is the patient administration system using, which is a 'live system' for storing information electronically from patient records.

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

Clinical Governance Meetings – Established for AFS, CYAF and Gender Divisions to support the delivery of high quality and safe services. They provided a mechanism for robust review, oversight and action. The Fundamental Standards of Care Regulations form the basis of topics and issues covered.

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

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

Commission for Health Improvement Experience of Service Questionnaire – This captures patient views related to their experience of service.

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

CGAS – Children's Global Assessment Scale

CYAF – Children, Young Adults and Families services.

CORE – Clinical Outcomes in Routine Evaluation

Did Not Attend (DNA) Rates – The DNA rate is measured for the first appointment offered to a patient and then for all subsequent appointments. There is a 10% upper limit in place for the Trust, which is the quality standard outlined in our patient services contract.

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

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

Data Security and Protection Toolkit (replacing the Information Governance Toolkit) – It is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardians' 10 data security standards. All organisations that have access to NHS patient data and systems must use this

toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. It also draws together legal rules and central guidance included in the various Acts (GDPR, DPA18) and presents them in one place as a set of data security and protection assertions.

EMT – Executive Management Team

EPRS – Electronic Patient Record System

ESQ – Experience of Service Questionnaire. An internal experience measurement tool used to obtain feedback from patients.

ESR – Electronic Staff Record

Fundamental Standards of Care Regulations – The standards which health providers are required to meet. They came into force for all health and adult social care services on 1 April 2015. (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (amended))

Goal-Based Measure – These are the goals identified by the child/young person/family/carers in conjunction with the clinician, where they enable the child/carer etc. to compare how far they feel that they have moved towards achieving a goal from the beginning (Time 1) to the End of Treatment (either at Time 2 at 3 months, or at a later point in time).

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

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

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

INSET (In-Service Education and Training/Mandatory Training) – The Trust recognises that it has an obligation to ensure delivery of adequate and appropriate training to all staff groups, that will satisfy statutory requirements and requirements set out by the NHS bodies, in particular NHS Resolution and the Care Quality Commission Standards for Better Health. It is a requirement for staff to either attend this training once every 2 years or to complete training using the staff electronic training system, as offered by the Trust.

iTHRIVE - The National i-THRIVE Programme is a national programme of innovation and improvement in child and adolescent mental health that is being implemented in sites across the country. i-THRIVE was selected as an NHS Innovation Accelerator in 2016 and is now endorsed in the NHS Long Term Plan.

Key Performance Indicators (KPIs) – service indicators set either by commissioners or internally by the Trust Board.

LGBT – Lesbian, Gay, Bisexual, and Transgender community.

Local Induction – It is the responsibility of the line manager to ensure that new members of staff (including those transferring to new employment within the Trust, and staff on fixed-term contracts and secondments) have an effective induction within their new department. The Trust has prepared a Guidance and checklist of topics that the line manager must cover with the new staff member.

Looked After Children - A child who has been in the care of their local authority for more than 24 hours is known as a 'looked after child'.

MAST – Mandatory and Statutory Training

Monitoring of Adult Safeguards – This refers to the safeguarding of vulnerable adults (over the age of 16), by identifying and reporting those adults who might be at risk of physical or psychological abuse or exploitation.

The abuse, unnecessary harm or distress can be physical, sexual, psychological, financial or as the result of neglect. It may be intentional or unintentional and can be a single act, temporary or occur over a period of time.

National Clinical Audits – Are designed to improve patient care and outcomes across a wide range of medical, surgical and mental health conditions. Its purpose is to engage all healthcare professionals across England and Wales in systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care.

National Confidential Enquiries – Are designed to detect areas of deficiency in clinical practice and devise recommendations to resolve these. Enquiries can also propose areas for future research programmes. Most confidential enquiries to date are related to investigating deaths and to establish whether anything could have been done to prevent the deaths through better clinical care.

The confidential enquiry process goes beyond an audit, where the details of each death or incident are critically reviewed by a team of experts to establish whether clinical standards were met (similar to the audit process), but also to ascertain whether the right clinical decisions were made in the circumstances.

Confidential enquiries are “confidential” in that details of the patients/cases remain anonymous, though reports of overall findings are published.

The process of conducting a national confidential enquiry process usually includes a National Advisory Body appointed by ministers, guiding, overseeing and coordinating the Enquiry, as well as receiving, reporting and disseminating the findings along with recommendations for action.

NCL – North Central London

OM – Outcome Measure.

OLM - Oracle Learning Management module of the Electronic Staff Record (ESR).

Participation in Clinical Research – The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited during the year to participate in research approved by a research ethics committee.

Patient Feedback – The Trust does not participate in the NHS Patients Survey but conducts its own survey annually, as it has been exempted by the Care Quality Commission from using the NHS Patient Survey, with the recognition that the nature of the services provided by the Trust differ to other mental health Trusts.

There are various other methods used to obtain feedback from patients, including surveys and audits, suggestions boxes, feedback to the PALS officer and informal feedback to clinicians and administrators.

Patient Forums/Discussion Groups – These meetings aim to increase the opportunities for patients, members and the public to obtain information, and to engage in discussions about topics, such as therapy - how it can help, and issues such as confidentiality. In turn, the feedback to the Trust generated by these meetings is used to improve the quality of our clinical services.

Patient Safety Incident – A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. Such incidents are reportable to the National Reporting and Learning System (NRLS).

Percentage Attendance – The number of staff members who have attended the training or completed the inductions (Trust-wide and Local) as a percentage of those staff required to attend training or complete the inductions. Human Resources (Staff Training) record attendance at all mandatory training events and inductions using the Electronic Staff Record.

Periodic/Special Reviews – The Care Quality Commission conducts special reviews and surveys, which can take the form of unplanned visits to the Trust, to assess the safety and quality of mental health care that people receive and to identify where and how improvements can be made.

Personal Development Plans – Through appraisal and the agreement of a Personal Development Plan for each member of staff we aim to support our staff to maintain and develop their skills. A Personal Development Plan also provides evidence that an appraisal has taken place.

PPI – Patient & Public Involvement

Protected characteristics – These are defined in Equality Act 2010 as: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

PTSD – Post Traumatic Stress Disorder

QI – Quality Improvement

Quality Improvement – Quality improvement (QI) is about improving patient (and population) outcomes, system performance and professional development. The Institute of Healthcare Improvement (IHI) Model for improvement (MFI) is one type of quality improvement (QI) methodology. More than a methodology, QI is about a change in behaviours, working together, change coming from bottom up, creative thinking and fundamentally, using measurement to guide improvement. The MFI consists of three questions which guide the course of a project namely: (i) What are we trying to accomplish? This guides the setting of the project aim and plan. (ii) How will we know that a change is an improvement? This concerns regular real time measurement, and (iii) What changes can we make that will result in improvement? This concerns the development of ideas to make improvement, and testing these.

Return rate – The number of questionnaires returned by patients and clinicians as a percentage of the total number of questionnaires distributed.

Standard Operating Procedures – A standard operating procedure (SOP) is a set of step-by-step instructions to help workers carry out complex routine operations. SOPs aim to achieve efficiency, quality output and uniformity of performance, while reducing miscommunication and failure to comply agreed processes.

Safeguarding of Children Level 3 – The Trust has made it mandatory for all clinical staff working in child and adolescent services and other clinical services working predominantly with children, young people and parents to be trained in Safeguarding of Children Level 3, where staff are required to attend Level 3 training every 3 years. (In addition, all other Trust staff regularly attend Safeguarding of Children Training, including Level 1 and 2 training.)

The training ensures that Trust staff working with children and young people are competent and confident in carrying out their responsibilities for safeguarding and promoting children's and young people's welfare, such as the roles and functions of agencies; the responsibilities associated with protecting children/young people and good practice in working with parents. The Level 3 training is modelled on the core competencies as outlined in the 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' (Intercollegiate Document 2010); Working Together to Safeguard Children, 2010; the London Child Protection Procedures 4th Ed, 2010; NICE Clinical Guidance 2009: 'When to Suspect Child Maltreatment'.

Sleep hygiene – Sleep hygiene is a variety of different practices and habits that are necessary to have good night time sleep quality and full daytime alertness.

Specific Treatment Modalities Leaflets – These leaflets provide patients with detailed information on the different treatment modalities offered by the Trust, to facilitate patients making informed choices and decisions about their treatment.

Strategic Executive Information System (STEIS) – The national serious incident reporting system. All Trusts are required to report serious incidents that meet a specific definition to STEIS.

TEL – Technology Enhanced Learning

THRIVE – A model of care which offers a radical shift in the way that child and adolescent mental health services (CAMHS) are thought about and potentially delivered. The developing model responds to and offers solutions to the current context for mental health services; recognising the rising need for provision in certain groups, clinical outcomes, budgetary constraints and a shift and step change in policy in this area.

Time 1 – Typically, patients are asked to complete a questionnaire during the initial stages of assessment and treatment, or prior to their first appointment.

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

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

Trust Forum Meetings – These include consultation meetings with stakeholders including patients, commissioners, Non-Executive Directors, a Governor and Quality and PPI representatives. The purpose of these meetings is to contribute to the process of setting and reviewing quality priorities and indicators and to help improve other aspects of quality within the Trust.

Trust-wide Induction –The face-to-face induction programme has been phased out over the past 2 years in line with a similar approach adopted by other trusts in North Central London (NCL) in order to align our common mandatory and statutory training requirements (MAST). New staff are offered the opportunity of becoming compliant with MAST via the Electronic Staff Records (ESR) Oracle Learning Management (OLM) solution and are required to complete a local induction checklist within two weeks of commencing. A virtual corporate induction programme is to be developed during 2021/22.

Trust Membership – As a Foundation Trust we are accountable to the people we serve. Our membership is made up of our patients and their families, our students, our staff and our local communities. Members have a say in how we do things, getting involved in a variety of ways and letting us know their views. Our members elect Governors to represent their views at independent Boards where decisions about what we do and how we do it are made. This way we can respond to the needs of the people we serve.

Waiting Times – The Trust has a policy that patients should not wait longer than an agreed time for an appointment from the date the referral letter is received by the Trust to the date of the first appointment attended by the patient. This varies from 8 – 18 weeks depending on contract requirements. However, if the patient has been offered an appointment but then cancelled or did not attend, the date of this appointment is then used as the starting point until first attended appointment.

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