NHS
The Tavistock and Portman
NHS Foundation Trust

Board of Directors Part One

Agenda and papers of a meeting to be held in public

Tuesday 28th July 2020

Please refer to the agenda for timings.

Meeting held online

The Tavistock and Portman
NHS Foundation Trust

AGENDA

BOARD OF DIRECTORS – PART ONE
MEETING HELD IN PUBLIC
TUESDAY, 28th JULY 2020, 2.00pm – 4.55pm
A MEETING HELD ONLINE

		Presenter	Timing	Paper No
1 Administrative Matters				
1.1	Vice Chair's opening remarks and apologies	Chair	2.00pm	Verbal
1.2	Board members' declarations of interests	Chair		Verbal
1.3	Minutes of the meeting held on 19 May 2020	Chair		1
1.4	Action log and matters arising	Chair		Verbal
2 Operational Items				
2.1	Vice Chair and Non-Executives' Reports	Chair and Non-Executive Directors	2.10pm	Verbal
2.2	Chief Executive's Report	Chief Executive	2.20pm	2
2.3	Finance and Performance Report	Deputy Chief Executive / Director of Finance	2.30pm	3 - late
2.4	Quality Dashboard (Q1)	Medical and Quality Director	2.35pm	4
3 Items for discussion				
3.1	Our LGBTQI+ Network and Work Programme	LGBTQI+ Diversity Champion	2.55pm	verbal
3.2	Centenary Celebrations update	Projects Director	3.05pm	5
4 Items for noting				
4.1	Board Assurance Framework (BAF)	Chief Executive	3.15pm	6
4.2	Operational Risk Register	Associate Director of Quality & Governance	3.25pm	7
4.3	Serious Incident Report (Q1)	Medical and Quality Director	3.35pm	8
4.4	Guardian of Safer Working Report (Q1)	Medical and Quality Director	3.45pm	9
4.5	Responsible Officer's Revalidation Annual Report	Medical and Quality Director	3.55pm	10
4.6	Infection prevention and control (IPC) measures and exceptions	Medical and Quality Director	4.05pm	11
4.7	Complaints and Whistleblowing Register	Complaints Manager	4.15pm	12
4.8	Education and Training EDI Report	Director of Education & Training / Dean	4.25pm	13

AGENDA Part 1

		Presenter	Timing	Paper No
5. Board Committee Reports				
5.1	Education and Training Committee	Committee Chair	4.35pm	14
5.2	Equality, Diversity & Inclusion Committee	Committee Chair	4.40pm	verbal
5.3	Integrated Governance Committee	Committee Chair	4.45pm	15
5.4	Audit Committee	Committee Chair	4.50pm	verbal
6. Any other matters				
6.1	Any other business	All	4.55pm	
7 Date of Next Meeting				
	29th September 2020, 2.00pm – 4.00pm – Online / The Board Room, Tavistock Centre, Belsize Lane, London, NW3 5BA			

Board of Directors Meeting Minutes (Part 1)
19th May 2020, 2.00pm – 3.00pm, via Zoom

Present:			
Paul Burstow Trust Chair	Paul Jenkins Chief Executive	David Holt Senior Independent Director	Dinesh Bhugra Non-Executive Director
Deborah Colson Non-Executive Director	Helen Farrow Non-Executive Director	Celestine Keise Associate Non-Executive Director	David Levenson Non-Executive Director
Terry Noys Deputy Chief Executive / Finance Director	Craig de Sousa Director of Human Resources and Corporate Governance	Sally Hodges Clinical Chief Operating Officer	Dinesh Sinha Medical and Quality Director
Rachel Surtees Director of Strategy	Chris Caldwell Director of Nursing	Ailsa Swarbrick Director of Gender Services	Rachel James Divisional Director – CYAF
Brian Rock Director of Education and Training / Dean of Postgraduate Studies	Richard Murray Governor		
Attendees:			
Fiona Fernandes Business Manager Corporate Governance			
Apologies:			
Tim Kent, Divisional Director of Adult and Forensic Services			

AP	Item	Action to be taken	Resp	By
1.	1.3.1	Amendments to the minutes of the previous meeting	CdS/FF	Immed
2.	1.4.1	Carried forward from previous meeting Narrative to be provided on mitigation plans for ongoing T1 and T2 delays in TAP	TK	On hold

1. Administrative matters

1.1 Welcome and apologies

1.1.1 Prof Burstow welcomed all of those present. Apologies were noted, as above.

1.2 Declarations of interest

1.2.1 No declarations of interest were declared.

1.3 Minutes of the previous meeting

1.3.1 The minutes were approved as an accurate record, subject to amendments **[AP1]**.

1.4 Matters arising and action points

1.4.1 All the actions were noted as completed, with the exception of two actions which were have been put on hold. **[AP2]**

2. Operational items

2.1 Chair and non-executives' reports

2.1.1 Prof Burstow gave an oral report and highlighted

- He had attended the gender identity clinic service meeting the week prior.
- The recent Cavendish Chair's group continued to take place and was meeting more frequently for discussions on recovery from COVID-19.

2.1.2 Dr Colson and Ms Keise both reported that they had attended the Gloucester House team meeting the week prior. They emphasised it was a good and positive meeting and that every student had an educational plan and that some pupils were taught on site.

2.1.3 Ms Keise noted that parental involvement was embraced well by the service and that the flexibility of the staff who were visiting some of the students at home was beneficial for both the pupils and staff.

2.1.4 The board of directors noted the report.

2.2 Chief executive's report

2.2.1 Mr Jenkins presented the report and highlighted:

- In light of the Prime Minister's announcement on 10 May 2020 and national guidance from NHS England the Trust was developing its approach for recovery from the pandemic.
- The aim was to begin to resume some face to face clinical services by mid-June.
- A demographic risk process had been developed to assess staff vulnerabilities and plan mitigations.
- Mr Garlington had led a programme of work to assess the Trusts sites and implement a range of solutions to make the estate safe.
- Term three teaching is continued to operate on a fully online basis and this had been implemented well.
- The planning process for academic year 2020/21 was underway.
- In his capacity as Chair of the Cavendish Square Group, he was leading a programme of work with other stakeholders to support the development of the London Mayor's strategy on mental health.
- A range of quality improvement projects had been initiated in both clinical and educational services to assess the impact of moving to remote working.
- The Trust was working with partners in London Borough of Camden to develop a range of tools for when children and young people return to school in September.
- The organisation had worked collaboratively with Maudsley Learning to launch an online education programme and 3,000 people were enrolled to attend an online course.

- Work continued with the two partner NHS organisations in north central London to develop the next phase of Together In Mind.

2.2.2 Ms Surtees noted that the Trust was developing a similar offering to Together In Mind for the education sector and there had been positive engagement.

2.2.3 Mr Holt noted that it was very important to document the evidence of going into the recovery phase and to have a good audit trail about decisions being made.

2.2.4 Dr Sinha noted that an executive emergency planning, readiness and response group had been established and met daily. He emphasised that he was working closely with Mr de Sousa about governance and decisions being made during the pandemic.

2.2.5 Responding to a query from Ms Keise, Dr Hodges noted that Ms Nicholson meets with a group of teachers in Camden and was working collaboratively sharing governance and risks.

2.2.6 Mr de Sousa noted that the Trust had worked collaboratively with partner organisations in north central London to develop the demographic risk assessment. He particularly highlighted that the tool was evidence based and was in the process of being piloted with four services.

2.2.7 Prof Burstow noted that moving forward the Trust needed to consider what to adopt, adapt and abandon from the pandemic.

2.2.8 The board of directors noted the report.

2.3 Finance and performance report

2.3.1 Mr Noys presented the report and highlighted:

- For 2019/20, the Trust expected to achieve its control total.
- At the end of April, the Trust had reported a deficit of £800k. Of this £100k related to additional expenditure attributed to COVID-19 and £700k as a result of a shortfall in income.
- It was expected that income shortfalls in 2020/21 would be offset by NHS England and NHS Improvement.
- The proposed capital budget for 2020/21 was £1m less than the Trust had expected.

2.3.2 The board of directors noted the report.

3. Items for discussion

3.1 Board Assurance Framework (BAF)

3.1.1 Mr Jenkins presented the report and highlighted:

- The framework had been updated to reflect the current circumstances from the pandemic.
- An ongoing risk for the organisation was the uncertainty of the financial landscape for the current financial year.

- There were further risks as the executive looked forward to 2021/22 surrounding income.

3.1.2 Mr Holt noted there is overarching risk to adapt/change services/models bearing in mind the educational and clinical strands. He emphasised that the executive may wish to consider whether to capture this as an overall risk.

3.1.3 Mr Jenkins noted that the heat map was not dramatically dissimilar to other organisations.

3.1.4 Dr Hodges noted that staff had adapted quickly to remote working but there was anxiety about moving towards a new normal.

3.1.5 Responding to a query from Prof Bhugra, Dr Hodges noted that Adult and Forensic Service (AFS) ran an online seminar on the impact of working remotely and it was well attended. She emphasised the quality improvement projects were designed to assess what care and treatment works effectively through remote delivery.

3.1.6 Ms Swarbrick noted that in relation to GIDS the risk had been refocused as more work needed to be done to implement the action plan.

3.1.7 Responding to Ms Farrow, Dr Hodges noted that the title for the GIDS related risk would be updated.

3.1.8 Ms Surtees noted that two risks, 10b and 13, were combined into risk 11.

3.1.9 Responding to Prof Burstow, Mr Jenkins noted that the Trust were looking forward to the next financial year and the potential long term impacts of a recession and a more challenged health and social care landscape.

3.1.10 The board of directors noted the report.

3.2 Quality Dashboard

3.2.1 Dr Sinha presented the report and highlighted the key points:

- The number of referrals (page 41) had decreased.

- Trust patient contacts increased by 140 over the quarter, with small increases in most services.

- CYAF saw 90% of patients for their first appointment within the contracted waiting time. The Adolescent service remained below target but increased 10% compliance from 67% to 78%. Within this service the differential for those under 18 years was 53% and those over 18 years was within target of 85%. Referral to second appointments decreased across all services this quarter with the exception of Adult Complex Needs. TAP had increased waiting times for first appointment however, it should be noted the data for the service for Q4 had been taken from two different sources owing to data migration.

- The overall Trust patient non-attendance rate was 7.9%. TAP and the Portman services were above 10%.

- Q4 saw the same number of complaints received as in Q3 at 30. There had been an improvement in average response days down to 18. Due to the pandemic, nine complainants were awaiting a response and had been advised of possible delays.

- Among the outcome measures, CORE improvement rates increased in Q4 to 100%. Both Time 1 and Time 2 Goal Based Measure completion rates further increased in Q4 and both remain under target but are improving. The QI project in Camden North and South continues to work on improving these.

- Mental Health Services Data Set (MHSDS) collection rates are from January 2020 and show an ongoing small decrease in the three areas where the Trust had been showing consistently performance – ethnicity; employment status (adults) and accommodation status (adults).

- Experience of service questionnaire responses remained positive. It was noted that the response rates to these were particularly low and work would be undertaken in 2020/21 to increase responses to these.

- HR mandatory training compliance had improved in Q4 to 85%.

- The Trust's commissioners had assessed CQUIN compliance for 2019/20 at 100%.

- Quality Priorities for 2019-20 show 1 fully met, 4 partly met and 1 not met

- The safety indicators in Q4 were relatively the same and safeguarding reporting was consistent. There had, however, been an increase in malicious emails for GIDS and staff were being encouraged to use the incident system to report these.

3.2.2 Dr Caldwell noted that it was positive to see a reduction in incidents at Gloucester House over the last year.

3.2.3 Responding to a query from Dr Caldwell, Dr Sinha noted that the number of incidents had been around 110-120 and reflected a change to the scoring methodology. He emphasised work was still being done on safeguarding and had not heard any reports suggesting that there had been a decline in practices. He clarified that the Gloucester House reduction in incidents was attributed to the school being closed for a few weeks during the beginning of the pandemic.

3.2.4 Responding to Dr Colson, Dr Hodges noted that there ongoing issues with the team around the practice contract, as it was sub-contracted via Camden and Islington NHS Foundation Trust, and a meeting would take place to discuss the impacts of the 30% contract reduction.

3.2.5 Responding to a query from Prof Burstow, Dr Sinha noted there had been an increase in clinical service accountability for data and performance. He emphasised the Trust had reconfigured its operational oversight of data quality.

3.2.6 Mr Rock noted that the directorate of education and training data work was progressing however it was paused due to the pandemic. He emphasised student recruitment activity for the current cycle was ahead of plan.

3.2.7 The board of directors noted the report.

3.3 Serious Incident Annual Report

3.3.1 Dr Sinha presented the report and highlighted:

- There were 28 clinical incidents reported in Q4, none of which met the threshold for classification as a serious incident. However, there was one incident logged in Q3, December 2019, which was later identified in January 2020 as a serious incident and logged externally on StEIS and NRLS in Q4.

- Within the 28 reported clinical incidents there were 5 patient deaths recorded during Q4; one patient from TAP service and the other four patients were from the adult gender services. Each of these were investigated internally via concise reports which were reviewed at the monthly incident panel. Due to the nature of the deaths, they were not escalated externally and did not reach the threshold for an external serious incident investigation.

- There were also 2 attempted suicides which were not successful; one from our children's gender service and one from the adult gender service. These had also been reviewed at the incident panel.

- In December 2019 the Trust agreed with its commissioners to undertake a thematic case review of three of its previous serious incidents which were linked to gang related violence. However due to the pandemic, the work had been delayed and the expected end date had been extended to July 2020.

- The Trust had maintained roll out of the organisation wide lessons learned events, with the last event held on 4th February 2020, and although virtual attendance had been more limited, it was felt essential that these events continue and are shared as widely across teams as possible, with all related information available via the intranet.

- The new adult safeguarding and PREVENT lead commenced in post on 25th March 2020 to this two session role. Level 3 adult safeguarding training had recommenced across relevant services and will continue until compliance is reached for all relevant staff.

- The patient safety aspects of the 2018 CQC Inspection continue to be monitored by the Executive Management Team for all services and there is continued progress on the actions identified to ensure patient safety.

3.3.2 Responding to a query from Ms Keise, Dr Sinha noted that GIDS were running various waiting list initiatives and the same applied to GIC.

3.3.3 Ms Swarbrick noted that the service takes the experience of patients on the wait list very seriously and quality priority three was an important one for the division to focus on.

3.3.4 Dr Hodges noted that when patients referred to GIDS are put on the waiting list there is a review of the referrals and those with high risks would be highlighted and reported to the relevant services. She emphasised that the Trust was working with NHS England on this as well as other concerns and issues.

3.3.5 The board of directors noted the report.

3.4 Guardian of Safer Working

3.4.1 Dr Sinha informed the board that the report underlines the amount of work the trainees are doing across the STP and it must be noted that some of them have had personal losses.

3.4.2 Dr Hodges noted that the junior doctor trainees had been exemplary during the pandemic.

3.4.3 On behalf of the Board, Prof Burstow noted the exceptional contribution of the junior doctor trainees and thanked them for their hard work during the extremely challenging circumstances.

3.4.4 The board of directors noted the report.

4. Board Committee Reports

4.1 Audit Committee

4.1.1 Mr Noys reported that the Trust will receive an amber/green opinion from the Head of Internal Audit (HoIA).

4.1.2 Local Counter Fraud Service (LCFS) ran its annual awareness survey that was completed by 14% of staff. The survey showed excellent awareness of the counter fraud service and it also highlighted that staff would prefer to go externally to report rather than internally.

4.1.3 The Audit Committee were pleased to hear that the business continuity plans worked well during this pandemic.

4.1.4 Responding to a query from Ms Farrow, Mr Noys noted that although it was only 14% who completed the survey, the figures were higher than NHS other organisations. The low response to the survey was also due to the current pandemic.

4.1.5 The board of directors noted the report.

4.2 Education and Training Committee

4.2.1 Prof Burstow reported that the last meeting was well attended. He noted and commended the work and engagement of the directorate of education and training staff across teaching and academic support services who had worked in collaboration to move in a short space of time to remote working and, to continue to plan and deliver the last term of the academic year.

4.2.2 The board of directors noted the report.

5. Any other matters

5.1 Any other business

5.1.1 There was no other business noted.

6. Date of next meeting

6.1 28th July 2020 at 2.00pm

6.1.1 The meeting closed at 3.47pm.

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	28 July 2020

Chief Executive's Report

Executive Summary

This report provides a summary of key issues affecting the Trust including our response to the pandemic

Recommendation to the Board

Members of Board of directors are asked to discuss this paper.

Trust strategic objectives supported by this paper

All

Author	Responsible Executive Director
Chief Executive	Chief Executive

Chief Executive's Report

1. Covid Recovery

1.1 The Trust has been working to build up its level of face to face clinical work as we move beyond the first phase of the pandemic and as the demand for services increases. This has been a careful process based on:

- Review of clinical caseloads to identify patients at risk or for whom remote delivery has not been effective.

- Demographic risk assessments for staff to identify those with ongoing vulnerability or for whom some adjustments in working patterns may be appropriate.

- Risk assessments for working spaces to identify safe working practices including the arrangement of furniture and the number of staff appropriate to occupy the space.

1.2 DET has completed a programme of total remote working for Term 3. This has been well received by students with a very high level of satisfaction with the quality of experience delivered. Plans are currently being finalised for the start of AY 2020/1. This will focus, for at least Term 1, on remote delivery.

1.3 At present corporate services, are for the most part, being delivered on a remote basis. We will keep this situation under review.

1.4 The Trust continues to make a significant contribution to plans for the recovery across North Central London and to wider work at the London level. This has included ongoing involvement in work on staff wellbeing and the management and longer-term development of the CAMHS crisis pathway. We are also involved in leading work on the development of CAMHS as part of the priorities identified by the Cavendish Square Group at a London level.

2. Demographic risk assessment

2.1 As members of the Board of Directors will be aware, the Trust launched a demographic risk assessment on 01 June to assess the staff vulnerabilities and social factors that will impact on their ability to deliver face to face work. Engagement with the process has been high and we are aware that a lot of effort has been invested in meeting with staff to have structured discussions about how best to support them.

2.2 The assessment tool was developed in collaboration with partner trusts across North Central London and our occupational health service provider. It also incorporated the latest guidance from the Faculty of Occupational Medicine.

2.3 The Trust is in the process of collating the data to inform regular national reporting on the number of staff that have undergone a risk assessment.

3. Remote working QI programme

3.1 There has been a significant engagement with QI to assess the experience of remote working. Since the launch of the project, over 15 teams across the clinical and education parts of the Trust have taken on the QI project on remote working. This project brief sets out a proposal for improving the user experience of remote working, both at staff, student and service user level, using Quality Improvement (QI) methodology. The project framework is intended for use by teams within the Trust who are remote working as a means to continue delivery and to gather data to help inform future service design once the current crisis has abated.

3.2 The work within the various teams has led to good use of the existing infrastructure and for the DeT, led to a blossoming of supportive structures. Individual teams have linked their aims with their particular settings and interventions. Early reports of implementation of change ideas using plan do study act (PDSA) cycles have begun with reports of improvements. Some examples include:

- GIC have been collecting the experience scale/ outcome measure data, alongside some additional questions
- GIDS plan to launch data collection of the experience scale/ outcome measure via survey format for YP and families
- South Camden aiming optimise the experience of a bi-monthly young people's feedback forum with scores and comments being completed by both service users and staff
- South Camden aim to enhance the experience of Zoom sessions for Multidisciplinary Team (MDT) case discussions
- CAISS reviewing change ideas to improve relational aspects of Zoom/phone interactions that have emerged through the project
- The Gloucester House project's main aim to maintain academic attainment scores through the remote working period
- The ASC/LD team pre-existing QI Project helping young people make an informed decision about Autism Spectrum Condition (ASC) assessments was adapted to enhance knowledge and confidence using Zoom. The team created decision-making grids (based on i-THRIVE grids) to facilitate shared decision making around participation in ASC diagnostic assessments and resources for young people
- The Trauma service is in the process of looking at gathering baseline data, including on patients who have declined to be seen remotely so that we can have more of an understanding about how many people did not wish to take up the offer and reasons

- TAP are in the process of collecting baseline data for two separate QI projects
- Complex Needs have conducted a series of interviews with staff about their experience of working remotely and are now analysing this data to introduce PDSA cycles

3.3 Reports from various projects suggest that there will be a combination of quantitative and qualitative data at team level, which is likely to lead to planned decisions on what aspects of remote working are worth embedding, as versus those where the experience is less useful.

3.4 This period of working with QI in a hands-on way could auger a different way of approaching the work of continuous improvement by giving ownership to our teams. Our attempt is for a broader cultural shift in how we generate change ideas in co-creation by using service users experience and then use granular data to drive broader improvement. This work has not been without its share of challenges, as staff report a combination of pressures of time, work and possible cultural issues in using QI methodology.

4. Black Lives Matter

4.1 As was discussed at the Board seminar in June the events around the death of George Floyd and the Black Lives Matter movement have provided a significant moment for the Trust to review its commitment to race equality

4.2 Particular credit should be given to the BAME Staff Network, under the leadership of Irene Henderson, for facilitating an open but challenging dialogue about the experience of BAME staff. An open meeting of the Network on 30th June was attended by 180 staff.

4.3 That meeting and other conversations across the organisation have highlighted the distance we still need to go to make the Trust genuinely diverse and inclusive and to eliminate conscious and unconscious bias and acts of racism which disadvantage staff, patients and students from black and minority ethnic backgrounds.

4.4 The Trust was due to refresh, this autumn, the Race Equality Strategy we launched in 2017 and we have started a consultation with staff on how we should approach this. In the joint statement Paul Burstow sent out at the beginning of July we have committed to a number of measures we believe will be an important part of our response. These include:

- A requirement for all staff to have an objective on race equality and diversity, which defines their personal commitment on this issue and fits into the overall equality objectives in their service.

- A commitment to take a different approach to diversity training with mandatory training on diversity for all staff and a specific approach for those who manage people.

- Changes to our recruitment and selection procedures to address better conscious and unconscious bias.

- Finding ways to make it easier for black and minority ethnic staff and students to raise concerns and to respond appropriately to the concerns.

- A commitment for each Trust division to provide quarterly milestone reports, directly to the Board and EDI Committee, to help identify areas where the strategy may not be fully embedded.

- A commitment to providing further opportunities for all staff and students to come together as an organisation to discuss these issues openly.

Paul Jenkins
Chief Executive
21st July 2020

Report to	Date
Board	28 July 2020

Finance and Performance Report – June 2020

Executive Summary

The YTD Finance and Performance Report is attached.
In line with NHSE/I guidance this shows the Trust at 'break-even'.
It should be noted, however, that there remains some uncertainty on the accounting for income. In line with guidance, the Trust is invoicing / accruing for income for activities for which it 'contracts' directly with other providers. However, as many of these are not issuing POs nor answering e-mails there is a risk that this income is overstated. The Trust is actively seeking clarification on this point.
In addition, the Trust has accrued the additional income Budgeted for GIC, however, it has yet to receive formal, contractual approval for this.
The Board are also asked to note the significant overspend in capital expenditure on Finchley Road. This will have an adverse impact on other capex projects and on income & expenditure.
Cash – at £11.8m is £1.6m ahead of Budget.

Recommendation to the Board

The Board is asked to note the report and the uncertainties regarding income

Trust strategic objectives supported by this paper

Services / Growth and Development / Finance and Governance

Author	Responsible Executive Director
Terry Noys, Deputy CEO and Director of Finance	Terry Noys, Deputy CEO and Director of Finance

The Tavistock and Portman NHS
NHS Foundation Trust

MONTHLY FINANCE AND PERFORMANCE REPORT

Period 3 **Jun-20**

Section

MONTHLY FINANCE AND PERFORMANCE REPORT **Section 1**

Period 3
Jun-20

	20/21 Actual YTD £'000	20/21 Budget YTD £'000	Variance Actual v Budget £'000	**Variance Actual v Budget %**	20/21 Actual YTD £'000	20/21 Covid Plan YTD £'000	Variance Actual v Plan £'000	20/21 Budget YTD £'000	20/21 Covid Plan YTD £'000	Variance Budget v Plan £'000
Income	14,454	13,453	1,000	**7%**	14,454	14,477	(23)	13,453	14,477	(1,024)
Staff costs	(10,606)	(10,686)	80	**1%**	(10,606)	(10,692)	86	(10,686)	(10,692)	6
Non-staff costs	(3,322)	(2,912)	(410)	**14%**	(3,322)	(3,332)	10	(2,912)	(3,332)	420
Operational costs	**(13,928)**	**(13,598)**	**(330)**	**(2)%**	**(13,928)**	**(14,024)**	**96**	**(13,598)**	**(14,024)**	**426**
EBITDA	**525**	**(145)**	**670**	**-463%**	**525**	**453**	**72**	**(145)**	**453**	**(598)**
- Margin	**4%**	-1%			**4%**	3%		**-1%**	3%	
Interest receivable	2	14	(12)	(87)%	2	12	(10)	14	12	2
Interest payable	(8)	(8)	(0)	6%	(8)	(6)	(2)	(8)	(6)	(2)
Depreciation / amortisation	(357)	(405)	48	(12)%	(357)	(297)	(60)	(405)	(297)	(108)
Public Dividend Capital	(162)	(177)	15	(8)%	(162)	(162)	0	(177)	(162)	(15)
Net surplus	**(0)**	**(721)**	**721**		**(0)**	**0**	**(0)**	**(721)**	**0**	**(721)**
- Margin	**(0)%**	(5)%								

COMMENTARY

Covid Plan

This is the income / expenditure profile for the Trust (based on December 2019 results) assumed by NHSE/I
The intention is that the Trust should 'break even'

Income

Accounting for income is still highly uncertain. Currently, the Trust is invoicing other providers for NPAs and other contracts (in line with formal guidance), however, with many providers not currently issuing POs (or even responding to e-mails), there is a risk that income is overstated. Further clarification regarding this matter is currently being sought from NHSE/I. It should also be noted that the increased value in the Adult GIC service plus the extension into Sussex have yet to be contractually approved

Pay costs

These are £0.1m favourable to Budget, or £0.3m favourable once COVID related costs are recognised

Non pay Operational costs are £0.4m adverse against the budget

This includes £0.3m of costs relating to COVID. Discounting these, non-pay operating costs are £0.1m adverse to Budget

Non-operating Costs

These are some £0.1m lower due to reduced levels of capital expenditure from 19/20

FINANCE AND PERFORMANCE REPORT **BALANCE SHEET**
Period 3 **Section 2**
01 June 2020

	Prior Year End £'000	June £'000
Intangible assets	95	80
Land and buildings	20,755	21,949
IT equipment	2,680	2,516
Other	0	0
Property, Plant & Equipment	23,435	24,465
Total non-current assets	23,531	24,545
Trade and other receivables	6,394	3,853
Accrued Income and prepayments	3,177	3,251
Cash / equivalents	9,761	11,786
Total current assets	19,332	18,890
Trade and other payables	(2,867)	(3,639)
Accruals	(3,524)	(3,844)
Deferred income	(5,756)	(5,236)
Provisions	(72)	(72)
Total current liabilities	(12,219)	(12,792)
Total assets less current liabilities	30,643	30,643
Non-current provisions	(322)	(322)
Long term loans	(3,555)	(3,555)
Total assets employed	26,766	26,766
Public dividend capital	(3,724)	(3,724)
Revaluation reserve	(12,171)	(12,171)
I&E reserve	(10,871)	(10,871)
Total taxpayers equity	(26,766)	(26,766)
	(0)	0

CAPITAL EXPENDITURE FORECAST

Period 3

Jun-20

TOTAL PROJECT SUMMARY - CAPITAL EXPENDITURE

2020/21

PROJECT	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	ANNUAL			Y.T.D		
	£000 Actual	£000 Actual	£000 Actual	£000 F/C	£000 F/C	£000 F/C	£000 F/C	£000 F/C	£000 F/C	£000 F/C	£000 F/C	£000 F/C	£000 F/C	£000 Budget	£000 Delta Fav (Adv)	£000 Actual	£000 Budget	£000 Delta Fav (Adv)
Endpoint Replacement 2019/20	90	(74)	36	-	-	-	-	-	-	-	-	-	**52**	-	**(52)**	**52**	**-**	
Care Notes Renewal	-	(1)	-	-	-	-	-	-	-	-	-	-	**(1)**	-	**1**	**(1)**	**-**	
Health Information Exchange	22	31	20	2	1	-	-	-	-	-	-	-	**76**	88	**13**	**76**		
MyTap Annual Upgrade 2019/20	-	36	20	-	-	-	-	-	-	-	-	-	**56**	-	**(56)**	**56**	**-**	
Endpoint Replacement 2018/19	0	-	1	-	-	-	-	-	-	-	-	-	**1**	-	**(1)**	**1**	**-**	
DET Record Management System	(27)	-	-	-	-	-	-	-	-	-	-	-	**(27)**	-	**27**	**(27)**	**-**	
Scheduling & Robotic Process Automation	14	16	13	47	47	48	48	47	47	-	-	-	**327**	329	**3**	**43**		
IT	**100**	**8**	**89**	**74**	**73**	**73**	**98**	**97**	**97**	**100**	**100**	**(33)**	**875**	**1,029**	**154**	**157**		
LH - 67 Belsize Lane	0	-	-	-	-	-	-	-	-	-	-	-	**0**	-	**(0)**	**0**	**-**	
Finchley Road	126	371	326	-	-	-	-	-	-	-	-	-	**823**	240	**(583)**	**823**		
ESTATES	**126**	**371**	**326**	**20**	**10**	**5**	**43**	**38**	**33**	**35**	**35**	**20**	**1,062**	**479**	**(583)**	**823**		
RELOCATION - Cost	105	44	108	65	65	75	110	65	85	65	65	171	**1,025**	1,000	**(25)**	**256**		
RELOCATION - Expense Transfer	-	-	(50)	-	-	(50)	-	-	(50)	-	-	(50)	**(200)**	(200)	**-**	**(50)**		
RELOCATION	**105**	**44**	**58**	**65**	**65**	**25**	**110**	**65**	**35**	**65**	**65**	**121**	**825**	**800**	**(25)**	**206**	**-**	
DIGITAL ACADEMY	**-**	**22**	**26**	**37**	**23**	**23**	**8**	**8**	**8**	**8**	**8**	**8**	**180**	**181**	**0**	**48**		
TOTAL	**330**	**445**	**499**	**197**	**171**	**126**	**259**	**209**	**174**	**209**	**209**	**117**	**2,942**	**2,489**	**(454)**	**1,233**	**-**	**-**

YTD Capital expnditure is £0.5m higher than budgeted. This is due to the signicicant overspend on Finchley Road

In order to ensure that the Trust remains within its STP agreed cap, other capex programmes will need to be curtailed

The Tavistock and Portman
NHS Foundation Trust

Board of Directors: July 2020

Report to	Date
Board of Directors	July 2020

Quality Dashboard and Commentary

Executive Summary

The attached report provides a summary and narrative for Q1 quality metrics for the Trust. The Commentary section provides service updates on waiting times and 'DNAs' where these are available, given constraints on services dealing with the covid-19 pandemic. Updates are also included on the current position of Trust Quality Priorities. Please note the data in this report is Trust wide.

The report includes the following **highlights and improvements**:

- Trust patient contacts decreased over Q1 by 317, with small increases in GIDs and FCAMHS.
- In Q1 CYAF continued to see 90% of patients for their first appointment within the contracted waiting time. The Adolescent service remains below target but increased compliance from 77% to 80%. Within this service the differential for those under 18 years increasing from 53% to 67% and those over 18 years dropping back from target to 82%. Referral to second appointments increased across all services this quarter with the exception of C&H. TAP saw 21% of referrals increasing waiting times for first appointment from 19% in Q4.
- Overall Trust DNA compliance is 8% compared with 7.9% in Q4, with improving performance in all AFS services – the Portman DNAs reduced from 11.2% to 7.8%. Gender services were on or under target. Adolescent services increased from 10% to 11.2% this quarter.
- Q1 saw 15 complaints compared to 30 in Q4. The biggest drop was in the Gender Services, reducing from 21 to 12 complaints this quarter. The 'pause' in the complaints process due to the coronavirus was for the Q1 period and all complainants were informed of this and advised of possible delays.
- HR information shows a reduction in staff sickness in Q1 at 1.3%. This is markedly below the NHS Benchmark of 4%. DBS compliance remains high at 98%. Mandatory training and staff appraisal % are low as these were on hold for Q1.
- Going forward DET have developed a reporting cycle for long course and short course activity and reporting which will be aligned to Trust strategic objectives. Covering recruitment, survey and academic outcomes, confirmed enrolments and retention. Data will be presented over time.

There are also details of continuing **Challenges**:

- The total number of Trust referrals received has shown a decrease of 1170 referrals this quarter. An increase is anticipated as a result of the pandemic.

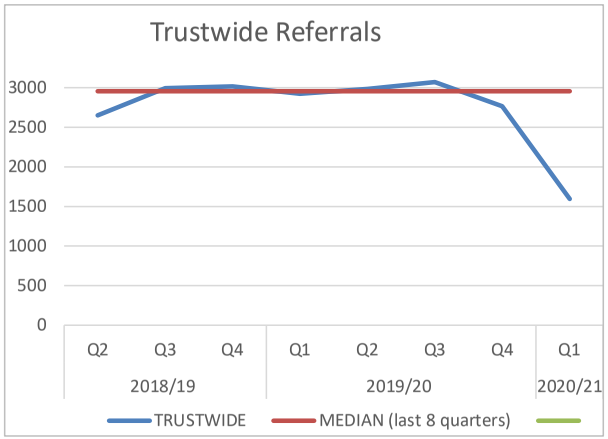
- Waiting times for Gender Services, Adult Complex Needs and TAP continue to be lengthy.
- Among our outcome measures, CORE improvement rates halved in Q1 to 50%. Time 1 Goal Based Measure completion rates decreased in Q1 from Q4, along with the Time 2 completion rate. Both remain under target. GBM and CGAS collection rates are under target although it is likely that the decrease in Q1 is as a result of the Covid-19 pandemic and the pressure to scale up collection of outcomes using electronic means, which now needs a Trust wide solution.
- MHSDS collection rates are from April 2020 and show an ongoing small decrease in two areas where we have been showing consistently poor data – ethnicity and accommodation status (adults). Compliance with the Ex-British Armed Forces indicator continues to improve. The most recent DQMI is for March 2020 with compliance at 95.6% against a target of 95%.
- The number of followers across all Trust social media platforms continues to increase quarter-on-quarter. We published less content compared with the previous quarter, as centenary events were cancelled due to the pandemic. The % of positive print media articles increased from 22% in Q4 to 45% in Q1. 83% involved GIDs.

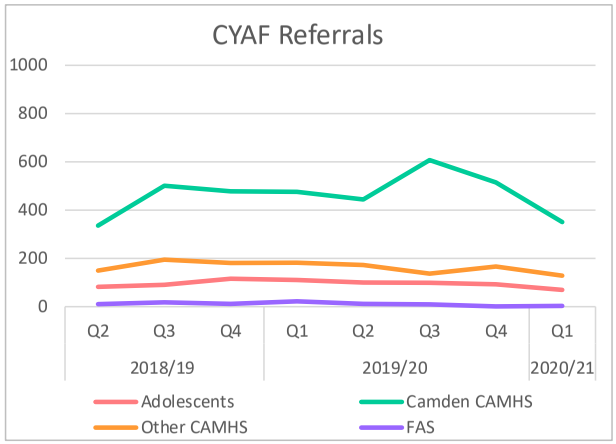
Recommendation to the Board of Directors
The Board of Directors is asked to discuss the report.

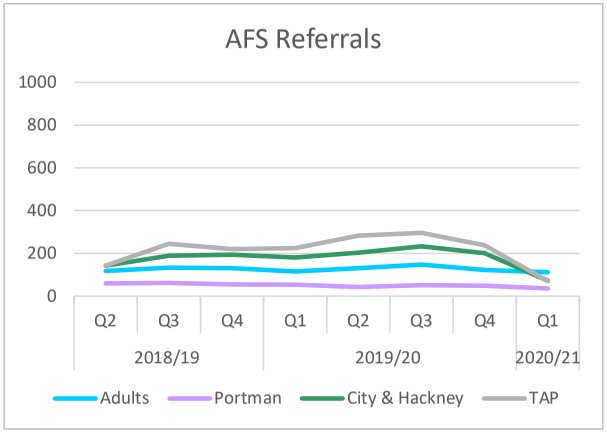
Trust strategic objectives supported by this paper
Finance and Governance

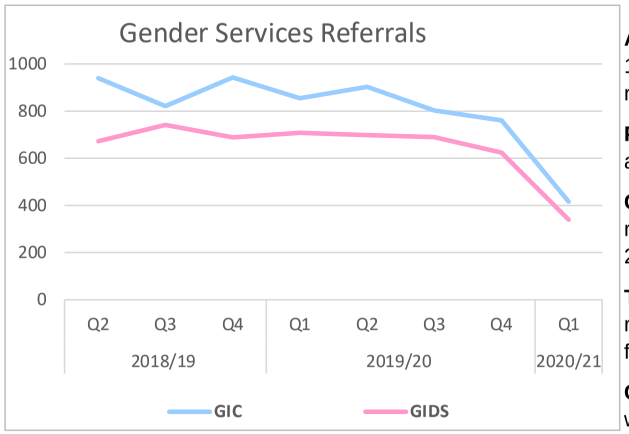
Author	Responsible Executive Director
Quality Assurance Team	Dr Dinesh Sinha, Director of Quality

Q1 20/21: Trust Reach – Access









Data source: Q1 data as recorded on 14/07/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports, they have not been re-run in line with commissioner resubmissions.
Reporting services were not operative from 15th Jun to 10th July, we believe this and Covid-19 could have affected our data

Number of Referrals Received:

In the data below we have included all referrals received over the last two years including accepted, rejected and pending. This data is Trust-wide and covers all contracts and all service lines.

Trust-wide we saw drop in referral numbers in Q1, we believe this is directly related to Covid-19. In Q1 the trust received 1596 referrals, which is 1341 lower than the average number of referrals over the last financial year.

Adolescents: in Q1 received 69 referrals, the average of referrals received during last financial year was 100 per quarter.

Camden CAMHS: in Q1 received 350 referrals, 164 fewer than in Q4. The average of referrals during last financial year was 510 per quarter.

Other CAMHS: in Q1 received 128 referrals, 94 fewer than in Q4. The average of referrals during last financial year was 166 per quarter.

Family Assessment Service: the number of referrals increased in Q1, with 3 referrals. The average of referrals during last financial year was 10 per quarter.

Adults Complex needs: experienced a slight decrease in referrals, receiving 112 in Q1 compared to the 122 received in Q4. The average number of referrals received during last financial year was 128.

Portman: in Q1 experienced a lower number of referrals - 36. The quarterly average last financial year was 49.

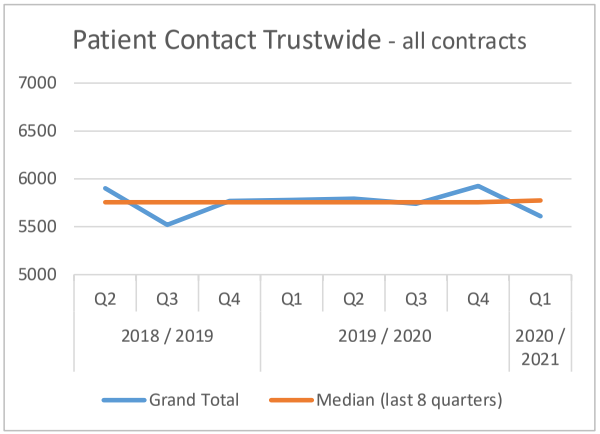
C&H PCPCS: had a significant decrease in Q1, when only 72 referrals were received 129 fewer than in Q4. The quarterly average last financial year was 204.

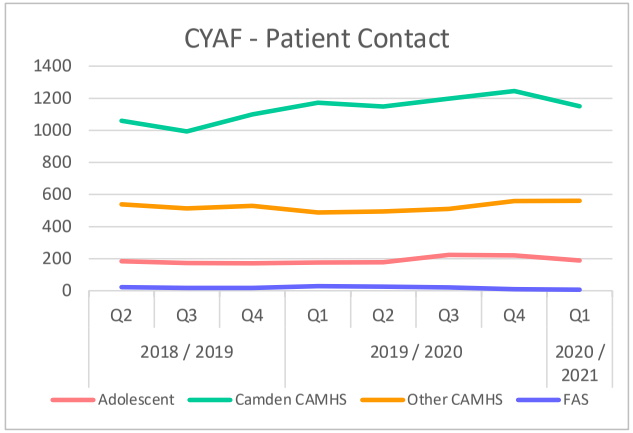
Team Around the Practice: had a significant decrease in Q1, when only 70 referrals were received 167 fewer than in Q4. The quarterly average last financial year was 260.

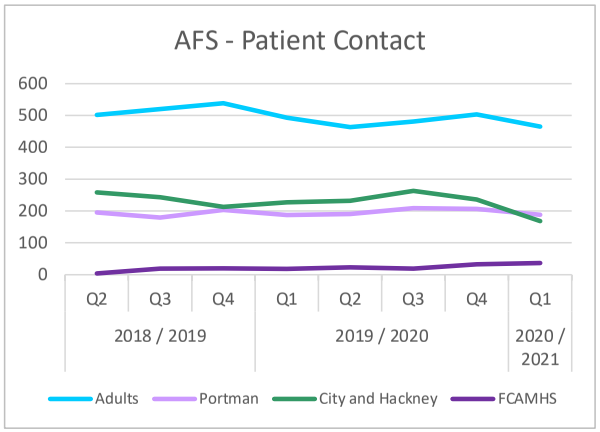
GIDS: in Q1 GIDS received 340 referrals, a substantial decrease on Q4, when 624 referrals were received. The quarterly average last financial year was 680.

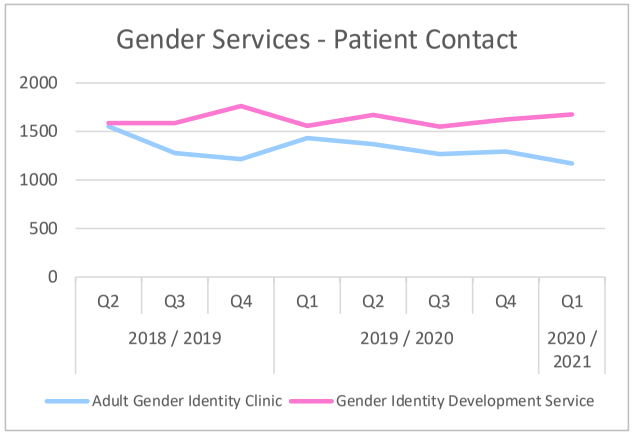
GIC: in Q1 received 416 referrals, a substantial decrease on the 761 referrals received in Q4. The quarterly average last financial year was 830.

Q1 20/21: Trust Reach – Access









Data source: Q1 data as recorded on 14/07/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports, they have not been re-run in line with commissioner resubmissions.
Reporting services were not operative from 15th Jun to 10th July, we believe this and Covid-19 could have affected our data

Individual patients in contact with our services

We include all individual patients in all contracts who have had contact with our service, excluding EIS and Mosaic. They are reported only once per quarter. Data includes telephone and zoom contacts. As a result of the pandemic the majority of consultations in Q1 were undertaken through the use of zoom.

Trust-wide, we saw a decrease in the individual number of patients seen in Q1. We believe this is directly related to Covid-19. In Q1 the trust saw 5609 individual patients, which is 196 lower than the average number of contacts over the last financial year.

Adolescents: in Q1 saw 189 individual patients. The average of number of patient contacts during last financial year was 199 per quarter, so there is been a slight drop in numbers.

Camden CAMHS: in Q1 saw 1150 patients, a slight drop from Q4 when they saw 1245, this was the highest number over the last two years. The average of number of patient contacts during last financial year was 1191 per quarter.

Other CAMHS: in Q1 had contact with 561 patients, an increase from the 559 seen in Q4 19/20. The average of number of patient contacts during last financial year was 513 per quarter.

Family Assessment Service: : experienced a decrease in contacts, in Q1 they saw 7 patients and in Q4 19/20 9.

Adults Complex Needs: in Q1 saw 465 patients, a decrease on Q4 data when 485 patients were seen. The average of number of patient contacts during last financial year was 480 per quarter.

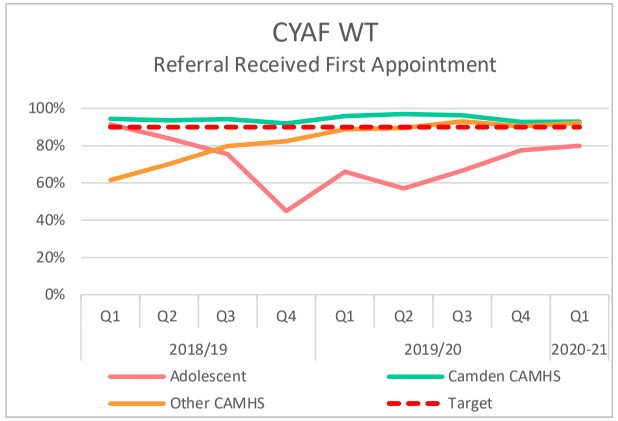
Portman: in Q1 had contact with 188 patients, slightly lower than in Q4 when they saw 206. The average of number of patient contact during last financial year was 198 per quarter.

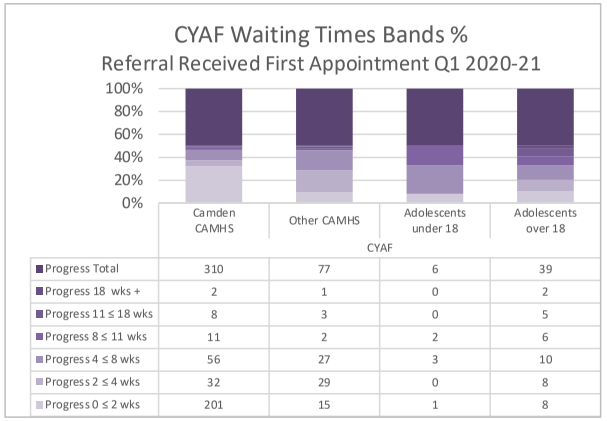
C&H PCPCS: in Q1 made contact with 168 patients, a significant decrease from Q4 when they saw 236. The average number of patient contact during last financial year was 239 per quarter.

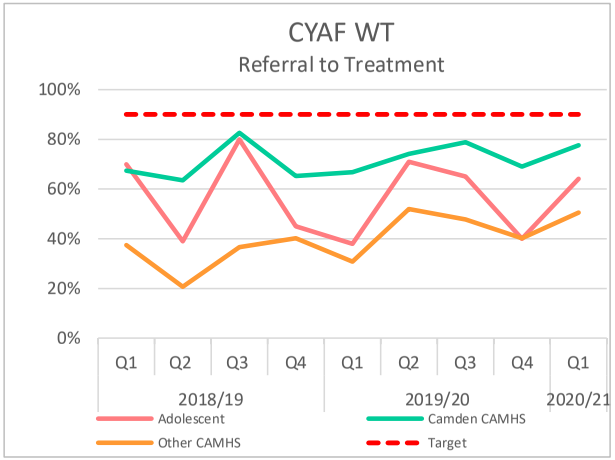
GIDS: in Q1 contacted 1675 patients, an increase on Q4 when saw 1622. The average last financial year was 1599.

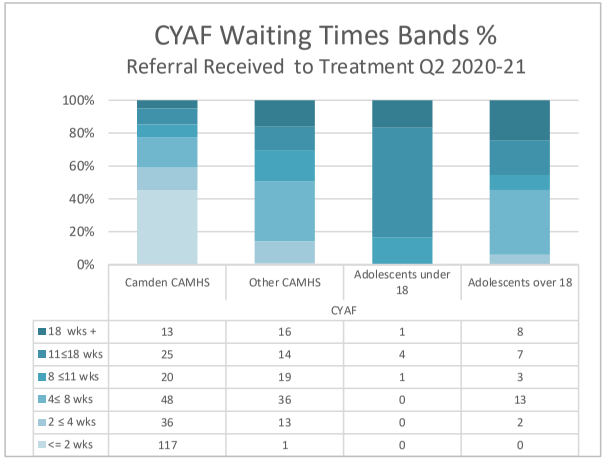
GIC: in Q1 contacted 1170 patients, The average of number of patients contact during last financial year was 1340 per quarter.

Q1 20/21: Quality Responsive – Access









Data source: Q1 data as recorded on 17/07/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports, they have not been re-run in line with commissioner resubmissions.
Reporting services were not operative from 15th Jun to 10th July, we believe this and Covid-19 could have affected our data

CYAF Waiting Times:

When calculating the waiting times we include all contracts and all activity including significant telephone conversations.

Referral to 1st appointment: In Q1 CYAF saw 92% of patients within the contractual waiting times. This is slight a improvement compared to 90% in Q4.
Referral to Treatment: In Q1 CYAF saw 70% of patients within the contractual waiting times. This is an improvement compared to 60% in Q4.

Adolescent services
Referral to 1st appointment – in Q1 the whole service line saw 80% of patients within contractual waiting times, an improvement on the 77% in Q4 19/20.
- Adolescents under 18 - **67%**
- Adolescents over 18 - **82%**

Referral to Treatment– – in Q1 the whole service line saw 64% of patients within contractual hours, compliance increase compared to 40% in Q4 19/20.
- Adolescents under 18 - **0%**
- Adolescents over 18 - **76%**

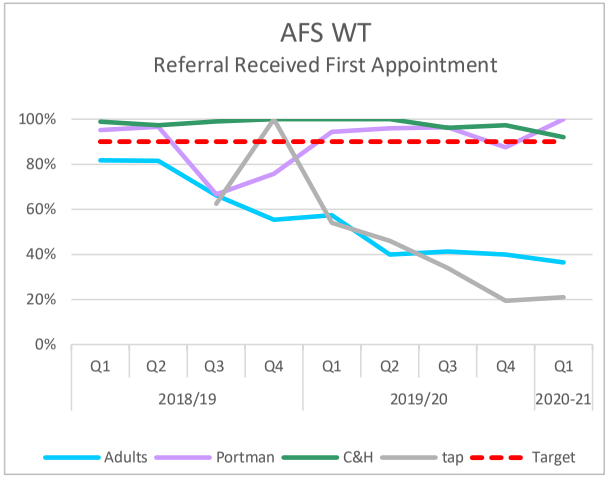
Camden CAMHS.
Referral to 1st appointment – has consistently done well since 2017/18. The compliance rate in Q1 was 93%, same rate as Q4 19/20.
Referral to Treatment– in Q1 78% of the patients had an appointment within 8 weeks, an improvement in compliance compared to 69% in Q4 19/20.

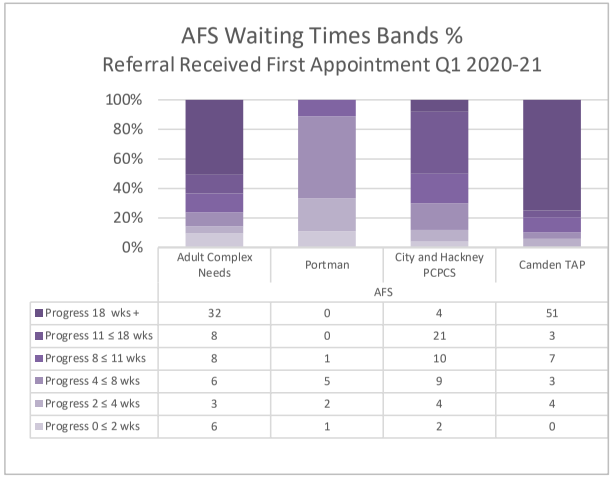
Other CAMHS
Referral to 1st appointment – In Q1 they achieved 92%. In Q4 19/20 the rate was 90%.
Referral to Treatment– in Q1 we noticed an improvement reaching a 51% compliance rate, compared to 40% in Q 19/20 4.

Family Assessment Service (FAS) is separate from the CCG and Mental Health Service contracts and the usual waiting time targets don't apply.

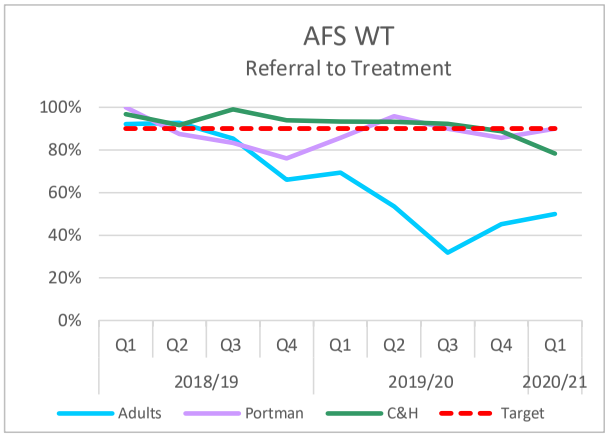
For further comments from service leads please see the commentary part of the report Page 22

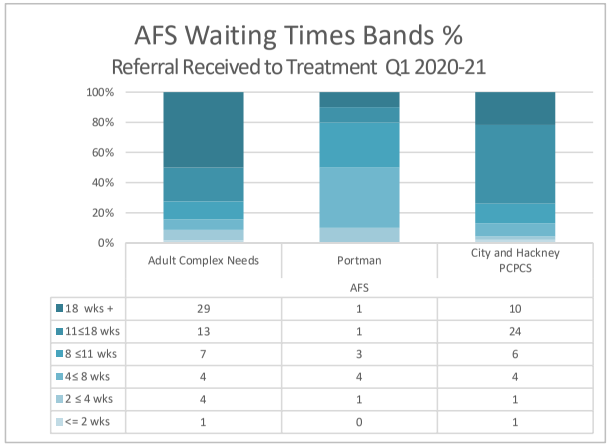
Q1 20/21: Quality Responsive – Access





AFS	Adult Complex Needs	Portman	City and Hackney PCPCS	Camden TAP
Progress 18 wks +	32	0	4	51
Progress 11 ≤ 18 wks	8	0	21	3
Progress 8 ≤ 11 wks	8	1	10	7
Progress 4 ≤ 8 wks	6	5	9	3
Progress 2 ≤ 4 wks	3	2	4	4
Progress 0 ≤ 2 wks	6	1	2	0





AFS	Adult Complex Needs	Portman	City and Hackney PCPCS
18 wks +	29	1	10
11≤18 wks	13	1	24
8 ≤11 wks	7	3	6
4≤ 8 wks	4	4	4
2 ≤ 4 wks	4	1	1
<= 2 wks	1	0	1

AFS Waiting Times:

When calculating the waiting times we include all contracts and all activity including significant telephone conversations.

Referral to 1st appointment: In Q1 AFS saw 48% of patients within the contractual waiting times. In Q4 this compliance was to 66%.
Referral to Treatment : In Q1 AFS saw 65%. of patients within the contractual waiting times. In Q4 this compliance was to 72%.

Adult Complex Needs
Referral to 1st appointment –in Q1 they had 37% compliance, a slight decrease on Q4, when 40% compliance was achieved.
Referral to Treatment– in Q1 they had 50% compliance, an increase on Q4, when they had 45% compliance.

Portman
Referral to 1st appointment – in Q1 they had 100% compliance, an increase on Q4, when they had 88% compliance.
Referral to Treatment– in Q1 they had 90% compliance, another increase on Q4, when they had 86% compliance. Both targets were met by Portman in Q1.

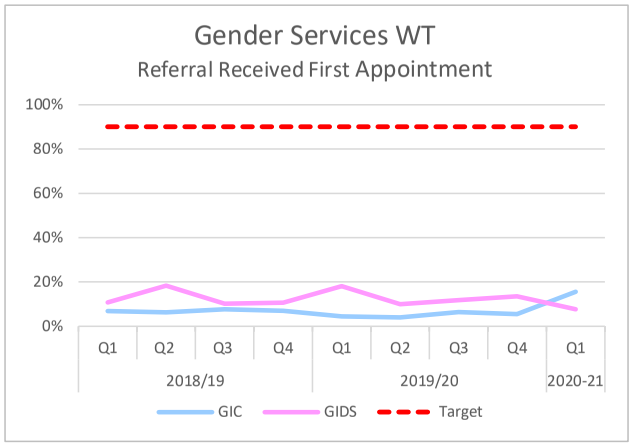
C&H PCPCS
Referral to 1st appointment – in Q1 92 they had 92% compliance, a decrease on Q4, when they had 97% compliance. The target was met.
Referral to Treatment– in Q1 they had 78% compliance, a decrease on Q4, when they had 89% compliance.

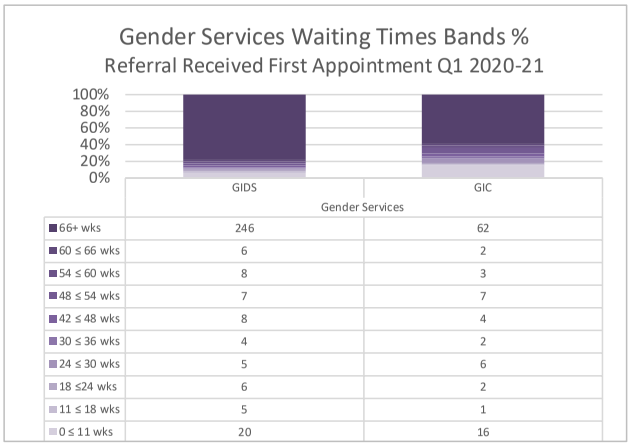
Team Around the Practice:
Referral to 1st appointment – in Q1 the percentage of patients seen on time increased slightly to 21%, in Q4 19/20 compliance was 19%.
Referral to Treatment– this service does not report on second appointments as their system (EMIS) is not able to provide the data.

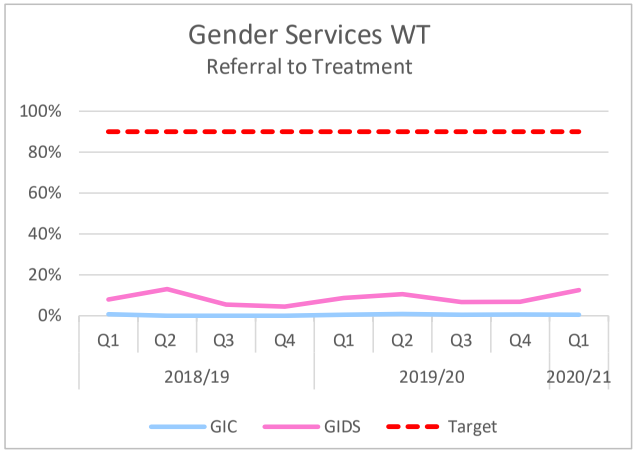
For further comments from service leads please see the commentary part of the report Page 23

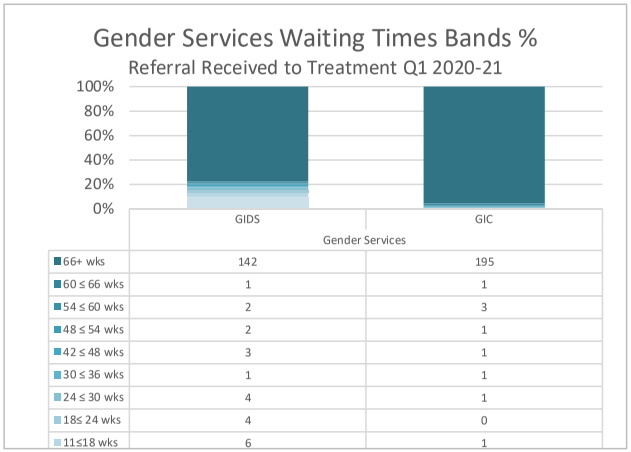
Data source: Q1 data as recorded on 17/07/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports, they have not been re-run in line with commissioner resubmissions.
Reporting services were not operative from 15th Jun to 10th July, we believe this and Covid-19 could have affected our data.

Q1 20/21: Quality Responsive – Access









Gender Services Waiting Times:

Gender Services Directorate have had an unusually high number of referrals over the past few years and challenging demand nationwide. Work is continuing to address Waiting Times issues.

Referral to 1st appointment: Gender Services Directorate saw in Q1 10% of patients within the contractual waiting times. There is no been change from Q4.
Referral to Treatment : Gender Services Directorate saw in Q4 6% of patients within the contractual waiting times. This is an improvement compared to 3% in Q4.

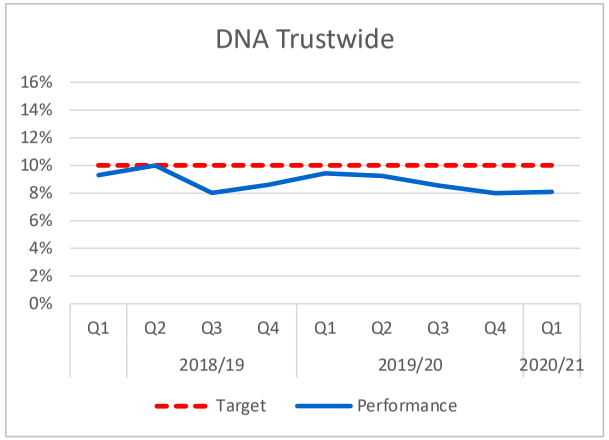
GIDS: as a measure of awareness the GIDS website shares information about the WT issue; the current waiting time is advised on the website to young people and referrers and explains that they currently see young people who were referred 22-26 months ago.
Referral to 1st appointment – in Q1 achieved 8% compliance, a decrease on 14% in Q4.
Referral to Treatment– in Q1 achieved 13% compliance, a slight increase on 7% in Q4.

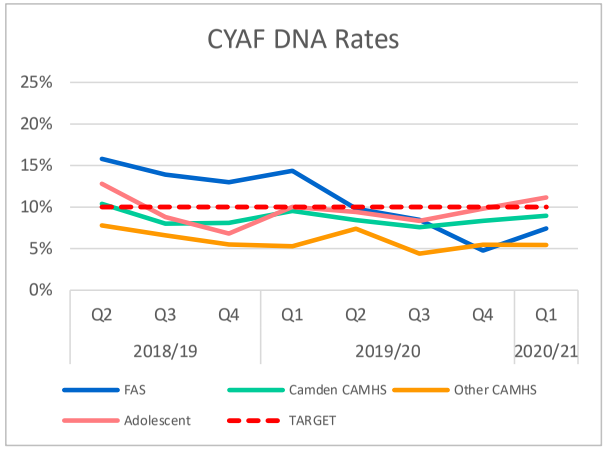
GIC: The Gender Identity Clinic in London continues to have an extremely high number of referrals, which is challenging within the current clinic parameters.
Referral to 1st appointment – in Q4 achieved 14% compliance, an increase on 5% in Q4.
Referral to Treatment– in Q1 achieved 0.49% compliance, a slight decrease on 0.54% in Q4.

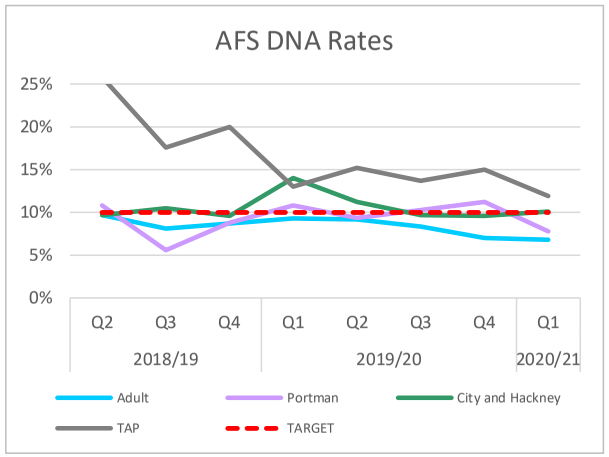
For further comments from service leads please see the commentary part of the report Page 24

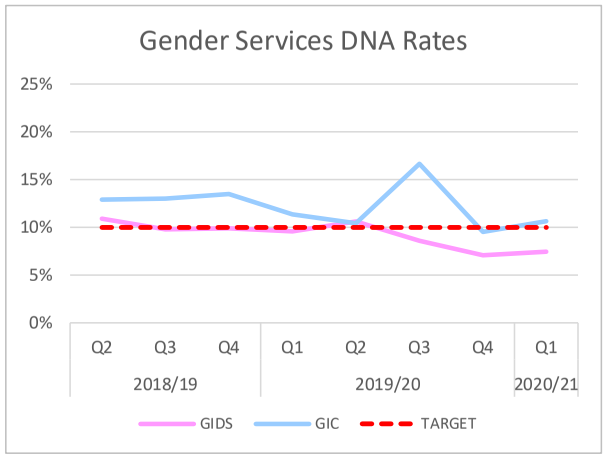
Data source: Q1 data as recorded on 17/07/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.
Reporting services were not operative from 15th Jun to 10th July, we believe this and Covid-19 could have affected our data.

Q1 2020/21: Quality Effective – Access









Data source: Q1 data as recorded on 13/07/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.
Reporting services were not operative from 15th Jun to 10th July, we believe this and Covid-19 could have affected our data.

Did Not Attend (DNA)

This data is Trust-wide and covers all contracts and all service lines. DNA rates are expected to be no higher than 10%.

Trust-wide, we continue to maintain a good DNA rate. In Q1 we achieved 8% compliance, slightly higher than in Q4 19/20, when 7.9% of patients DNAed. The average DNA rate over the last financial year was 8.80%.

Adolescents: 148 DNAs out of 1178 attended appointments, giving a DNA rate of 11.16% in Q1 – this is a higher rate compared to 9.81% in Q4. This is the first time the target has not been met.

Camden CAMHS: in Q1 had a 8.96% DNA rate (696 DNAs out of 7075 attended appointments), slightly higher than in Q4, when the rate was 8.33%. Target was met for the last 7 quarters.

Other CAMHS: in Q1 there were 193 DNAs out of 3349 attended appointments, achieving a rate of 5.45%, almost identical to that in Q4, when it was 5.46%.

Family Assessment Service: 4 patients DNAed out of 50 attended appointments, achieving 7.41%. The target was met this quarter.

Adults Complex Needs: in Q1 6.79% of patients were DNAs, a lower percentage than in Q4, when 7.01 % were DNAs. 218 patients DNAed out of 2994 attended appointments.

Portman: in Q1 7.79% of patients were DNAs, a lower percentage than in Q4, when 11.23% were DNAs. 114 patients DNAed out of 1349 attended appointments.

C&H PCPS: in Q1 10.09% of patients were DNAs, a slightly lower percentage than in Q4, when 9.59% were DNAs. 59 patients DNAed out of 526 attended appointments.

Team Around the Practice: saw a decrease in DNAs in Q1, resulting in a 12% DNA rate compared to a 15% rate in Q4.

GIC: in Q1 186 patients DNAed out of 1563 attended appointments. This signifies a slight increase. In Q1 the DNA rate was 10.63% and in Q4 was 9.52%

GIDS: in Q1 there were 325 DNAs out of 4031 attended appointments, achieving a rate of 10.63%, slightly higher than in Q4, when it was 9.52%.

For further comments from service leads please see the commentary part of the report Page 25, 26 & 27

Q1 2020/21: Single Oversight Framework – Access

NHS Improvement's (NHSI) Single Oversight Framework provides the framework for overseeing providers, with the indicators acting as a trigger to detect possible governance issues and identify potential support needs. The framework looks at five themes. MHSDS data is viewed alongside other quality of care information e.g. formal complaints, staff FFT, patient safety incidents (reported externally), and operational performance. The other four include Finance and use of resources (covered separately), Operational performance, Strategic change and Leadership and improvement capability (well-led)

Mental Health Service Data Set (MHSDS) and Data Quality Maturity Index (DQMI) Dataset Score

The DQMI was introduced into reporting in April 2018, with new data sets added in April 2019 and is in line with the Single Oversight Framework.

-Single Oversight Framework: 1 (the best of the four possible ratings, no identified support needs)

-The DQMI is published with a three-month delay

The Quality Assurance Team use the Data Warehouse Information, which is used for internal reporting, to identify gaps in reporting. In order to improve on DQMI and MHSDS completion rate, the reports are discussed at the Quality Assurance Meeting (QAM) on a regular basis to see where demographics of patients have been collected appropriately and where they need to be improved. The Quality Assurance Group (QAG) has been defining and implementing operational changes in all service lines to accommodate the requirements. We have accomplished an increment in collection rates of Primary reason for Referral, Care Professional Service or Team Type Association and the Ex-British armed forces indicator. During Q4 the QA team developed an new tool to help team improve their data quality in basic patient details. Unfortunately due to lockdown we have not been able to implement this as it requires patient contact.

*The most recent published DQMI is for March 2020. We are pleased to report we have achieved the 95% target, with a compliance rate of 95.60%.

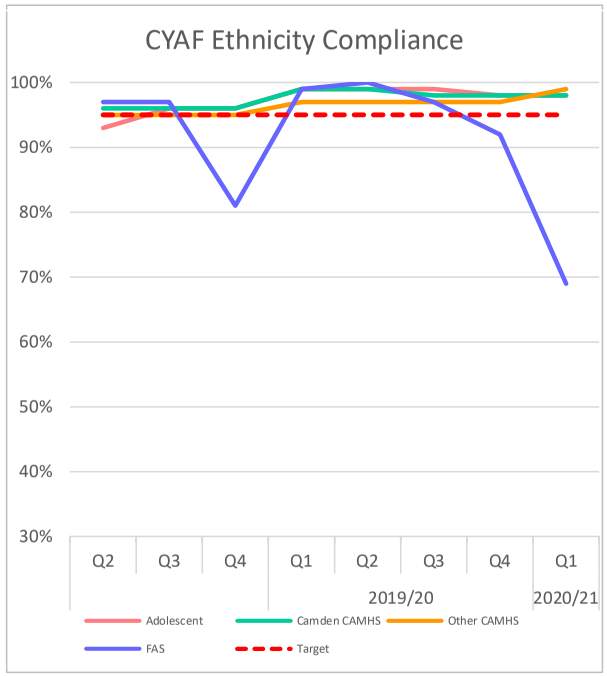
	Target	Month 7 October 2017/18	Month 10 January 2017/18	Month 1 April 2018/19	Month 4 July 2018/19	Month 7 October 2018/19	Month 10 January 2018/19	Month 1 April 2019/20	Month 4 July 2019/20	Month 7 October 2019/20	Month 10 January 2019/20	Month 1 April 2020/21
Valid NHS number	95%	99.10%	98.60%	98.60%	98.70%	98.90%	98.90%	99.00%	98.99%	98.95%	99.01%	98.97%
Valid Postcode	95%	99.80%	99.70%	99.80%	99.80%	99.80%	99.80%	99.70%	100%	99.72%	99.71%	99.79%
Valid Date of Birth	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Valid Organisation code of Commissioner	95%	99.50%	99.10%	99.00%	99.20%	99.00%	99.00%	99.20%	99.21%	99.15%	99.21%	99.14%
Valid Organisation code GP Practice	95%	99.20%	98.20%	97.80%	98%	98.10%	98.20%	98.90%	98.88%	98.78%	98.46%	98.55%
Valid Gender	95%	99.80%	99.80%	99.80%	99.70%	99.40%	99.40%	99.40%	99.44%	99.47%	99.41%	99.38%
Ethnicity	85%	79.60%	78.40%	77.30%	76%	75.80%	76.10%	80.60%	81.88%	78.76%	77.79%	75.94%
Employment Status (for adults)	85%	36.90%	43.40%	49.10%	50.50%	51.60%	54.00%	59.30%	59.79%	57.94%	56.67%	56.68%
Accommodation status (for adults)	85%	36.60%	42.90%	48.50%	49.90%	51.00%	53.20%	58.30%	58.78%	56.90%	55.64%	55.48%
Primary Reason For Referral	-	-	-	-	-	-	-	-	96%	98%	99%	99.00%
Ex-British Armed Forces Indicator	-	-	-	-	-	-	0%	-	27%	41%	46%	48.00%
DQMI -Data Quality Maturity Index	95%	The DQMI, Primary Reason for Referral and Ex-British Armed Forces Indicator are not submitted in the same intervals. The data listed is for March.							88.90%	94.10%		95.60%*

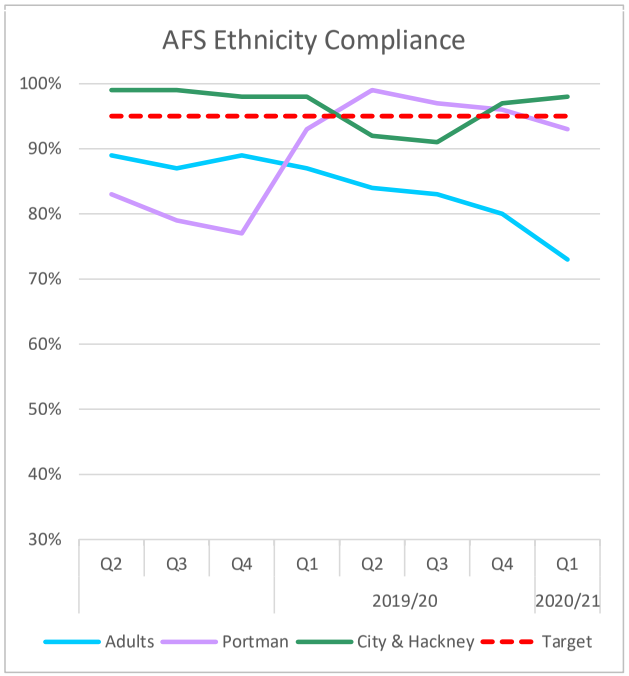
Data source: Data warehouse, informatics team 08/07/2020

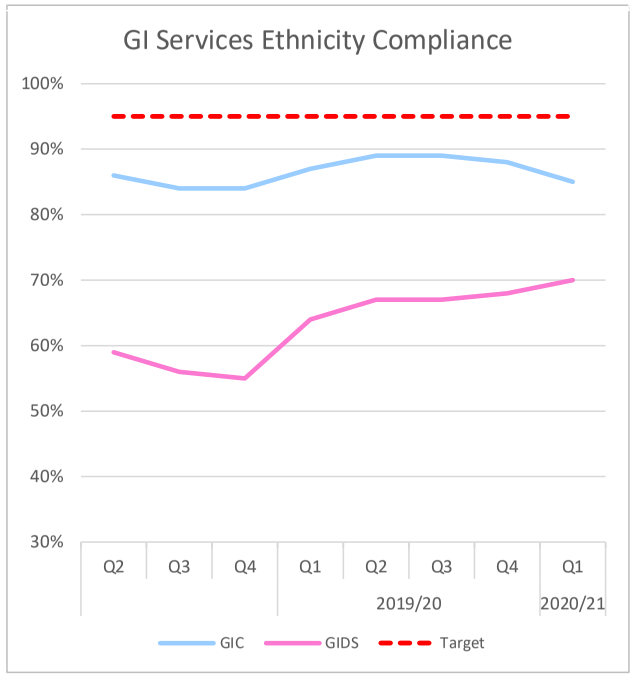
Q1 2020/21: Single Oversight Framework – Access

Ethnicity Rates

Ethnicity completion rates has been one of the most challenging MHSDS and DQMI data indicators as this financial year the target increased to 95%.
The majority of our services are meeting the 95% Ethnicity rate requirements. The services where this is difficult are the Gender Services, Adult Complex Needs and the Family Assessment Service (FAS). The FAS has very little impact on the overall ethnicity rate owing to small patient number whereas GI Services has greater impact.
A major aspect in not reaching the target is the large number of patients open to teams who have not been seen.
Quality Assurance Team (QA team) continue to work with teams in the Quality Assurance Group, raising awareness of the situation in order to improve this data further. Over the last few months the QA team has been working with informatics and admin leads developing a new report/tool to improve their data quality in basic patient details. This new report is called 'Patient Contact Details Update ' and it allows teams to validate the current information held in CareNotes and to collect missing pieces of information in our system. As it relies on the service administrators asking patients for the missing information when they visit, unfortunately we have not been able to implement this due to lockdown.





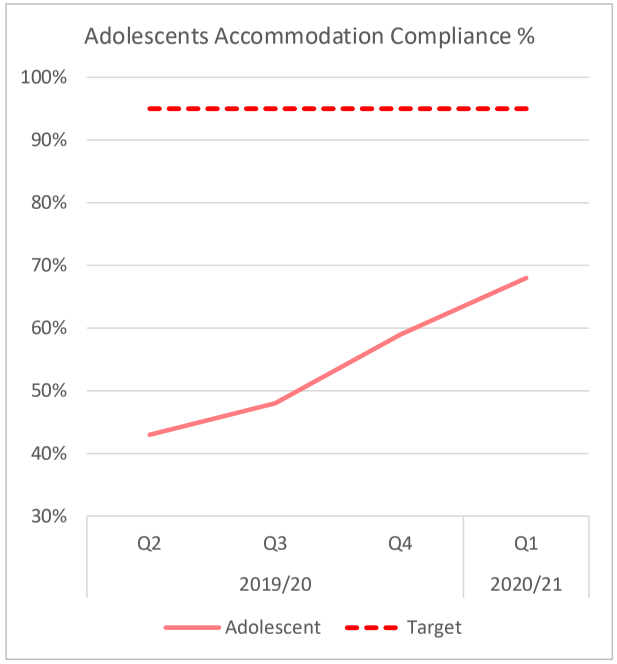


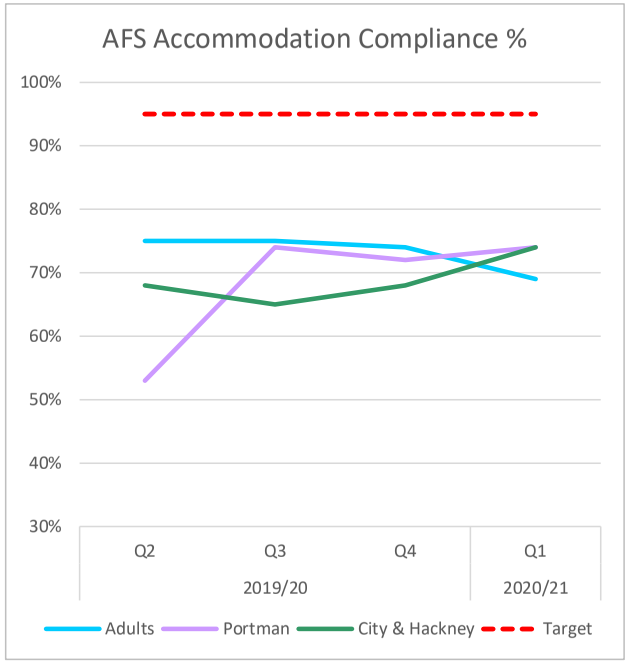
Data source: Q1 data as recorded on 13/07/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

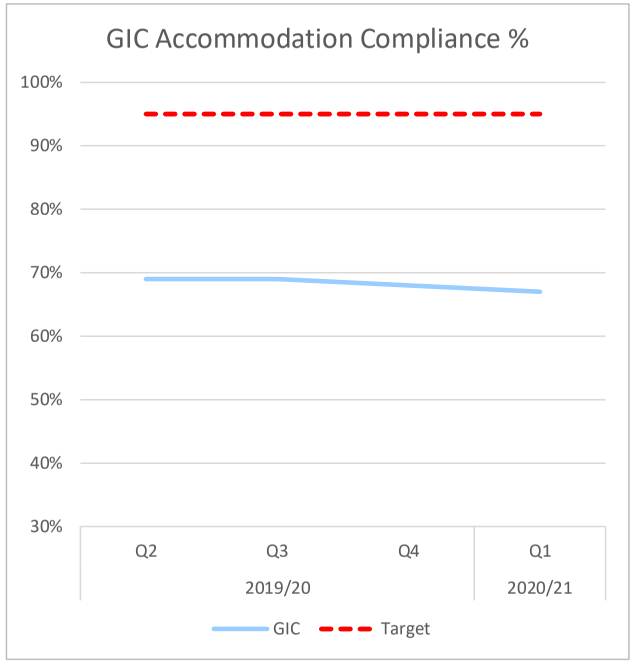
Q1 2020/21: Single Oversight Framework – Access

Accommodation Rates

This parameter is only required for patients over 18 years of age – hence it is not applicable to Camden CAMHS, Other CAMHS, Adolescents under 18s and GIDS.
Please note sustained improvement of Adolescents and C&H Services data collection.
Over the last few months the QA team has been working with informatics and admin leads developing a new report/tool to improve their data quality in basic patient details. This new report is called 'Patient Contact Details Update ' and it allows teams to validate the current information held in CareNotes and to collect missing pieces of information in our system. Unfortunately due to lockdown we have not been able to implement this as it requires patient contact. Individual services are considering the best way to implement this tool within different teams





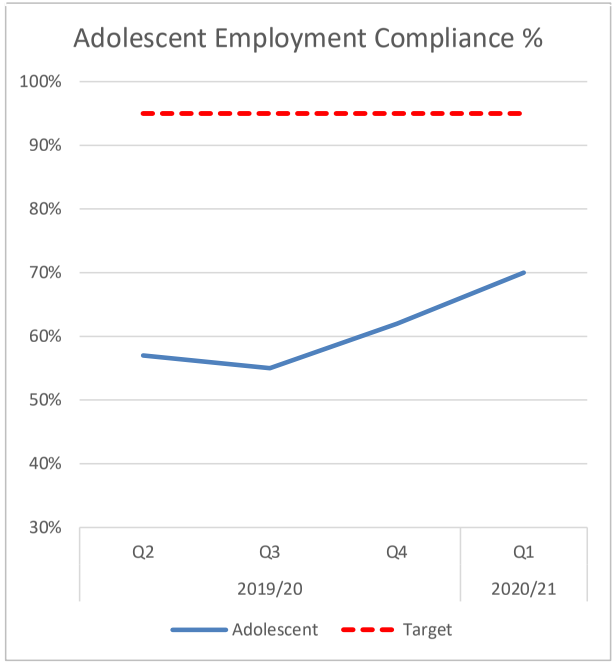


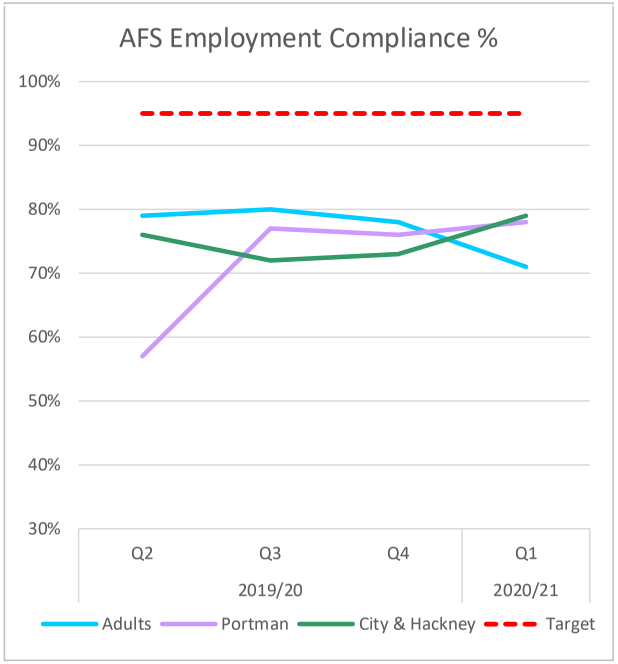
Data source: Q1 data as recorded on 13/07/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

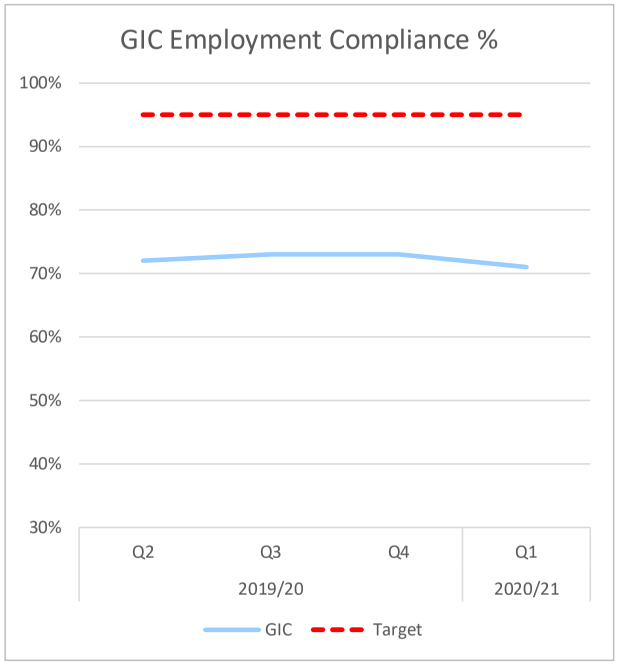
Q1 2020/21: Single Oversight Framework – Access

Employment Rates

This parameter is only required for patients over 18 years of age – hence it is not applicable to Camden CAMHS, Other CAMHS, Adolescents under 18s and GIDS.
Please note sustained improvement of Adolescents and C&H Services data collection.
Over the last few months the QA team has been working with informatics and admin leads developing a new report/tool to improve their data quality in basic patient details. This new report is called 'Patient Contact Details Update ' and it allows teams to validate the current information held in CareNotes and to collect missing pieces of information in our system. Unfortunately due to lockdown we have not been able to implement this as it requires patient contact. Individual services are considering the best way to implement this tool within different teams





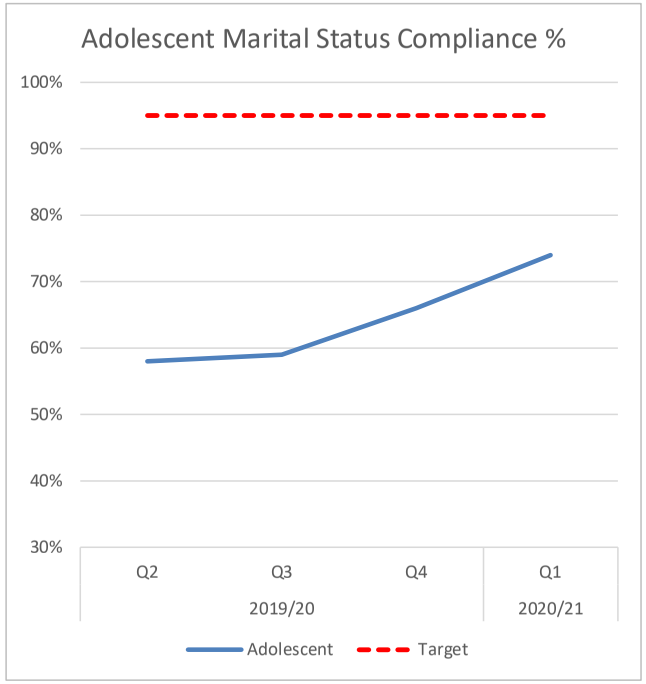


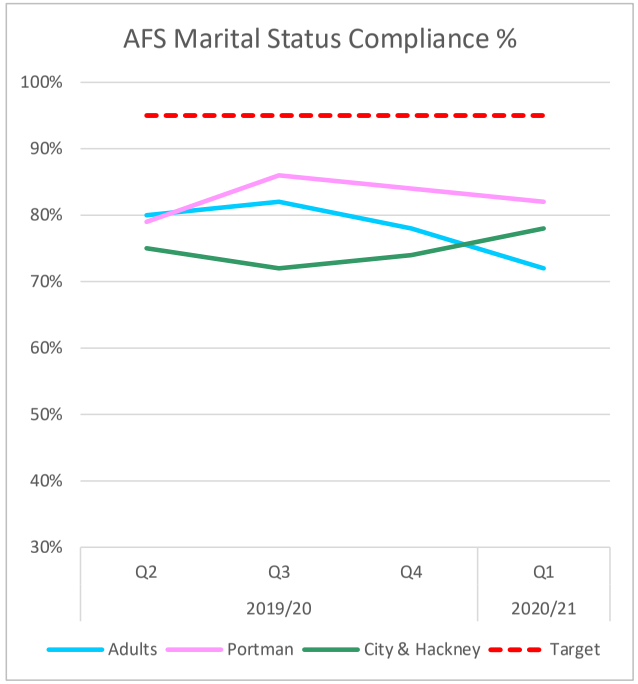
Data source: Q1 data as recorded on 13/07/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

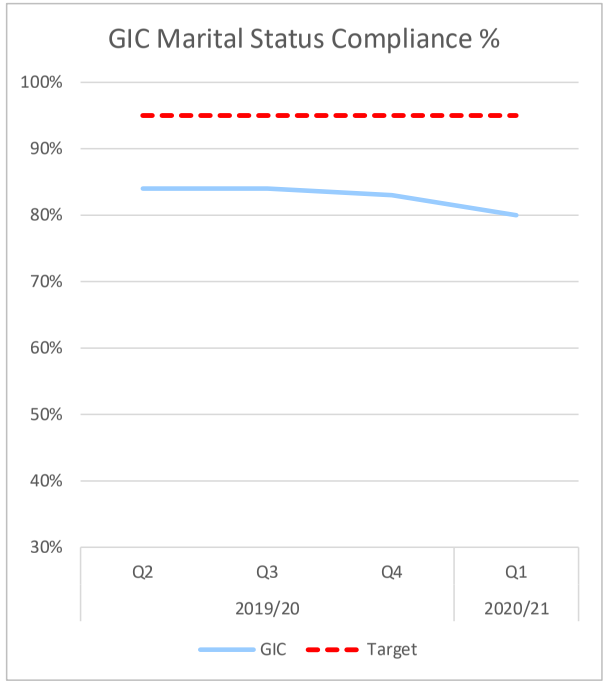
Q1 2020/21: Single Oversight Framework – Access

Marital Status Rates

This parameter is only required for patients over 18 years of age – hence it is not applicable to Camden CAMHS, Other CAMHS, Adolescents under 18s and GIDS.
Please note sustained improvement of Adolescents and C&H Services data collection.
Over the last few months the QA team has been working with informatics and admin leads developing a new report/tool to improve their data quality in basic patient details. This new report is called 'Patient Contact Details Update ' and it allows teams to validate the current information held in CareNotes and to collect missing pieces of information in our system. Unfortunately due to lockdown we have not been able to implement this as it requires patient contact. Individual services are considering the best way to implement this tool within different teams

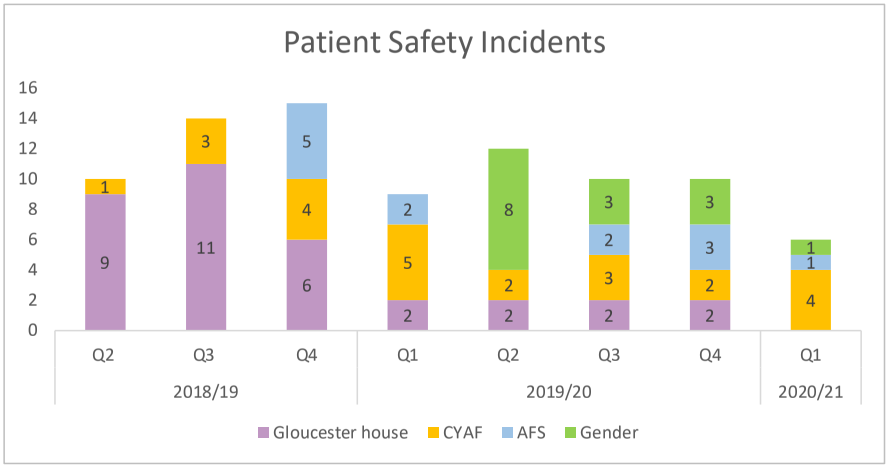


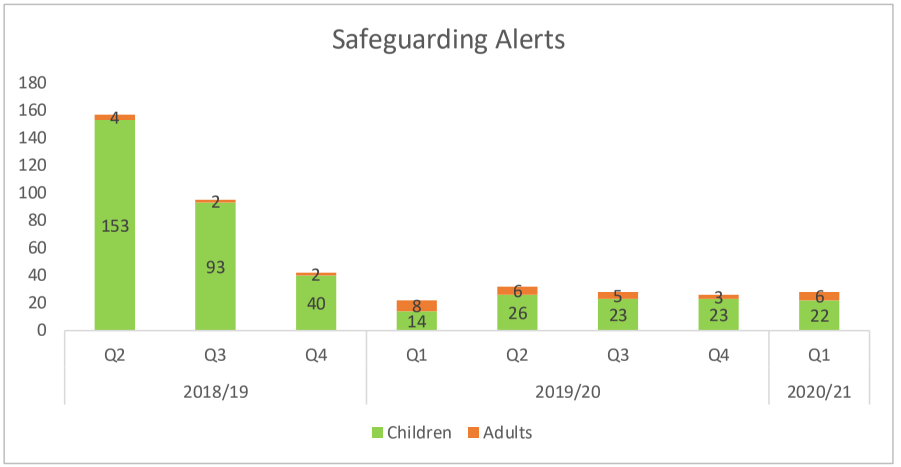




Data source: Q1 data as recorded on 13/07/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

Q1 2020/21: Quality Safety – Care





NRLS reportable incidents include:
Gloucester House – None;
CYAF (4) 1 CAMHS hand stabbing 'accident', 1 CAMHS attempted suicide – related to premature discharge from the Beacon Centre; **FDAC**: 1 drug test result shared with another service user. This was by the testing facility not the Trust; **AYAS**: 1 patient in crisis , suicidal and with an underlying Eating Disorder and heart damage, concerns for inpatient admission in an Acute Trust; **AFS**: (1) AFS Complex needs , problems with housing - attempted suicide; **Gender:** (1) GIDS letter sent to a parent in error despite alert on CareNotes not to contact parents

As always, the above incidents are reported to the monthly incident panel which is chaired by the Medical Director. Mortality reports are reviewed for the Adult and GIC deaths for relevant services.

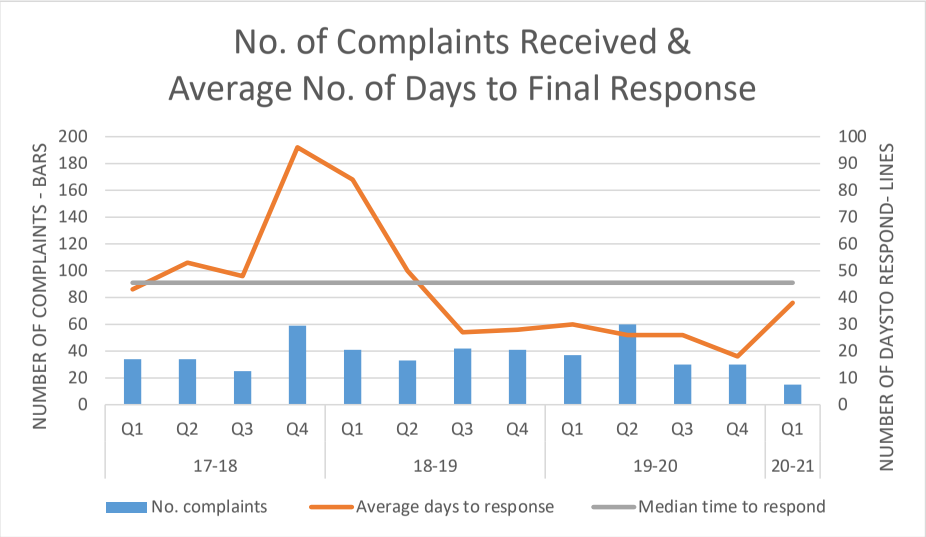
Some cases have more than one type of concern and were counted as one for accurate reporting

Data & commentary source: Clinical Governance 13/07/2020

Incidents Reported by Risk Level – Trust wide	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1
1-4	81	117	82	101	65	65	60	37
5-8	42	38	23	28	27	28	30	11
9-12	7	3	9	3	11	12	18	3
15+	0	1	1	0	2	0	1	1
Total	130	159	115	132	105	106	109	52

Data & commentary source: Health & Safety Department 16/07/2020

Q1 2020/21: Quality Responsive – Care



Directorate	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1
Adult and Forensic Services (A&F)	5	2	4	0
Children, Young Adult and Families (CYAF)	0	4	4	3
Gender Services	55	24	21	12
Corporate	0	0	1	0
No Directorate	-	-	-	-
Total	60	30	30	15

During Q1 a total of 15 complaints were received. This is a reduction in the number of complaints received during the previous quarter, 30 complaints were received in Q4, 2019/20. Of the 15 complaints received in Q1 only 2 have been responded to, leaving 13 open. This is due to a 'pause' in the complaints process in place from the end of March due to the coronavirus crisis. All complainants have been informed of this pause in the process so that staff can focus on coping with the coronavirus crisis. Of the complaints that have been responded to one was not upheld and one was partially upheld.

See Slide 33 for further KPI complaints information

Total PALS enquiries Q1		
Quarter	Total	Main enquires:
2020/21 Q1	**216**	•Communications
2019/20 Q4	178	•Access to Treatment or Drugs
2019/20 Q3	212	
2019/20 Q2	191	GIC & Adult Complex Needs continue to be the services receiving most enquiries.

Data & commentary source: Complaints Department 13/07/2020

Q1 2020/21: Quality Responsive – Care

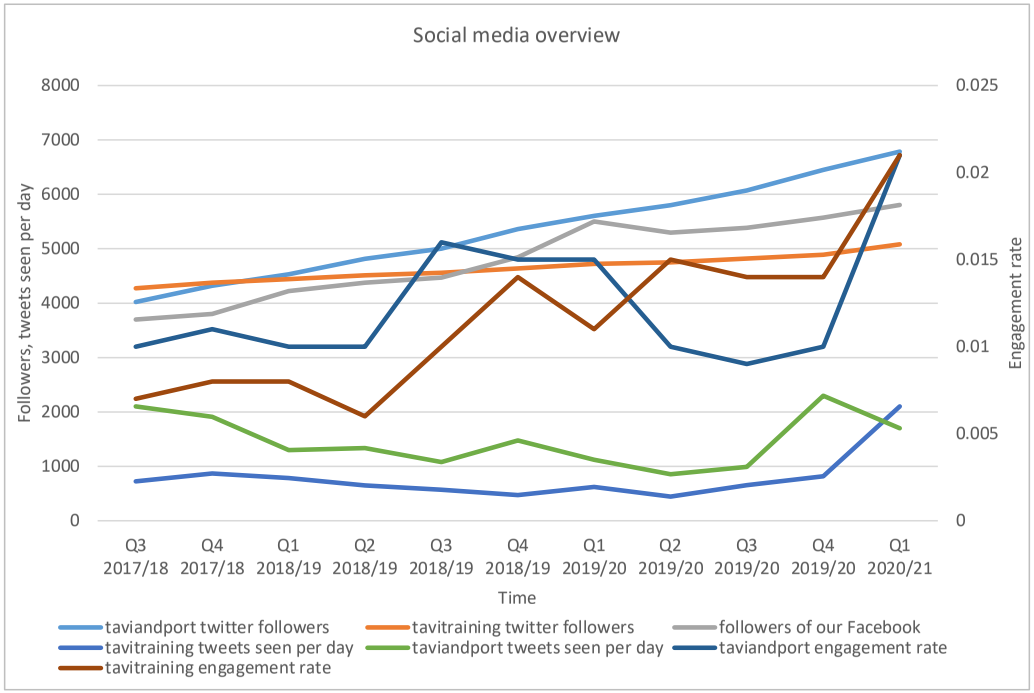
Quality Key Performance Indicators																	
KPI – London Contracts	Monitoring	Target %	2019/20									2020/21			RAG Progress			
			Q2			Q3			Q4			Q1			Q1	Q2 19/20	Q319/20	Q419/20
			N	D	%*	N	D	%	N	D	%	N	D	%	Q1	Q2	Q3	Q4
Q4 from ESQ 'Views and worries were taken seriously'	Quarterly	n/a	150	151	**99%**	113	113	**100%**	106	107	**99%**	43	43	**100%**				
Q6 from ESQ "The information I received about the Trust before I first attended was helpful."	Quarterly	75%	114	124	**92%**	88	91	**97%**	81	84	**96%**	35	33	**94%**				
Q11 ESQ 'If a friend or family member needed this sort of help, I would suggest to them to come here'	Quarterly	80%	143	144	**99%**	106	106	**100%**	103	103	**100%**	43	41	**95%**				
Q12 from ESQ "Options for my care were discussed with me"	Quarterly	n/a	97	99	**98%**	70	72	**97%**	58	59	**98%**	28	28	**100%**				
Q13 from ESQ 'Involved in important decisions about my care'	Quarterly	n/a	96	98	**98%**	70	72	**97%**	59	61	**97%**	26	26	**100%**				
Q15 from ESQ "Overall, the help I have received here is good"	Quarterly	92%	146	147	**99%**	107	107	**100%**	105	105	**100%**	42	42	**100%**				

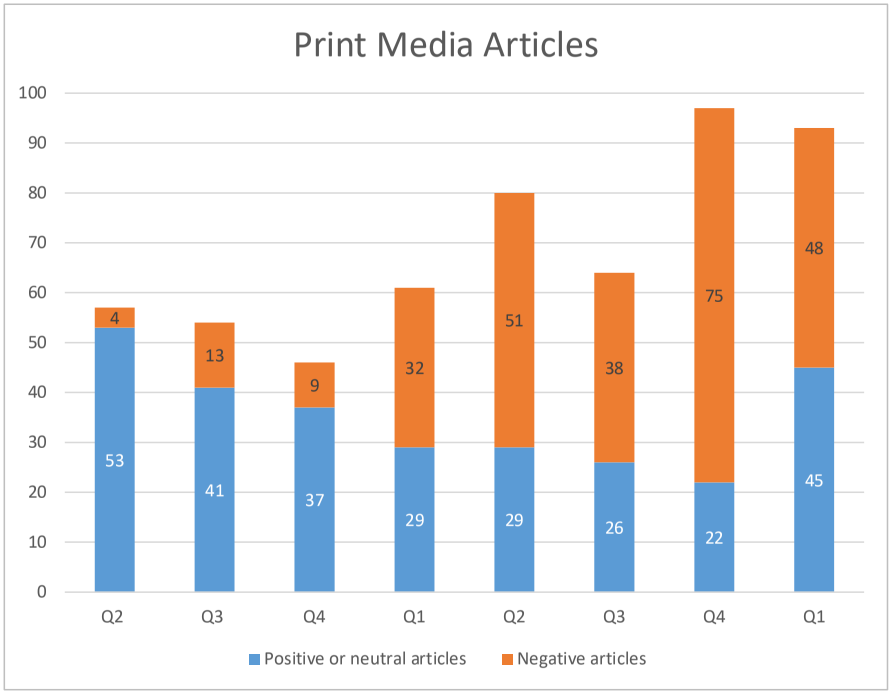
ESQ Rates

Traditionally the responses and feedback from our patients are very positive and we are very pleased with the comments and scores received. But we feel that the number of forms returned could be higher. The trust has piloted a new shorter form which aims to improve the collection rates and next month are implementing a new stage of the pilot project. 'ESQ Implementation' is one of our current year Trust Quality Priorities.

Data source: SRRS (Internal Reporting System) Reported by the Quality Assurance Team 13/07/20
*ESQ % = (Certainly true + Partly true)/(Certainly True + Partly True + Not True)

Q1 2020/21: Media – Care





The number of followers across all platforms continues to increase quarter-on-quarter.
We published less content on social media compared to the quarter previous, as the centenary events that we were set to promote were cancelled due to the COVID-19 outbreak

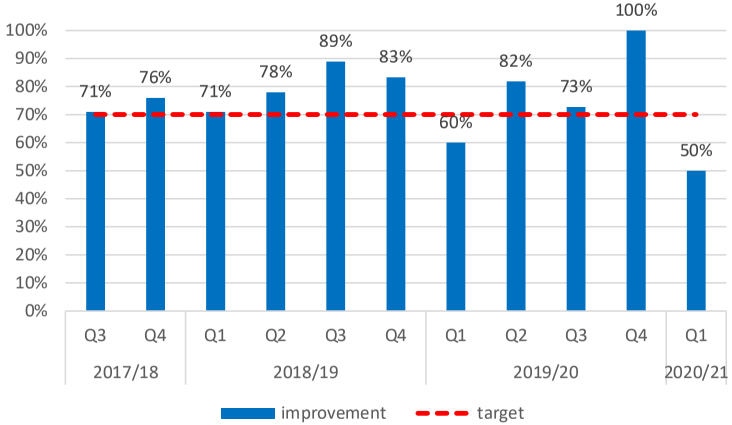
This is a similar volume of overall coverage compared to Q4, and a similar proportion of GIDS related coverage, with an increase in sentiment: 48% positive or neutral coverage, compared to 23% positive or neutral in Q4, and 40% in Q3 of 19/20.

Gender versus non gender work
17% of coverage related to non GIDS issues (22 items)
83% involved GIDS (61 items)

Data & commentary source: Communications Department 16/07/2020

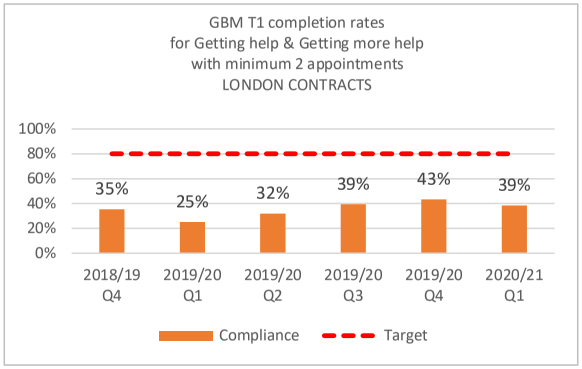
Q1 2020/21: Quality Effective – Outcome Measures

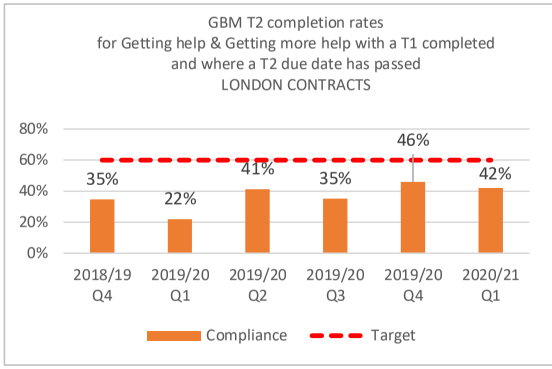
A F S and over 18 Adolescents

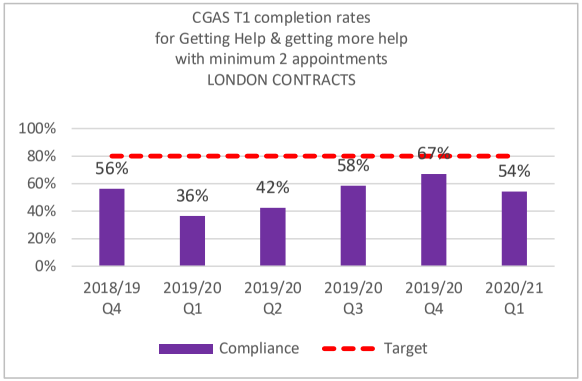


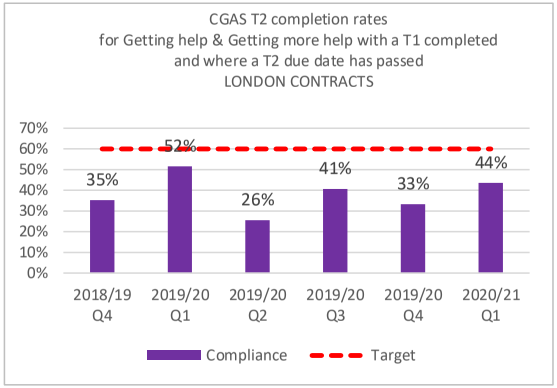
To calculate the CORE improvement rates **we compared patients with a Pre-Assessment and an End of Treatment score** (EOT). The number of cases within these parameters has been traditionally very low, but this quarter due to Covid-19 even more. The current way of calculating improvement has been under review as the parameters used (Pre assessments and End of Treatment) do not apply to all the teams producing CORE forms. In addition to this the stage names will become obsolete with the new upgrade of CareNotes. Consequently QA Team and AFS Clinical Governance Group have been reviewing the clinical and operational process around CORE forms. We have developed a new report, and we are at the stage of refining analysis of the data so that is meaningful. Unfortunately this has been delayed due to Covid-19 crisis, we hoping to make enough progress by Q2 and to be able to present the data in a new improved and inclusive way,

C Y A F







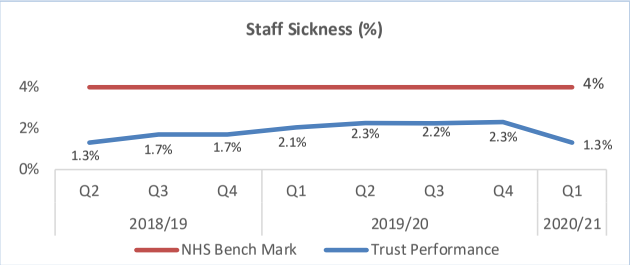


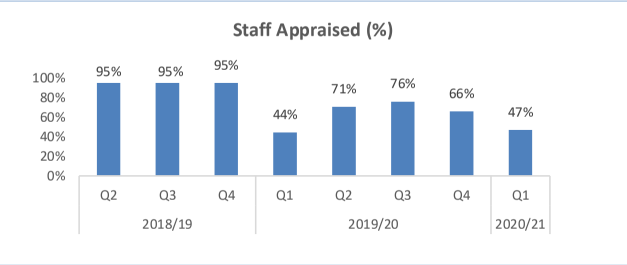
The GBM and CGAS completion rates are part of our KPIs and as such they include London Contracts only.
-GBM rates: GBM T1 has slightly decreased for first time in the last 4 quarters, achieving 39% on Q1. GBM T2 has also decreased in Q1 achieving 42%. QA team is working with CYAF on improving the CareNotes logic in the Assist Panel. Currently correcting system glitch in the Adolescents department for under 18s. We believe the drop on the completion rates is due to Covid-19.
-CGAS rates: CGAS T1 decrease in Q1, with 54% completion rates. CGAS T2 has increased 11% achieving 44% in Q4.

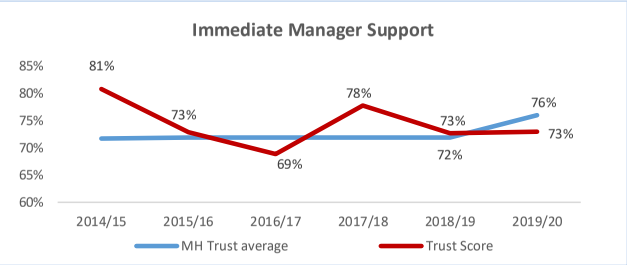
Data source: Q4 data as recorded on 13/07/2020 SRRS (Internal Reporting System) Reported by the Quality Assurance Team
Previous quarters' data as reported in relevant earlier reports.

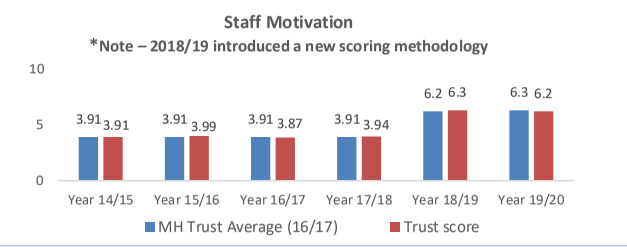
Q1 2020/21: Quality Well-Led

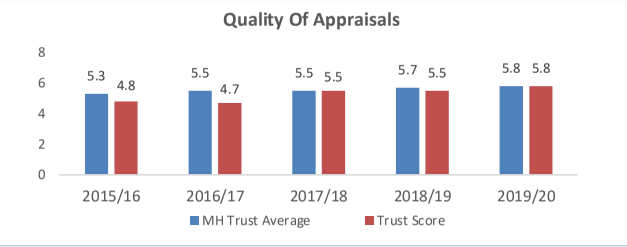
reporting on HR metrics to external bodies has currently been suspended across NCL

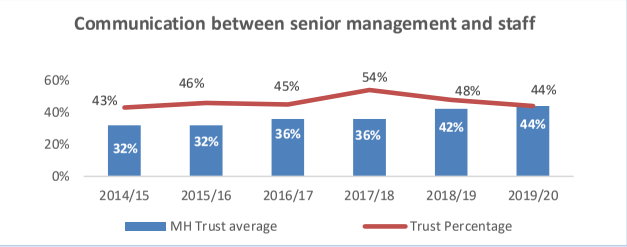


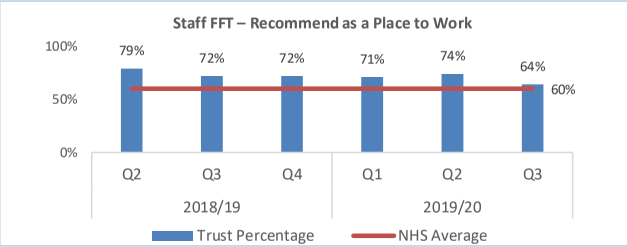


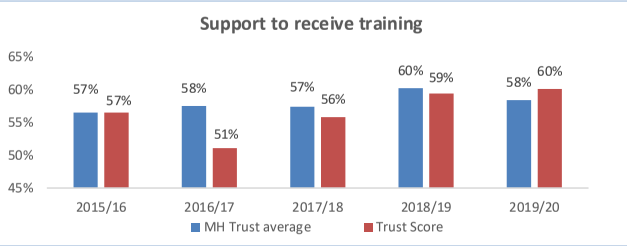


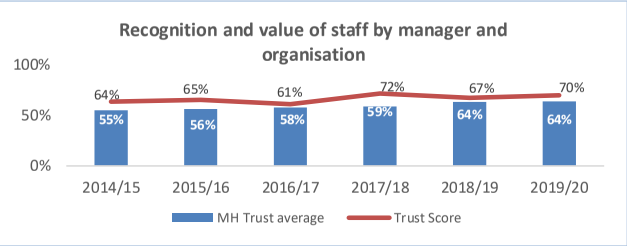


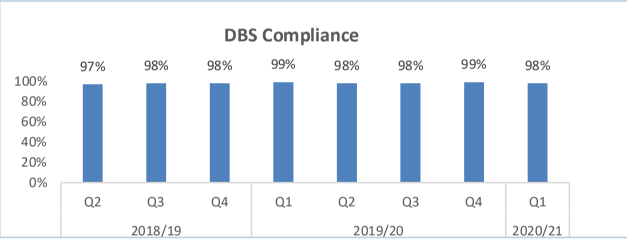


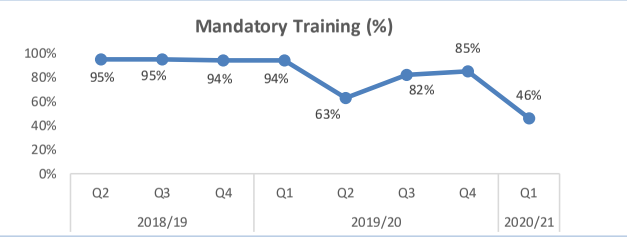












Staff FFT reporting was suspended in 2019/20 Q4 and 2020/21 Q1 due to Covid-19

Data source: Human resources

Q1 2020/21: Directorate of Education and Training (DET) – Access/Recruitment

Long Course Recruitment: Applications Summary by Portfolio*

* Showing recruitment details up until 18th June for each year.

	2020/21 Entry			2019/20 Entry			2018/19 Entry		
Portfolio	**Applications**	**Offers Made**	**Offers Accepted**	**Applications**	**Offers Made**	**Offers Accepted**	**Applications**	**Offers Made**	**Offers Accepted**
Psychoanalytic Applied	**191** ↑	**99** ↓	**53** ↑	**175**	**130**	**44**	**197**	**145**	**49**
Psychoanalytic Clinical	**181** ↑	**68** ↓	**42** ↑	**159**	**91**	**38**	**165**	**92**	**36**
Psychological Therapies	**63** ↓	**24** ↓	**16** ↓	**90**	**62**	**26**	**97**	**69**	**21**
Social Care, Management and Leadership	**33** ↑	**23** ↓	**11** ↑	**32**	**27**	**10**	**31**	**26**	**8**
Systemic	**147** ↓	**71** ↓	**31** ↓	**154**	**97**	**42**	**130**	**75**	**32**
Total	**615** ↑	**285** ↓	**153** ↓	**610**	**407**	**160**	**620**	**407**	**146**

Narrative: The applications cycle for long courses opens annually in November. By the end of June, it is possible to review progress against previous cycles, as the Trust prepares for registration on long courses in September. Long courses are a vital source of income to the Trust, bringing in approximately £x in the 2019-20 financial year.

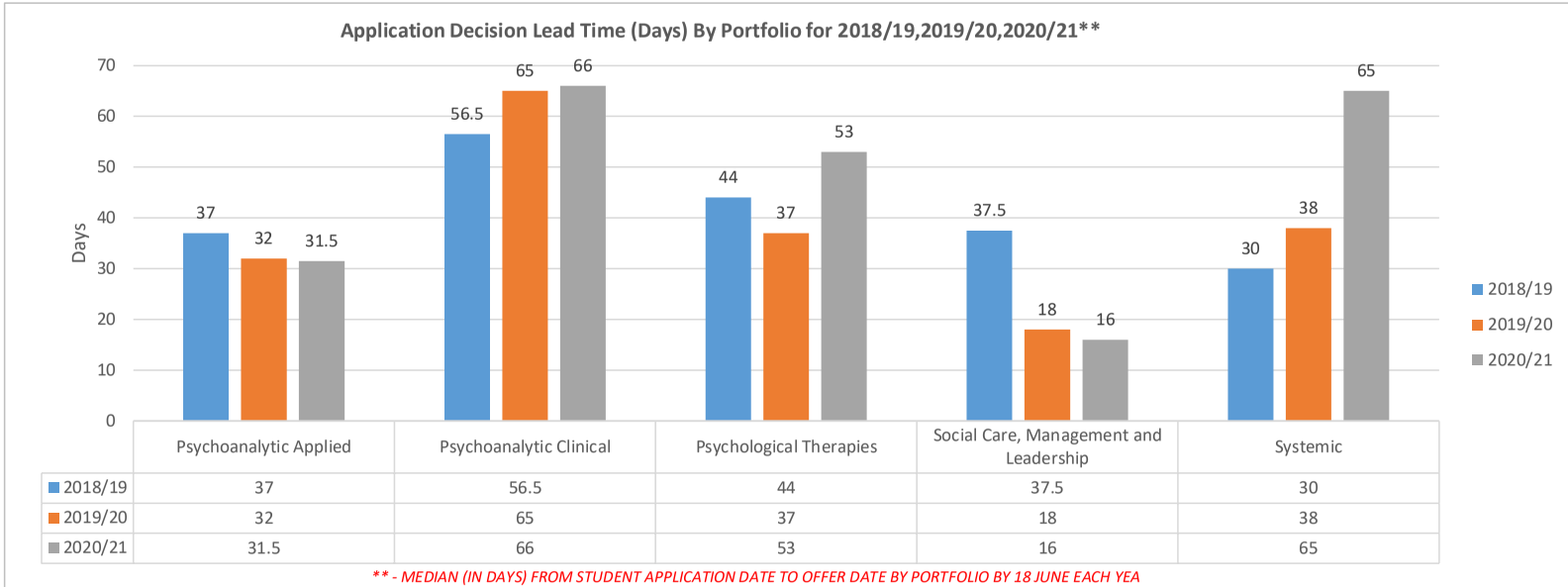
Data for 2020-21 entry shows applications remaining buoyant, despite the COVID-19 pandemic. In particular, courses within the Psychoanalytic Applied and Psychoanalytic Clinical portfolios have received more applications than at the same point in the previous cycle – and also have more offers accepted by applicants than at the same point last year. Recruitment to the Psychological Therapies and Systemic portfolios is currently tracking down against last year's recruitment cycle.

Student registration runs from July to October, at which point the student recruitment cycle is completed.

Data & commentary source: DET Department 20/07/2020

Q1 2020/21: Directorate of Education and Training (DET) – Access/Recruitment

Long Course Recruitment: Application Decision Lead Time by Portfolio



	Psychoanalytic Applied	Psychoanalytic Clinical	Psychological Therapies	Social Care, Management and Leadership	Systemic
2018/19	37	56.5	44	37.5	30
2019/20	32	65	37	18	38
2020/21	31.5	66	53	16	65

*** - MEDIAN (IN DAYS) FROM STUDENT APPLICATION DATE TO OFFER DATE BY PORTFOLIO BY 18 JUNE EACH YEA*

Narrative: Application decision lead times are an important metric for student recruitment, as they can show how responsive the Trust is being to prospective students. The metric shows the time taken from receiving an application to providing an 'offer' or 'decline' decision. Applicants to the Trust's long courses are asked to attend interviews, which lengthens the decision lead time but ensures the applicant is well-informed about studying at the Trust.

Data & commentary source: DET Department 20/07/2020

Q1 2020/21: Directorate of Education and Training (DET) – Access/Recruitment

Short Course Activity and Financial KPIs

Q1 CEDU Activity						
1 April - 30 June	2020-21		2019-20		2018-19	
	No. courses	No. students	No. courses	No. students	No. courses	No. students
Portfolio CPD	15	323	16	258	21	465
Bespoke**	4	70	18	503	9	131
International	0	0	1	28	4	41
Other funded activity*	3	23	6	270	0	0
Total	**22**	**416**	**41**	**1059**	**34**	**637**

*Includes HEE funded perinatal and nursing training programmes
** includes LCPPD funded trainings for 2019-20 and 2020-21

Q1 CEDU Financials						
1 April - 30 June	2020-21		2019-20		2018-19	
	Income	Costs***	Income	Costs***	Income	Costs***
Portfolio CPD	£69,460	£13,904	£82,817	£33,260	£119,183	£55,829
Bespoke**	£27,659	£17,120	£140,239	£83,543	£83,636	£55,159
International	£0	£0	£31,472	£18,479	£44,790	£24,126
Other funded activity*	£30,481	£21,000	£138,869	£99,962	£0	£0
Total	**£127,600**	**£52,024**	**£393,397**	**£235,244**	**£247,609**	**£135,114**

***direct costs only, not including staff costs
All 2020-21 costs are subject to change as courses continue through the year

Narrative: The CEDU KPI's, as reported above, are based on training activities that start within the reported timeframe (Q1). CEDU activities take place throughout the year and so, unlike the long courses, the number of courses, student numbers, income and costs will continue to change throughout the full financial year and will be reported here accordingly on a quarterly basis and compared to the same period in recent years.
Portfolio CPD represents the range of external courses that we run for individuals to book onto. Bespoke activities are those commissioned by organizations for their staff either through a direct approach to us or through a tender process, and for 19-20 and 20-21 also includes the funds received from HEE through their indirect commissioning funding contract (formerly known as LCPPD).
Other funded activity includes predominantly HEE funded perinatal training programmes, including the London Perinatal Training Programme for 19-20.
Data for Q1 of 2020-21 shows a decrease across the board from this time last year, but most notably in **Bespoke, International and Other funded activity areas**. This is predominantly as a result of Covid-19 and the necessity of postponing most activity that was planned for the summer months. All activity is being or has already been rescheduled to run later in the year and we should see these figures represented in Q2, 3 and 4 reports. All international work has also been impacted and put on hold by the pandemic.
Portfolio CPD has remained relatively stable this quarter due to the quick way in which we were able to move most of our CPD courses online and were able to deliver them as planned over this period.

Data & commentary source: DET Department 20/07/2020

Quarterly Quality Report Commentary Q1 2020/21

Introduction

As requested by the Board of Directors the following paper provides additional commentary and narrative from the Q1 Quarterly Quality Dashboard, specifically commentaries form Service Leads on Waiting Times and DNAs which covers the reporting period and plans for the following quarter.

Quality Priorities and KPIs are also covered, this year CQUINS are not part of the report due to Covid -19 crisis.

Please note the data in this report is mainly for Trustwide, with the exception of KPIs that apply to London Contracting or NHSE contracts only.

The following metrics are summarised below:

1.2 **Waiting Times – Commentary and planned actions - CYAF**

Waiting Times - feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q1	Objective / plan for next Quarter
Adolescent /AYAS	'not received due to Covid'	
Camden CAMHS	'not received due to Covid'	
Other CAMHS	'not received due to Covid'	

1.1 **Waiting Times – Commentary and planned actions - AFS**

Waiting Times - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q1	Objective / plan for next Quarter
Adult Complex Needs	'not received due to Covid'	
Portman:	Our waiting time from referral to first appointment is at 100% for the last quarter despite the complexities of the COVID situation. For referrals accepted, clinicians were able to offer assessments by Zoom quickly. Our waiting time for treatment, similarly, reached the required target of 90% of patients accessing treatment in a timely manner following their assessment.	As is visible, the majority of referrals received their first assessment appointment within the first 8 weeks, with only 5 patients exceeding this. The one referral that shows as having exceeded 18 weeks for treatment was erroneously entered on the system as a patient appointment, whereas this was a professionals consultation to a professional network. This will be rectified.
City and Hackney PCPCS	'not received due to Covid'	
TAP	'not received due to Covid'	

1.3 **Waiting Times – Commentary and planned actions – Gender Services**

Waiting Times - feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q1	Objective / plan for next Quarter
GIC	'not received due to Covid'	
GIDS	'not received due to Covid'	

2.2 **DNA – Commentary and planned actions - CYAF**

DNAs - Feedback and action plan from Service Leads – CYAF Services		
Service line	Commentary Q1	Objective / plan for next Quarter
Adolescent /AYAS	'not received due to Covid'	
Camden CAMHS	'not received due to Covid'	
Other CAMHS	'not received due to Covid'	

2.1 **DNA – Commentary and planned actions - AFS**

DNAs - feedback and action plan from Service Leads – AFS Services		
Service line	Commentary Q1	Objective / plan for next Quarter
Adult Complex Needs	'not received due to Covid'	
Portman:	Our DNA rate for the last quarter was within the required range.	As we reached the target for this quarter, we do not plan to change our current system.
City and Hackney PCPS	' not received due to Covid'	
TAP	'not received due to Covid'	

2.3 **DNA – Commentary and planned actions – Gender Services**

DNAs - Feedback and action plan from Service Leads – Gender Services		
Service line	Commentary Q1	Objective / plan for next Quarter
GIC	'not received due to Covid'	
GIDS	'not received due to Covid'	

3. Quality Priorities

3.1 Quality Priority 1

Quality Priority	1. Standardise the use of Carenotes Alerts to enhance patient safety and communication	Quality Priority
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
Complete audit of Carenotes Alerts within each of the clinical directorates (AFS, CYAF and Gender) to clarify current use of Alerts	An audit has been completed on alerts in CYAF and the main uses identified. This points to a reliance on alerts to compensate for issues with Carenotes or as poor practice for storing information. These audits are yet to be carried out in the other divisions.	Ongoing
Agree parameters for when Carenotes Alerts should be used across the Trust	The North Camden Community CAMHS team have begun a QI project aiming to develop a protocol for the use of alerts and what the parameters of their use should be. Once completed this will be reviewed across all CYAF teams before taking to AFS and Gender for their input. This iterative approach is being taken in the aim of developing our understanding of the use of alerts over time, and not overwhelming the project with lots of questions at once.	Ongoing
Develop guidance and parameters regarding the standard use of Alerts across clinical services, and a system for their review	The weekly Divisional Directors meeting will now include General Managers once a month to ensure consistency across the trust and to monitor progress on the QP's across the directorates.	Ongoing
Implement guidance and re-audit across the directorates to assess adherence to the new guidance.		n/a

3.2 **Quality Priority 2**

Quality Priority	2 - Experience of Service Questionnaire (ESQ) implementation	Quality Priority
Key Workstreams	Quarter 4 Narrative Updates	RAG Rating
Evaluate and review Q4 testing and test in 2 Adult and Forensic Services teams, reviewing and adjusting the form following these tests	At the close of Q1 the test form responses have been retrieved from the adult service test following them being unable to be accessed during the initial reorganisation following the outbreak of Covid-19. The Forms are with a PPI team coordinator to be compiled and reviewed.	Ongoing
Identify and assess methods of streamlining collection of the information and obtain a consensus for delivery across the Trust	To be reviewed with overall methods of collection for data Trustwide in current climate.	Ongoing
Evaluate effectiveness of the new form for increasing ESQ return rates and improving qualitative feedback	Return rate of new form was 20 forms during Q1. Will liaise with PCPCS team to establish what their return rate was previously when using their old feedback forms.	Ongoing
Work with teams to increase use of the ESQ data to improve and develop services	Ongoing – This would be best assessed once feedback is provided to team in Q2 to see what service improvements are implemented as a result of ESQ data.	n/a

3.3 **Quality Priority 3**

Quality Priority	3. Improve Waiting Times Across the Trust	
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
Review waiting times across Trust services (Q2) and identify range, variation and areas of good practice	Trust wide waiting time data has been requested, which will be reviewed during Q2. Depending on the outcome of that, my plan is to use that information to build a sample of staff and patients to survey, to probe further in relation to areas of particular challenge and also good practice (milestone 2 – due end Q3 but I'd like to do earlier if possible).	Ongoing
Survey staff and patients to understand their experience of being on or working in services with long waiting lists, and their thoughts about how to manage these (Q3)	Gender specific meeting on waiting times have been convened and a brief is being developed for a large divisional project to address Gender waiting times that would inform and be informed by the QP work.	Ongoing
Based on this information, design and implement QI projects in different Trust Divisions. Measure impact (Q3 & Q4)	Dependent on the above.	n/a

3.4 **Quality Priority 4**

Quality Priority	4. Embed meaningful use of outcome measures across the Trust	
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
To grow and develop a data led culture that makes consistent use of appropriate outcomes & patient feedback	Conversations taking place within all three directorates – details below.	Ongoing
Standardise the application and EPRS logic behind OMs in order to improve the accuracy and validity of reports and their applications	The Data Quality Team is undertaking the following workstreams in relation to OM's: ➢ CareNotes interface- we are reviewing that the relevant fields are made mandatory, that the descriptions are intuitive for the end user encouraging accuracy and consistency. ➢ CareNotes Assist panel logic- we are revising that the logic meets the clinical needs and expectations. ➢ Completion Date in the CORE form. Data Quality have led on a project to make OM Completion Date field mandatory, and in the field description on CareNotes to describe it as: 'Completed Date, when form completed or form received by Trust'. Where the form is returned without completion date we will use date of return by email or post." ➢ Date sent would be when physically passed to the patient, emailed or posted.	Ongoing
To develop a robust and standardised system of user friendly reminders and follow up on missing OM through the EPR and team level reporting	The Data Quality team are exploring new methods to both monitor compliance and encourage completion rates with reliable data and meaningful visualizations.	Ongoing

3.4 **Quality Priority 4**

Quality Priority	4. Embed meaningful use of outcome measures across the Trust	
Key Workstreams	**Quarter 4 Narrative Updates**	**RAG Rating**
To embed patient as well as staff consultation and feedback on the value and meaningful qualities of measures	**CYAF Update** We are reviewing the logic around the creation and due dates of OM in the assist panel in an attempt to make this align to our expectations of what OM is due. Initial meetings with informatics and the Quality Assurance Team have taken place to support this work. One CYAF service is leading on a piece of work, involving service users, to improve the appearance of the graphs/charts Carenotes generates about OM to make them more meaningful when shared with service users. Our new CYAF service admin manager will be taking forward our work on improving the reminders and chasing we do on missing OM. **AFS Update** The aim is to enhance the efficiency of administrative systems alongside clinician awareness of when and why to apply OM. There is now a performance report showing quite different return rates across the three service lines of AFS which will require local review and understanding through executive and team meetings. The low update of certain OM tools have been discussed with the Service lead and Unit heads for Complex Needs and it's been agreed that the Core TA and EOT don't constitute patient reported outcome measures (actually clinician completed) and that there isn't a clinical need for the forms. A formal request has been made for access to an appropriate digital platform to allow and promote user reported OM input. **Adult Complex Needs:** have started a QI project to increase OM return rates. The first PDSA cycle has now been completed, an increase in return rates has been seen, from 5% prior to the project to 20%. Further interventions are being thought about and will be piloted. **Primary Care:-** it is notable that OM returns in PCPCS are significantly higher than in Adult & Portman, this may be a historical and cultural matter as well as administrative processes being better embedded, it will need some scrutiny and dissection to understand better. **Gender Services Update** **GIDS**: The service is moving the ESQs online. This was implemented very close to the end of the first quarter (approximately 3 weeks prior to the deadline for providing the data) so there was only 11 completed (although arguably for 3 weeks collection that is high for ESQs). CGAS is not being completed through Qualtrics (the online questionnaire platform being used), and continues to be completed through Carenotes. It is anticipated that OM ESQ completion will continue to improve with the online system. **GIC:** The GIC outcome measure that they have been using for the decades is the PEQ (Patient Experience Questionnaire) which the patients receives from their clinician at the end of their session and anonymously leaves it in a box in reception on their way out of the clinic. As we are currently not in the clinic, there has been an on line survey created. This is being sent out by the Appointments team to all patients after their telemedicine appointments and the data is being collected.	Ongoing

Section Five: Trust Targets – KPI

Quality Key Performance Indicators										
Target See Slide 13 for complaints graphical representation	Monitoring	Target %	% Progress 20/21				RAG Progress 19/20			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Complaints* - % Response to Complaints A - 90% of complaints acknowledged within 3 working days.	Quarterly	>90%	1/15 93%							
B - 80% of complaints responded to within 25 working days. We are including closed rather than open, recent open complaint might not have been open for 25 working days.	Quarterly	>80%	0%							
D - 100% of upheld complaints identify learning and improvements as a result.	Quarterly	100%	100%							
E - Trends and themes of PALS concerns and complaints identified and published on a quarterly basis.	Bi-annually	n/a	Quarterly reports will be uploaded to the Trust's website							
F - Evidence of relevant complaint action plan implementation	Quarterly	n/a	Yes, action plans are drafted for all complaint which are fully or partially upheld							
Complaints: A - Provide quarterly complaints and claims update to include: i) no. of complaints where response is outstanding at 3 months and reasons why	Quarterly	n/a	2 outstanding. These are complex complaints. It has not been able to complete investigations due COVID 19							
ii) Number of complaints reported to CQC	Quarterly	n/a	none							
iii) Numbers of complaints partially and fully upheld by Parliamentary Ombudsman	Quarterly	n/a	none							
iv) Number of re-opened complaints.	Quarterly	n/a	none							

Section Five: Trust Targets – KPI

Quality Key Performance Indicators											
Target	Monitoring	Target %	% Progress 20/21				RAG Progress			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Trust Service cancellation rates Target: <5% green (5-9% amber, >10% red)	Quarterly	<5%	4.60%							
Audit of Trust Consent Policy standards To perform an audit on 20 patient notes in Q2.	Q4	n/a								
Clinical Audit A - Provide CCGs with copy of Trust wide audit programme in Q2.	Q2	n/a								
B - Provide CCGs with bi-annual findings and recommendations of audits carried out, evidence of action plans and Board Involvement	Q2 & Q4									
C - Provide CCGs with copies of Clinical Audit Annual report to include learning the lessons from audit, demonstrating achievement of outcomes	Q4									
Reporting on Guidelines Report on compliance with new relevant NICE Clinical Guidelines, Quality Standards and Technology appraisals within 3 months of publication date.	Q2 & Q4	n/a								

Section Five: Trust Targets – KPI

Quality Key Performance Indicators – KPIs rolled over from last financial year										
Target See Slide 17 on HR for graphical representation	Monitoring	Target%	% Progress Q1 20/21				RAG Progress			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Appraisal/ Personal Development Plan Quality and Development of staff: Target 90% of staff to have a PDP.	Quarterly	90%	47%							
Sickness and Absence Sickness and absence rates. Target: <2% green (2-6% amber, >6% red)	6 monthly	<2%								
Staff Training % of staff with up-to-date mandatory training for infection control. Target >95% green. 80-95% is amber < or = 80% red	Annually	>95%								
Mandatory Training % of eligible staff are currently compliant on all of their mandatory training	Quarterly	>95%	46%							
Mandatory Training, *Staff FFT reporting was suspended in 2019/20 Q4 and 2020/21 Q1 due to Covid-19*										
DBS checks - Standard and enhanced % of staff that require an Enhanced DBS check and have one within the 3 year renewal period	Quarterly	100%	98%							
Enhanced DBS Checks: The DBS is not 100% because the report will account for staff who are on career break, long-term sickness absence, career breaks and maternity leave. In addition the report will not be reflective of staff who have expired and currently going through the re-check process. The process still remains where the team will produce monthly DBS reports and contact staff who are due for renewal and chase those that require renewals.										

Section Five: Trust Targets – KPI – London Contracts

Target	Detail of indicator	Reported	Target %	% Progress Q1 20/21	RAG Progress			
					Q1	Q2	Q3	Q4
CAMHS Transformation Targets	80% initial completed care plans	Q1-Q4	80%	*During Q1 20/21 69 assessment summaries were completed, out of those 38 initial care plans were created/shared giving a **increased compliance of 55%** (48% in Q4 19/20)* *The small improvement is encouraging but we still need to understand why care plans are not routinely done. This question is on the agenda of many internal quality and governance meetings and needs to move into QI projects to understand.. There is feedback from staff about the burden of carenotes forms, and there is ongoing dialogue to reduce the number of admin tasks staff need to complete.*				
	80% Care plans reviewed every 6 months (jointly developed with young people; increased evidence of collaborative working) by March 2019	Q1-Q4	80%	*During Q1 there were 152 Assessment Summaries completed. Of those, there were 69 Review Care Plans created/shared – giving a **increased compliance rate for Q1 of 45%** (down from 21% in Q4). The percentage of those care plans completed with in 6 months of the initial Assessment Summary also increased from 8% in Q4 19/20 to 20% in Q1 20/21* *The small improvement is encouraging but we still need to understand why care plans are not routinely done. This question is on the agenda of many internal quality and governance meetings and needs to move into QI projects to understand.. There is feedback from staff about the burden of carenotes forms, and there is ongoing dialogue to reduce the number of admin tasks staff need to complete.*				
	85% CYP in relevant services (CAMHS in CSF integrated service) reporting 'certainly true' or 'partly true' to CHI-ESQ question 7 ('I feel that the people who have seen me are working together to help me')	Q1-Q4	85%	*During Q1 there were 36 responses from CAMHS patients to the ESQ question 7 ('I feel that the people who have seen me are working together to help me'). Of these 36 responses, 33 patients answered 'certainly true' and 1 answered 'partly true' **giving a compliance rate of 91.6%*** *ESQ data for integrated working continues to be good. Efforts are being made to increase the number of ESQ forms that are being completed.*				

Data source: 14/07/20 SRRS (Internal Reporting System) Reported by the Quality Team

Section Five: Trust Targets – KPI – London Contracts

Target	Detail of indicator	End of Year Target %	% Progress Q1 20/21 See Slide 16 for OM graphical representation	RAG Progress Q1	Q2	Q3	Q4
CYAF Outcome Monitoring **GBM** - Goal Based Measure **CGAS** - Children's Global Assessment Scale Reported Quarterly	**GBM** Time 1 % of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice	80%	***52 out of 135 due GBM T1's completed during Q1 - 39% compliance*** A slight drop in GBM completion from the previous quarter of 43%. An update of the GBM logic for the Adolescent Service has been agreed but not yet implemented. Once the changes are implemented patients from the AYA Service will be included in this cohort. This will be from Q2.				
	CGAS Time 1 % of CYP in the 'Getting help' and 'Getting more help' domains who had been seen minimum twice	80%	***69 out of 127 due CGAS T1's completed during Q1 - 54% compliance*** A decrease in compliance for CGAS from 67% in Q4 could be linked to remote working, Q3 and Q4 2019-20 compliance saw significant increases. Team managers will be asked to inform staff of this decrease and to confirm the target.				
	GBM Time 2 % patients who had an second appointment 4 months prior Q2 or closed cases on CYP in the 'Getting help' & 'Getting more help' domains who have paired GBM Time 1	60%	***56 out of 133 due GBM T2's completed during Q1 - 42% compliance*** A slight decrease here from the 46% increase last quarter. We are confident that this number of completed GBM's will increase with the continued support from team administrators and Informatics and the OM Logic that has been enhanced to increase reminders for clinicians.				
	CGAS Time 2 % patients who had an second appointment 4 months prior Q2 or closed cases on CYP in the 'Getting help' & 'Getting more help' domains who have paired CGAS Time 1	60%	***64 out of 147 due CGAS T2's completed during Q1 - 44% compliance*** An increase this quarter compared to 33% in Q4. The figures suggest that with reminders from the administrator compliance the GBM's T2 can increase over time.				

Data source: 13/07/20 SRRS (Internal Reporting System) Reported by the Quality Team

Report to	Date
Board of Directors	July 20 2020

Centenary celebrations

Executive Summary

The Covid 19 crisis has had a significant impact on the planned centenary celebration programme.

Many events have been cancelled whilst some have been successfully transferred to digital delivery

The centenary celebration planning group has worked over the last few months to review and reconsider options for safe and successful celebrations within an uncertain context.

This paper gives an overview of our proposals for a celebration on September 25th for staff, patients, alumni, Board of Directors ,Council of Governors, and including the organisations sharing out roots, Tavistock Relationships and Tavistock Institute of Human Relations.

In addition a we propose a festival of twenty events to be held over the period between October 2020 and April 2021. These will be widely publicised, open to all, delivered via a digital platform, free, with an invitation to donate to the Tavistock and Portman Charity.

Recommendation to the Council of Governors

Approval

Trust strategic objectives supported by this paper

Author	Responsible Executive Director
Projects Director	Chief Executive

Centenary celebrations

1. The centenary celebration planning group has continued to meet fortnightly to plan, approve and monitor progress on the development of a broad programme. As the impact of Covid 19 became increasingly apparent in early March, the group has been working to devise new ways of delivering planned events and developing a new programme suitable for the pandemic conditions.

2. Whilst many events have been cancelled , some have been successfully delivered digitally. The Trust Scientific Meetings, open to staff , students and alumni , have attracted numbers of participants far in excess of the capacity of our lecture theatre. This confirms that there is an audience for online events. Although presenters and participants miss the greater immediacy and interaction of face to face events this is offset by the increased reach geographically and mitigated by use of break out groups and the chat function to pick up questions and communicate with the audience.

3. **Marking our centenary on September 25 th, 2020.**

   The first patient was seen on September 27th1920. The group decided that is was important to mark this date albeit in a more low- key way than originally anticipated. A planning group led by Nell Nicholson, Head teacher, Gloucester House School, was convened which includes representatives from across the Trust. The original aim was to focus on developing an event for the Tavistock 'family' including patients.

   Proposed programme

   1.10am to 2pm– Open Day to be delivered via a digital platform.
   Open to staff, students, patients, alumni (including former staff) , Council of Governors, Board of Directors, colleagues from TIHR and Tavistock Relationships. Booking via Eventbrite required.

   Welcome and introduction- Paul Jenkins, Paul Burstow

   Presentation on our history, based on research undertaken by Glenn Gossling, Senior Communications Officer. Discussion between generations of staff.

   Virtual open day video contributions invited from across the Trust, TIHR and Tavistock Relationships to give a picture of our organisations, linking the rich legacy of the past with the present

   2. 1.30pm to 3pm. Digital inter professional style event for all staff. Facilitated discussion of our past, present and future. Eventbrite booking required

   3. 3.30pm to 4.30pm Patient and Public Involvement team contribution in collaboration with patients and their families to include poetry, visual material and patient stories. Online- open to patients and staff, Council of Governors, Board of Directors. Eventbrite booking required.

   4. Evening event for staff and former staff, Council of Governors, Board of Directors- to be confirmed.

   Feedback from our staff survey showed that many staff would welcome a safe, socially distanced event whilst others would prefer a digital event. We are exploring options for a face-to face event but we are aware this will require robust risk assessment and that last minute cancellation is a realistic possibility if Covid19 guidance changes in response to an upsurge in cases.

We will develop a digital option to include music and poetry.

5. Community statue- either virtual or real, Nell Nicholson to discuss with the Art Board how best to create the statue. Other ideas include using eg murals on our physical environment to draw the public's attention to our celebrations.

4. Launch of centenary microsite

We propose to develop a dedicated microsite to be launched on September 25th . The site can be added to in the coming months to allow time for materials to be developed.

It will hold materials gathered through historical research, including the timeline , gallery of drawings of influential staff, interviews with former and current staff members.

Staff, former staff, patient and student stories. In collaboration with the PPI team, a call has gone out for Tavistock and Portman stories to provide a varied and personal picture of our organisation.

The planning group has linked with the BAME network and the LGBTQI network to invite BAME and LGBTQI history and current experience in the Trust to be represented in a variety of ways, including through art works and spoken word contributions.

Links to centenary events can be made available through the microsite.

5. Centenary festival events.

The conference to be held at King's Place on September 24th 2020 was initially postponed with a view to holding it as a face to face event in March 2021 if safe to do so. It has become increasingly apparent that it is impossible to be sure that conditions will be safe enough for a large gathering within the next year. Whilst safe conference facilities may be available, the reduced capacity may make a large conference financially unviable.

The centenary planning group has carefully considered a number of options including postponing a face to face conference for a year or mounting a fully digital conference. We have taken into account the issue of capacity and appetite for a large scale conference given the continuing additional demands on staff through the Covid 19 crisis. We have noted that digital events have been well- attended, provide greater reach and that there has been an upsurge in concern about mental health issues, especially in relation to inequalities.

We therefore propose to offer a series of 20 roughly weekly events from October 2020 through to April 2021 to mark our centenary. Events will be digitally delivered, available free with an invitation to donate to the Tavistock and Portman Charity.

We will use the original conference title as an umbrella for the events *Who do we think we are? Identity and relationships in the 21st century*. The programme will comprise , where possible, the original 14 events which made up the conference programme supplemented by 6 events with a focus on equality, diversity and inclusion. As the events will be delivered digitally, we will have a greater opportunity to invite speakers from outside London or the UK.

6. Collaborations

6.1 Drama event in collaboration with the TIHR and East 15 acting school. Chris Caldwell will resume working on developing a theatre piece based on conversations with those involved with the Trust.

6.2 A joint conference with the Cassel Hospital and the Institute of Psychoanalysis is in development. All three organisations have shared beginnings in the 1920s.

6.3 A joint conference on later life was discussed with Tavistock Relationships but put on hold.

Louise Lyon
Projects Director
Chair, Centenary Planning group

July 20th 2020

Report to	Date
Board of Directors	28 July 2020

Board Assurance Framework

Executive Summary

The following Assurance Framework (BAF) identifies key risks to achieving the Trust's strategic objectives.

There are two risks rated 16 and five rated 12. No risks reduced and one risk (risk 1, relating to the delivery of our Race Equality Strategy) increased from 8 to 12. See page 3 for summary detail.

The new electronic risk register module is currently being piloted in DET and IM&T. This will be reviewed in September with plans for further implementation agreed. The annual internal audit of risk registers will be undertaken in July.

The BAF was reviewed by the Executive Management Team 14th and 21st July 2020.

Recommendation to the Board

The Board are asked to discuss the board assurance framework

Trust strategic objectives supported by this paper

All Trust Strategic Objectives

Author	Responsible Executive Director
All Directors, AD Quality & Governance	Deputy Chief Executive & Finance Director

BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

1.1. The Board Assurance Framework ("BAF") seeks to identify the key risks that could prevent the Trust from achieving its strategic objectives.

1.2. The following Framework and approach are in line with the Risk Management Policy and Strategy, and Risk Management Procedure. The approach is outlined below. The Risk Management Procedure has been updated to support implementation of the electronic risk register.

1.3 The BAF Heatmap presents all BAF risks on a single page as an overview of the current position.

1.5 The new electronic risk management system is currently being piloted in DET and IM&T services for Operational Risks only. Further rollout of the implementation will be confirmed in September.

2. APPROACH TO RISK SCORING

2.1. Significant risks are identified by the Executive Management Team after discussion with each other, with their direct reports and with the Board. In identifying significant risks, various factors are taken into account including, amongst other factors, both the local and general environments for health and social care; the Trust's current and future operational performance; the current and future availability of resources.

2.2. Each significant risk is then given a score for the:

2.2.1. **initial risk:** the risk level assessed at the time of initial identification.

2.2.2. **current risk:** the risk at a point in time, taking in account completed actions / mitigating factors.

2.2.3. **target risk:** this is the level of risk which the Board is expected / willing to accept after all necessary planned measures have been applied.

2.3. Scoring is based on the Trust's Risk Management Policy, as follows:

1 – 4 Green 9 – 12 Amber 5 – 8 Yellow 15 – 25 Red

2.4. The risks have been numbered for easier referencing (although the number does not imply a higher or lower level of inherent or residual risk).

2.5. Assurances are defined as (+) or (-) as per internal audit recommendations and controls map against at least one source of assurance (evidence).

2.6. Directors have reviewed and updated the BAF and confirmed the **initial/ current risk** scores for each risk

2.7. The BAF has been reviewed by the Executive Management Team.

3. RISK SUMMARY [risk descriptions are shortened]

3.1 There were no new risks added since the May Board.

3.2 There are two risks rated 16

- Risk 8: Wider financial pressure in NCL with negative consequences for delivering the mental health programme in the ~~STP~~ ICS and Trust
- Risk 10b: That changes in the commissioning environment and impact of the pandemic on funding and delivery models will risk long term sustainability of the Trust's current service configuration.

3.3 There is one risk which increased from risk score 8 in May 2020 to 12 July 2020

- Risk 1: The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services

3.4 There are five risks rated 12 as follows:

- Risk 1: The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services
- Risk 2: The risk that there is a deterioration in staff morale and engagement with a potential impact on patient and student experience
- Risks 5. Risk of failure to deliver affordable and appropriate Estates solutions
- Risk 9b: Ongoing pressure on the GIDS service which could make it difficult to continue to deliver the challenging agenda, including addressing the impact of COVID-19.
- Risk 11: Risk to developing the Trust's educational offering and continuing to be sustainable.

3.5 No risks reduced in July 2020

4. RISK APPETITE

4.1 Risk Appetite Statement:

'*The Trust recognises that its long term sustainability depends on the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. As such, the Trust will not accept risks that could materially impact on patient or staff safety. It will also not accept any risks that could jeopardise its regulatory compliance or have a significant impact upon its reputation. However, the Trust has a greater appetite to accept risks in relation to its pursuance of innovation and the challenging of current working practices in order to realise positive benefits.'*
Agreed Board, March 2018 and reconfirmed July 2019

Overarching risk appetite descriptions

Appetite level	Described as:
Negligible (1)	Avoidance of risk and uncertainty
Low (2)	Preference for ultra-safe delivery options that have a low degree of inherent risk and limited reward potential
Moderate (3)	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
High (4)	Willing to consider all potential delivery options and choose while also providing an acceptable level of rewards (and VfM)

Significant (5)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Risk Appetite assessment against Strategic Aims

Strategic Aims/ Risk Category	Safety	Financial	Reputation	Compliance/ Regulation	Delivery
People	L	M	M	L	H
Services: Clinical	L	M	H	L	M
Services: Education	L	M	M	L	M
Growth and Development	M	S	H	L	H
Finance and Governance	M	M	M	M	H

5. CONCLUSION

5.1 The Board is invited to approve the Board Assurance Framework and to comment whether, with the action plans as set out, the risks are tolerated.

July 2020 BAF HEAT MAP

Likelihood	Risk Matrix		Consequence				
			Negligible	Minor	Moderate	Severe	Extreme
			1	2	3	4	5
	Very unlikely to occur	1					
	Unlikely to occur	2			4	12	
	Could occur	3		7		1↑9b, 11	
	Likely to occur	4		6	2, 5	8, 10b	
	Almost certain to occur	5					

May 2020 BAF HEAT MAP

Likelihood	Risk Matrix		Consequence				
			Negligible	Minor	Moderate	Severe	Extreme
			1	2	3	4	5
	Very unlikely to occur	1					
	Unlikely to occur	2			4	1, 12	
	Could occur	3		7		9b, 11	
	Likely to occur	4		6	2, 5	8, 10b	
	Almost certain to occur	5					

Board Assurance Framework 2019/20 – Summary –

					Current Risk Score						
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**June 2020**	**July 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
1	The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.	DoHRCG	People	1		8 (2x4)	8 (2x4)	8 (2x4)		12 (3x4)	**Green (1x4)**
2	The risk that the pandemic and pressures on leadership have a negative impact of staff morale and engagement with consequences for the delivery of the Trust's strategic objectives and the quality of its current services.	CEO/ DoHRCG	People	2		12 (4x3)	12 (4x3)	12 (4x3)		12 (4x3)	**Yellow (2x3)**
4	The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England	DoN	People	4		9 (3x3)	6 (2x3)	6 (2x3)		6 (2x3)	**Green (1x3)**
5	If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy	DoF	People	5	15 (3x5)	15 (3x5)	12 (4x3)	12 (4x3)		12 (4x3)	**Amber (2x5)**
6	The risk of insufficient staff capacity to keep activity within contracted levels across all services and manage all regulatory requirements because of a	CCOO	Services: Clinical	6			8 (4x2)	8 (4x2)			**Green (2x2)**

					Current Risk Score						
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**June 2020**	**July 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
	range of factors including morale, staff sickness, staff shielding and system pressures. This may also lead to poor engagement with the quality agenda with a negative impact on service quality and performance resulting in non-compliance with CQC fundamental standards of care					6 (3x2)				8 (4x2)	
7	The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress and outcomes resulting in poor performance, commissioner scrutiny and poor CQC ratings.	CCOO	Services: Clinical	6		6 (3x2)	6 (3x2)			6 (3x2)	**Green (2x2)**
8	The risk that wider financial pressures in North Central London in relating to the pandemic or finance have negative consequences for the delivery of the mental health programme in the STP and the delivery of the Trust's wider objectives	CEO	Services: Clinical	8		12 (3x4)	16 (4x4)	16 (4x4)	16 (4x4)	16 (4x4)	**Amber (3x3)**

					Current Risk Score						
	Risk	**Owner**	**Strategic Aim**	**Corporate Objective**	**Oct 2019**	**Nov 2019**	**Mar 2020**	**May 2020**	**June 2020**	**July 2020**	**Target Risk** L=likelihood C=consequence Risk = L x C
9b	If ongoing pressure on the GIDs service affects morale it will be difficult to continue to deliver a challenging agenda, which now includes addressing the impact of COVID 19.	CCOO	Services Clinical					12 (3x4)		12 (3x4	**Amber (3x3)**
10b	The risk that changes in the commissioning environment, and impact of the pandemic on funding and delivery models, will mean that the Trust's current service configuration will not be sustainable in the long term.	DoS	Growth and Developme nt	11		9 (3x3)	9 (3x3)	16 (4x4)	16 (4x4)	16 (4x4)	**Yellow (2x4)**
11	The risk that a failure to develop and modernise the Trusts Educational offering has a negative impact on the sustainability of our provision	DoET/ DeanPGS	Services: Education	12		12 (3x4)	12 (3x4)	12 (3x4)		12 (3x4)	**Amber (3x3)**
12	If the Trust fails to respond to changes in the regulatory environment following the pandemic there will be negative consequences for our reputation and the quality of patient and student experience	MD	Finance and Governanc e	14		8 (2x4)	8 (2x4)	8 (2x4)		8 (2x4)	**Green (1x4)**

Strategic Aims 2019: People; Services: Clinical; Service: Education; Growth and Development; Finance and Governance

Strategic Aim: People
Corporate Objectives:

1. Increase equality of opportunity across the organisation with focus on implementing the next stage of the Race Equality Strategy **Director of HR and Corporate Governance**
2. Continue to strengthen engagement with staff addressing issues highlighted in staff survey and further strengthening arrangements for Trust response to concerns. **Chief Executive**
3. Refresh the Trust's People Strategy with a focus on future workforce needs including supporting the resilience, development and performance of our staff: **Director of HR and Corporate Governance**
4. Position the Trust as a respected authority on workforce development: **Director of Nursing**
5. Establish clarity about long-term plans for the Tavistock Clinic site **Deputy Chief Executive**

<table>
<tr><td colspan="2">RISK 1): The risk that the Trust fails to deliver the commitments of its Race Equality Strategy with a negative impact on staff engagement and the quality of its services.</td></tr>
<tr><td><u>Risk Owner</u>: Craig de Sousa</td><td>Date reviewed 20 July 2020</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 2 x Consequence 4 = 8 <u>TARGET risk rating</u> 1 x 4 = 4
<u>CURRENT risk rating:</u> Likelihood 3 x Consequence 4 = 12 ↑</td></tr>
<tr><td colspan="2"><u>Rationale for current score</u>:
The Trust has established a race equality strategy to a number of recurrent themes around black, asian and minority ethnic staff experience.</td></tr>
<tr><td><u>Controls/Influences</u> (what are we currently doing about this risk?):
Implementation of the Race Equality Strategy is monitored at the Equality Diversity and Inclusion Committee
Race Equality Champion appointed and BAME network established: regular communication between the Champion and the Director of HR and Corporate Governance provides feedback on the implementation as the Strategy is under review in the BAME network
2019 action plan developed and approved by the Trust board.</td><td><u>Assurances received</u> (independent reports on processes; when; conclusions):

Workforce Race Equality Standard annual report (+/-)
Staff survey 2019 (-)
November CQC report confirmed that staff remain concerned about the pace of progress (-) Revised action developed in consultation with BAME network, approved by the Board March 2019 (+)</td></tr>
<tr><td><u>Gaps in controls/influences</u>:
Further training for managers who have attended Thinking Space events to ensure clarity about action necessary to implement the strategy at local level
Significant impact of social factors and issues within our organisation that have impacted on staff sentiment and morale.</td><td><u>Action plans in response to gaps identified</u>: (with lead and target date)
Develop further training plan for managers, (DoHRCG, May 20)
Using funds allocated by the Tavistock Clinic Foundation, review the implementation and impact of the bursary scheme to support individuals to gain access to Trust professional qualifying programmes (DoHRCG, Sept 2020)</td></tr>
</table>

	Increase capability and confidence of senior leaders, across the organisation, to engage in conversations about race, culture and difference (DoHRCG, May 2020) Review and implement ways of integrating discussion on health inequalities and access issues within clinical and training team meetings (CCOO, ongoing)

RISK 2): **If we are unable to maintain good staff morale and engagement there is a risk of negatively impacting on patient and student experience and the quality of services delivered**	
Risk Owner: Paul Jenkins/ Craig de Sousa	Date reviewed 07 July 2020
INITIAL risk rating (at identification): Likelihood 4 x Consequence 3 = 12 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12 (risk score unchanged)	TARGET risk rating 2 x 3 = 6
Rationale for current score: Recognition of negative impact of COVID-19 on staff morale and engagement with work	
Controls/Influences *(what are we currently doing about this risk?)*: Weekly all staff meetings held via Zoom Trust inter-professional meetings Piloting in CYAF of Stress and resilience Framework Follow through of 2019 staff survey results Refresh of people strategy including further action on middle management training Engage with staff to develop new organisational narrative linked to the Centenary. Demographic risk assessments	Assurances received *(independent reports on processes; when; conclusions)*: Staff survey (+/-) Staff feedback (formal and informal) (+/-)
Gaps in controls/influences: Strengthen staff engagement More formal strategy for addressing staff morale and wellbeing	Action plans in response to gaps identified: *(with lead and target date)* Develop staff engagement events building on experience of new formats during pandemic (31/07) CEO) Relaunch extended staff wellbeing offer (31/05) DHRCS Refresh people strategy (September 2020 DoHRG) Deliver engagement ~~for~~ to develop~~ing~~ a new organisational narrative linked to Centenary (RS)-(31/07)

RISK 4): **The risk that the Trust fails to raise its profile as an authority on workforce issues impacting on external reputation and the future viability of the National Training Contract with Health Education England**	
Risk Owner: Chris Caldwell	Date reviewed: 02 July 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 3 = 9 CURRENT risk rating: Likelihood 2 x Consequence 3 = 6 (risk score unchanged)	TARGET risk rating 1 x 3 = 3
Rationale for current score: Risk relating to the viability of the National Training Contract with HEE decreased from risk level 9 to 6 following: 1. Positive review of the Unit by HEE MH Delivery Board and recommendation to HEE national Board that the Unit element of the NTC is rolled continued and rolled into the NTC annually renewable contract. 2. Feedback from HEE London (contact managers) that they are recommending no change to the NTC contract for 2021/22 The NWSDU has maintained a profile and exposure in year through conferencing and the engagement of the Unit with Arms-Length Bodies (ALBs) in the development of the Long Term Plan People Strategy and other engagement activity. DET recruitment and CPPD profile has been positive and demonstrated measurable contribution to increased supply and upskilling of MH workforce. If HEE national Executive agree 'no change' position risk rating will be reduced to 1x3. At review date we have not received this confirmation	
Controls/Influences *(what are we currently doing about this risk?)*: NWSDU and NMHWDC Communications strategies and Plans in place NWSDU/ IJT /CC Objectives: Planned conference delivered to March 2020 IJT attendance at Pan ALB Health & Wellbeing Group CC profile in MH workforce and wider nursing agenda locally and nationally T&P presentation of work to HEE national MH Delivery Group meeting in Jan 2020 IJT Engagement in Pearson 'Learner MH & Wellbeing' HEE Workstream Exposure of Stress & Resilience work to Cavendish Square and 'Top Leaders' groups IJT presentation to HSJ workforce leaders conference and subsequent HSJ follow up article.	Assurances received *(independent reports on processes; when; conclusions)*: Coms Strategy and Plan documents in place (+) Conference evaluation and end of project report (+) Communications support proposal and contract (+) Report on the activity that was planned for NWSDU to deliver on presence at NHS Employers Health & Wellbeing conference, NHS Confed and PWP conference (+) Report of planned activity that is now completed – presence and conference presentation at NHS Expo Sept 19, Presence at NHS Providers Oct 19. (+) Completed work with Pearson Commission Group and Pan ALB H&WB group (+) Report of activity planned for conference season 2020 (+) Agreement and ongoing work for development of shared communications strategy with HEE Mental Health Programme Board (+)

Gaps in controls/influences: None identified	Action plans in response to gaps identified: *(with lead and target date)* Communications support in place from July19 (IJT July 19) Communications action plan in delivery (IJT April 20)

RISK 5): **If the Trust fails to deliver affordable and appropriate Estates solutions there may be a negative impact on patient, staff and student experience resulting in the possible need to reduce Trust activities and resulting loss of organisational autonomy**	
Risk Owner: Terry Noys	Date reviewed: 2 July 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 5 = 15 CURRENT risk rating: Likelihood 4 x Consequence 3 = 12 (risk score unchanged)	TARGET risk rating 2 x 5 = 10
Rationale for current score: Outcome of Competitive Dialogue process remains uncertain whilst NHSI/E capping of capital expenditure makes delivering internal (non JTR) solutions difficult Post COVID-19 working solutions unclear	
Controls/Influences *(what are we currently doing about this risk?)*: Tavistock Centre Strategic Programme Scheduling Project Estates Strategy 67 Belsize Lane Finchley Road	Assurances received *(independent reports on processes; when; conclusions)*: Minutes of Tavistock Centre Strategic Programme Board (+/-) Minutes of Scheduling Project Programme Board (+/-) Estates and Facilities Work sub-committee reporting into IGC (+/-)
Gaps in controls/influences: Uncertainty over Relocation project Post COVID-19 working solutions unclear	Action plans in response to gaps identified: *(with lead and target date)* Competitive Dialogue process (IG 31 December 2020) Remodelling of space at Tavistock Centre (IG – On hold) Review of corporate services use of space (TN – 30 September 2020)

Strategic Aim: Services: Clinical
Corporate Objectives:

3. Continue to delivery high quality clinical services adopting QI processes across the Trust to ensure continuous improvement **DoCYAF/DoAFS**
4. Explore use of technology and other approaches to develop more sustainable models of care with defined outcomes **DoCYAF**
5. Actively contribute to the development of integrated care models in Camden and NCL **Chief Executive**
6. Implement recommendations of GIDS Review and wider lessons from review of Trust's services with clearly measurable outcomes **DoCYAF**

<table>
<tr><td colspan="2">RISK 6): The risk of insufficient staff capacity to keep activity within contracted levels across all services and manage all regulatory requirements because of a range of factors including morale, staff sickness, staff shielding and system pressures. This may also lead to poor engagement with the quality agenda has a negative impact on service quality and performance resulting in non-compliance with CQC fundamental standards of care</td></tr>
<tr><td><u>Risk</u> Owner: Sally Hodges</td><td>Date reviewed: 15 July 2020</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 3 x Consequence 2 = 6 <u>TARGET risk rating</u> 2 x 2 = 4
<u>CURRENT risk rating:</u> Likelihood 4 x Consequence 2 = 8 (risk score unchanged)</td></tr>
<tr><td colspan="2"><u>Rationale for current score</u>: staff report capacity issues and this is backed by HR and team manager reports. Staff survey results reflect this also. COVID-19 is significantly affecting staff capacity. It is anticipated there will be new demand for mental health services as a result of COVID-19 which may further increase pressure on service provision. Remote working makes managing activity and quality activity more challenging.</td></tr>
<tr><td><u>Controls/Influences</u> (what are we currently doing about this risk?):
New divisional director structure to ensure engagement
New Operations Delivery Board will provide a drive to engagement and will address issues that prevent engagement</td><td><u>Assurances received</u> (independent reports on processes; when; conclusions):
Directors appointed July 2019 (+)</td></tr>
<tr><td><u>Gaps in controls/influences</u>:
New board and new general manager roles need to bed in.</td><td><u>Action plans in response to gaps identified</u>: Work on structure and engagement, led by CCOO, new structure to be in place by October 2019, embedded by April 2020</td></tr>
</table>

RISK 7): The risk that our data systems and processes do not provide reliable information in a consistent way, making it difficult to track progress and outcomes resulting in poor performance, commissioner scrutiny and poor CQC ratings.	
Risk Owner: Sally Hodges	Date reviewed: 15 July 2020
INITIAL risk rating (at identification): Likelihood 4 x Consequence 2 = 8 CURRENT risk rating: Likelihood 3 x Consequence 2 = 6 (risk score unchanged)	TARGET risk rating 2 x 2 = 4
Rationale for current score: Data reports from different sources e.g. team reports and contract still not consistent. Staff concerned that data does not reflect their experience. New IM&T structure and approach to process management appears to be having an impact, data becoming more reliable	
Controls/Influences *(what are we currently doing about this risk?)*: Group overseeing data process set up	Assurances received *(independent reports on processes; when; conclusions)*: Minutes of working group (+) Data strategy in place (+)
Gaps in controls/influences: Improvements required in relation operational data entry; and data analysis, operations delivery board will need to oversee some of this	Action plans in response to gaps identified: *(with lead and target date)* Work on data to continue (JR with data strategy fully implemented by ASAP) and Operations board

RISK 8): **The risk that wider financial pressures in North Central London in relating to the pandemic or finance have negative consequences for the delivery of the mental health programme in the ICS and the delivery of the Trust's wider objectives**	
Risk Owner: Paul Jenkins	Date reviewed: June and July 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4 = 12 CURRENT risk rating: Likelihood 4 x Consequence 4 = 16 (risk score unchanged)	TARGET risk rating 3 x 3 = 9
Rationale for current score: Wider financial pressure across the STP with increased disruption owing to COVID-19. A significant amount of uncertainty remains.	
Controls/Influences *(what are we currently doing about this risk?)*: Work closely with partner provider organisations Development of Recovery Plan including CAMHS Anticipation of challenges through roll out of financial sustainability programme Support for NHS Provider Alliance	Assurances received *(independent reports on processes; when; conclusions)*: ICS Recovery Plan for mental health (+)
Gaps in controls/influences: Wider financial position across the ICS Impact of changes in governance arrangements Changes in priorities in the ICS in the light of the pandemic	Action plans in response to gaps identified: *(with lead and target date)* Continued engagement with sector Recovery Plan (PJ ongoing) Successful implementation of Tier NCEL Provider Collaborative (SH Ongoing)

RISK 9b): If ongoing pressure on the GIDs service affects morale it will be difficult to continue to deliver a challenging agenda, which now includes addressing the impact of COVID 19	
Risk Owner: Sally Hodges	Date reviewed: 15 July 2020
INITIAL risk rating (at identification): Likelihood 3 x Consequence 4= 12 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12 (risk score unchanged)	TARGET risk rating 2 x 4 = 8
Rationale for current score: It was agreed that BAF risk 9 should be closed. This had addressed a GIDS risk that inadequate staff capacity and poor morale may lead to failure to deliver against the GIDS Action Plan and lead to Trust reputational damage. While the action plan has now progressed well, risks around GIDs still remain.	
Controls/Influences *(what are we currently doing about this risk?)*: Regular internal meetings and support from Trust; routine data monitoring, routine Trust governance	Assurances received *(independent reports on processes; when; conclusions)*: Regular feedback sought; staffing levels; routine monitoring data on activity
Gaps in controls/influences: Careful post COVID-19 planning; reviewing workload and tasks clinical and admin staff do; further engagement and feedback from staff	Action plans in response to gaps identified: *(with lead and target date)* Post COVID-19 planning (ongoing, AS) Review staff workload and tasks (ongoing AS)

Strategic Aim: Growth and Development
Corporate Objectives:

7. Progress the Trust's longer-term priorities for new service development and meet the target for new growth in 2019/20 **DoS**
8. Develop opportunities to broaden the reach and target audiences of the Trust's training and educational work including international work and development of the Trust's Digital Academy **DoE&T/DPGS**
9. Develop, in preparation for the organisation's 2020 Centenary, a narrative for the role of the Trust's work and expertise in the 21st Century **DoC&M**

<table>
<tr><td colspan="2">RISK 10b): The risk that changes in the commissioning environment, and impact of the pandemic on funding and delivery models, will mean that the Trust's current service configuration will not be sustainable in the long term. [Risk combined with Risk 13 and updated]</td></tr>
<tr><td><u>Risk Owner</u>: Rachel Surtees</td><td>Date reviewed: June and July 2020</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 4 x Consequence 4 = 16 <u>TARGET risk rating</u> 2 x 4 = 8
<u>CURRENT risk rating:</u> Likelihood 4 x Consequence 4 = 16 (risk score unchanged)</td></tr>
<tr><td colspan="2"><u>Rationale for current score</u>:
The Trust has a strong record of good financial performance which has allowed it to maintain the quality and safety of our patient and education services. This has been achieved each year through a combination of modest cost improvement programmes; new income generation through the development of new courses and services; and annual contract activity uplifts. However whilst the organisation's overall financial position has been balanced, there is significant variation between services which has been exacerbated by a number of contract losses. In addition, costs have been incurred to support development and infrastructure work, and contribution from new business has been significantly affected by instability in the external commissioning environment. With the move towards the development of Integrated Care Systems, the impact of the pandemic, and the move towards 'digital first' it is anticipated that opportunities for growth will reduce and the pressure to reduce costs will increase. A significant amount of uncertainty remains.</td></tr>
<tr><td><u>Controls/Influences</u> (what are we currently doing about this risk?):
- Active management of pipeline to have even spread of prospects across the three directorates and at different stages of development (prospect development; proposal writing; in implementation).
- Regular discussion and review of individual prospects and overall pipeline at Business Development Group (BDG).
- Named target markets, including areas outside of health commissioning, to enable better focus and prioritisation on our target routes to growth and diversification of income source
- Active engagement with commissioners including regularly scheduled contract review meetings
- Board approved Budget
- Regular reforecasting of full year out-turn</td><td><u>Assurances received</u> (independent reports on processes; when; conclusions):
- Pipeline report to Business Development Group (BDG) on a monthly basis and Strategic Commercial Committee (SCC) on quarterly basis (+/-)
- Monthly reporting on contract performance data to BDG and quarterly to SCC
- Contribution forecast report to BDG on a monthly basis and SCC on quarterly basis (+/-)
- Management accounts reviewed monthly by EMT and Board</td></tr>
</table>

Gaps in controls/influences:	Action plans in response to gaps identified: *(with lead and target date)*
- No current active plans for service reconfiguration - Limited ability to 'seed fund' new income generating service development opportunities - Lack of joined up data sets to allow objective analysis of underlying sustainability	- Business Development team rebalancing focus to give increased priority to service development opportunities, and growth outside of health commissioned provision (ongoing RS) - Active engagement with a number of STP forums focused on integration and transformation across the patch (all EMT members - ongoing) - Trust-wide task and finish group to look at service configuration and sustainability (TN and RS – pilot in summer 2020, Trust-wide roll out from September 2020) - Development of Trust-wide long term strategic vision statement (RS -completion autumn 2020)

Strategic Aim: Services: Education
Corporate Objectives:
10. Continue to delivery high quality educational services adopting quality improvement processes across the Trust to ensure continuous improvement **DoE&T/DPGS**

RISK 11): **The risk that a failure to develop and modernise the Trust's educational offering has a negative impact on the sustainability of our provision**	
Risk Owner: Brian Rock	Date reviewed: 17 July 2020
INITIAL risk rating (at identification): Likelihood 4 x Consequence 4 = 16 CURRENT risk rating: Likelihood 3 x Consequence 4 = 12	TARGET risk rating 3 x 3 = 9
Rationale for current score: Progress is being made in the establishment of the Digital Academy following Board sign off and is on course to launch as planned. International development is being adversely impacted by COVID-19 though we continue to focus on communicating our offer and developing potential partnerships, including the delivery of an international conference. We expect a dip in activity and income through FY20/21 but believe this position will be mitigated following a resolution to the spread of coronavirus. Delivery of term 3 has been successfully delivered with high rates of student satisfaction. Further work is underway to determine the delivery of AY20/21 building on the experience gained in this last period. Staff have worked very hard and the fatigue might contribute to difficulties considering changes for the year ahead. DET senior leadership team with support from the Education Training Committee has also set out a framework for changing some of our teaching delivery to improve manageability regarding teacher and student load and to reduce costs of provision. The current focus on supporting core Trust activity in this period of uncertainty and reduced capacity will limit new course developments. In this period the adoption of remote delivery and technology will lead to a lasting change in people's willingness to access and preference for online delivery across our provision (long and short courses). There will also be an increase in our capability to deliver through remote means. The market will also become more crowded and competitive and therefore more sustainable development will require a longer period for more fundamental change. There is an opportunity to increase our reach beyond current geographical constraints. This has a longer time horizon aimed at AY21/22.	
Controls/Influences *(what are we currently doing about this risk?)*: Clarity in the focus on the international strategy and plan. Project team established for Phase 2 of the DA. Successful procurement leading to the identification of preferred partner. ~~Task & Finish group phase 2 has led to greater market insights for each portfolio and internal discussion with portfolio managers though the achievements are more incremental. Scoping of Phase 3 underway.~~ Clear framework for delivery changes to programmes launched and being engaged with, including reviewing of lecture and seminar length. This is based on previous insights and proposals considered by two cycles of Task & Finish group co-chair by FD & DoET.	Assurances received *(independent reports on processes; when; conclusions)*: Agreement on international strategy at ETC (July 2019) (+) International coordinator in role to support core team (April 2020) (+) Board sign-off on phase 2 of the DA (Sept 2019). (+) Branding guidelines agreed and soft launch of website on track (July 2020), key marketing role recruited to (July 2020) (+)

Working group with internal and Essex representatives underway of scoping new long course development with agreed milestones including focus groups with students and employers. This is being scoped for AY21/22 due to impact of COVID-19.	
Gaps in controls/influences: International plan delivery is slowed by current COVID-19 situation, Focus diverted and capacity reduced in the foreseeable future on new developments.	Action plans in response to gaps identified: *(with lead and target date)* Reviewing current delivery plan for new modes of delivery including virtual international conference and other events. (DoE/DPGS & International Working Group, Sept 2020) Establishing Development Forum with Director of Strategy to engage across the organisations for new developments for educational delivery (DoE/DPGS & DoS~~, July~~ October 2020)

Strategic Aim: Finance and Governance
Corporate Objectives:

14. Meet the Trust's requirements with its national regulators. Implement the Action Plan from its 2018 CQC inspection including actions to strengthen integrated governance **CEO**
15. Develop 10-year plan for financial sustainability and meet Trust's budget and control total for 2019/20: **DepCEO**

<table>
<tr><td colspan="2">RISK 12): If the Trust fails to respond to changes in the regulatory environment following the pandemic there will be negative consequences for our reputation</td></tr>
<tr><td><u>Risk Owner</u>: Medical Director</td><td>Date reviewed: 6th July 2020</td></tr>
<tr><td colspan="2"><u>INITIAL risk rating (at identification):</u> Likelihood 2 x Consequence 4 = 8 <u>TARGET risk rating</u> 1 x 4 = 4
<u>CURRENT risk rating:</u> Likelihood 2 x Consequence 4 = 8 (risk score unchanged)</td></tr>
<tr><td colspan="2"><u>Rationale for current score</u>: CQC Well Led Inspection expected shortly.</td></tr>
<tr><td><u>Controls/Influences</u> (what are we currently doing about this risk?):
Completed well-led assessment in line with CQC/NHSI guidance and developed action plans to address identified gaps
Continuing engagement with CQC
Implementation of QAA review action plans and established plans from university partner institutional reviews (Essex and UEL)
Annual student survey completed</td><td><u>Assurances received</u> (independent reports on processes; when; conclusions):
Work streams reporting to the Board level Integrated Governance Committee to provide assurance of compliance with CQC requirements and raise issues of risk (+)
Formal CQC report – 'good overall' and 'outstanding' for the Effective KLOE. Requires improvement in gender services for Responsiveness KLOE because of waiting times (+)
Excellent outcome from 2018 QAA monitoring visit (+)
Positive university partner institutional reviews commending course provision and faculty expertise and commitment (+)
Progress on CQC action plan monitored via EMT and IGC (+)
Service Line self-assessments for CQC compliance (+/-)
CQC Planning group monitoring implementation of actions (+)
Service Manager and Board CQC seminars (+/-)</td></tr>
<tr><td><u>Gaps in controls/influences</u>:
Ongoing service line assessments of CQC compliance and action updates required in preparation for inspection</td><td><u>Action plans in response to gaps identified</u>: CQC action plan (DS/CCOO August 2020)
Staff communications - 'values'(LT July 2020)
Staff communications – updated CQC handbook (MS July 2020)</td></tr>
</table>

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	28 July 2020

Operational Risk Register

Executive Summary

1.1 Operational risks graded 15+ and new risks are brought to the attention of the Board. There have been no risks which significantly increased this quarter. All changes are highlighted in Red.

1.2 There are currently 82 risks on the Operational Risk Register.

1.3 In July the new electronic risk register module will be piloted in DET and IM&T services for operational risks. These risks will be moved from the current excel spreadsheet to the new electronic module and reporting will be adapted to ensure that information from both systems is available to the Board.

1.4 The following report includes information on three risks:

- GIDS risk 127. Concerns staffing. Risk level 16. Focus is on GIDs action plan and acknowledging the impact of media.
- GIDS risk 128. Concerns waiting times. Risk level 16. Focus is on recruitment. Waiting list actions being reviewed at Divisional level.
- Trustwide risk 133. Concerns the risk of disruption to service delivery from COVID-19 pandemic. Risk level 20. Demographic risk assessment process in place to manage staff vulnerabilities.

1.5 Risks 9+ continue to be reviewed via the relevant Integrated Governance Committee sub-committees on a quarterly basis.

1.6 The annual internal audit of Risk Management is to be undertaken in July.

1.7 perational Risk Register risks 15+ were reviewed by the Executive Management Team on Tuesday 14th July 2020.

Recommendation to the Board	
The Board of Directors is asked to note the new risks, updates and actions	
Trust strategic objectives supported by this paper	
Finance and Governance	
Author	**Responsible Executive Director**
Associate Director of Quality and Governance	Deputy Chief Executive / Director of Finance

	Date raised	Risk Owner	Scope of risk	Risk Category	Risk Summary	Risk Description Detail: Cause	Risk Description Detail: Event	Risk Description Detail: Effect	L	C	Initial Risk	Controls (measures in place to reduce the risk)	Assurance (evidence of the controls)	Gaps	L	C	Current Risk	Action Plan	Actions update	Operational Lead	Next Review	Operational Monitoring Group	Governance and Reporting Group	Review Cycle	L	C	Target Risk
127	25/07/2019	Gender Divisional Director	GID Service, Communications staff, senior management	**Delivery**, financial, Quality of care, Safety, Reputation, Compliance	GIDS staffing	If internal and external scrutiny GIDS continue to escalate and involve Trust staff	Some staff may feel the work becomes too stressful, with an impact on morale, quality and staff retention	Resulting in a negative impact on service delivery and a further growth to waiting list.	5	4	20	Support from Director and Executive leads with the GIDS team and from Trust senior management through meetings, supervision and other fora; Consultation support service; Staff satisfaction survey review; Proactive communications taking forward recommendations of GIDS action plan and acknowledging impact of media.	Staff satisfaction survey; information from meetings with staff individually and in groups. (+/-) Strategy for supporting staff (+) Communications presentation at service awayday 16th August 2019, 15th October 2019 (+) Analysis of Exit Interviews (+/-) Monthly forum established to support London based 8A's in the service as a result of the 2019 staff survey results Communications presentation at service awayday March 2020 (+)	Further work to deliver GIDS action plan recommendations. Increased visiblity of and contact with senior Trust staff. Comms exercise to support positive media attention around patient experiences. Further detailed analysis of Exit interviews, Build on positive staff survey results and ESQ	4	4	**16**	Analysis of Exit interviews (ongoing)	Reviewed July 2020. No change to score or actions Leadership CPD for senior management team via Tavistock Consulting (+)	Kathleen Hughes	19/08/2020	Gender Executive	Risk and Safety Sub-committee	Monthly	3	3	9

The Tavistock and Portman
NHS Foundation Trust

128	25/07/2019	Gender Divisional Director	GID Service, Trust	**Safety,** delivery, financial, Quality of care, Reputation, Compliance	GIDS waiting times	If action is not taken to increase flow through the service waiting times will continue to increase.	The needs of young people and their families at a vulnerable time in their lives would not be met.	There may be an increased chance of a serious incident for a YP on the waiting list, and increased anxiety and stress for those patients waiting. Poorer quality service delivery if staff time is spent addressing urgent clinical and managerial issues arising rather than delivering well managed services and attending to longer term quality improvement and sustainability. Potential for loss of faith in the service by families waiting Burden on primary care increases.	4	4	16	Focus on recruitment; GIDS DNA and cancellation policy revised; caseload and activity monitoring and management strategy; waiting list project pilot; support for local services to manage concerns locally; quality improvement project for assessment clinics (Midlands) Monthly activity data reviews standing item on GIDS senior team agenda.	NHS Improvement meeting to discuss demand and capacity strategy (Sept 2019) (+) Continued monitoring of waiting list and other data (+/-) Monthly audit of activity data (+/-) Network model and enquiries line CPD for professionals	Data on impact of initiatives being taken and planned to address the issue.	4	4	16	Commencement of further data analysis work by service to understand referral trends, and initiation of relevant Quality Improvement work (Sept 2019 and ongoing AS) Review waiting list initiatives (30 April 2020 - PC)	Reviewed July 2020. Divisional meeting in June 2020 reviewing waiting list actions to date. Score remains the same. Demand and capacity meeting was paused but is due to start again.	Kathleen Hughes	19/08/2020	Gender Executive	Risk and Safety Sub-committee	Monthly	2	4	8

The Tavistock and Portman
NHS Foundation Trust

133	17/03/2020	CCOO; DET; GH	Trustwide	Delivery, Safety, Compliance/Regulation	Risk of disruption to service delivery, non compliance with contracts if COVID-19 pandemic not appropriately managed	If COVID-19 pandemic is not appropriately managed	There is a risk of increasing respiratory outbreaks affecting staff and patients who would be unable to work or attend appointments due to illness. There will be a need to self-isolate owing to the wider impact of COVID-19 and further issue will emerge from actions affecting schools, Universities, wider health and transport systems. Exposure to the virus through contact may also result in a minority of individuals having significant negative impact. Impact on provision of Trust services is already being experienced and could be severe, which will need ongoing mitigation.	The result would be disruption to service delivery, non-compliance with contract requirements and possible serious health impacts. Unmitigated risks to safety of service users and staff	5	4	20	1.Local Business Continuity Plans 2. Weekly EPRR group was shifted to EPRR Gold Command group Chair CEO, membership of key directors, meet daily and WhatsApp group for 24/7 3. Director on call for any Alerts from NHSE 4. Recently revised BCP and Major Incident Plan 5.Trust Pandemic Influenza Plan 6. Demographic risk assessment process to manage staff vulnerabilities.	1.Local Business Continuity Plans 2.EPRR Executive group Chair is AEO for the Trust, Clinical and DET leads, meet weekly and WhatsApp group for 24/7 3. Director on call for any Alerts from NHSE 4. Recently revised BCP and Major Incident Plan 5.Trust Pandemic Influenza Plan	Unknown how long the Virus will be prevalent and endangering lives and service delivery. While there are signs that wave 1 is reducing, it remains possible that there will be further waves of infection	5	4	20	Follow PHE / NHS advice and ensure safety of vulnerable staff and patients and students - concerns about personal health and family. Ensure core staff group available to ensure delivery, mass communications (Ongoing)	All staff, managers and EPRR Exec Risk approved at EMT 17 March 2020 Score unchanged for July 2020	Dinesh Sinha	17/08/2020	EMT	Risk and Safety Sub-committee	Monthly	2	2	4

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	13th July 2020

Serious Incidents – Quarterly Report – Q1 2020-21

Executive Summary

This quarterly serious incident summary report for the Board covers Q1 2020-21. There were no serious incidents identified in Q1, although one incident was logged as an SI, it was de-escalated in agreement with the CCG.

There were 22 clinical incidents reported in Q1, which sadly included three patient deaths, making it a total of ten incidents for review at the June Incident Panel. We reviewed one of the patient deaths, an apparent suicide, with a mortality review, and are awaiting further information on the other patient death to determine whether it will be reviewed via a concise report or mortality review, and this will go to the July incident panel. A further patient suicide was discussed at the incident panel and a concise report was completed. The remaining incidents involved two attempted suicides, which were reviewed via concise reports and each incident had been appropriately managed by the associated teams with no further action required.

There were 10 incidents which were deemed to be Information Governance breaches and each were managed appropriately with relatively low numbers of patients involved, and none of which reached the threshold of a serious incident.

In December 2019 the Trust agreed with our commissioners to undertake a thematic case review of three of our previous serious incidents which were linked to gang related violence. It was envisaged this would be completed within four months, but due to the Covid-19 pandemic, this work has been obviously delayed and there has been no new agreed extension date yet, as this work will involve many agencies working together to review these cases and provide a combined report.

As the Covid-19 pandemic situation continues, the Trust has continued to provide the lessons learned events, which is now done via online platforms. The last lessons learned event was dedicated to gang related violence affecting some of our patient populations and this was an extremely well attended event, which staff found very relevant but due to the nature, sensitivity and material content of this event it was agreed it would not be recorded. This online training provision has also enabled greater staff attendance at lesson learned events right across the Trust and may well be the delivery method of choice going forward.

All patient safety aspects of the 2018 CQC Inspection action plan continue to be regularly monitored by the Executive Management Team for all services and there is continued progress on the actions identified to ensure patient safety.

Recommendation to the Board	
The Board of Directors is asked to note this paper	
Trust strategic objectives supported by this paper	
Clinical Services	
Author	**Responsible Executive Director**
Clinical Governance and Quality Manager	Medical Director

Report to	Date
Trust Board	28th July 2020

Guardian of Safer Working Hours 2020 – 2021 Quarter 1

Executive Summary

The number of exception reports for fines increased in April and May. This seems due to changes in the out of hours arrangements for the higher trainees in Child and Adolescent Psychiatry. The trainees have attempted to spend some of the fines accrued but this has been complicated by the impact of the pandemic. A new GOSWH will be starting in post in August.

Recommendation to the Board of Directors

Members of Board are asked to note this paper.

Trust strategic objectives supported by this paper

Author	Responsible Executive Director
Sheva Habel, GOSWH	Medical and Quality Director

Guardian of Safe working hours Q1 2020 - 2021 report

1. Introduction

1.1. The Guardian of safer working hours provides a report for the trust board on a quarterly and annual basis. This is the report for Q1.

1.2. This is my final report in role.

2. Exception reports (with regard to working hours)

2.1. Total exception reports:

Month	Total reports	Toil	Fine	NFA
April	7	2	5	0
May	6	1	5	0
June	6	4	1	1
Totals	19	7	11	1

The junior doctors and child and adolescent psychiatrists have been extremely flexible in support of the NCL STPs wish to provide a joined up out of hours crisis provision for children during the pandemic. This has been complex at times and resulted in an increased work load out of hours which is reflected in a number of exception reports for significantly longer hours than would be usually expected. More recently there have been some changes and the provision now more closely resembles business as usual which is reflected in there being more toil reports than fines .

The exception reports in Q1 of this year were higher than Q4 but lower then Q1 2019 - 2020 when there were 25.

2.2 Work schedule reviews

- The numbers staffing the non-resident out of hours on call rota is a 1 in 11
- There have been no formal requests for a work schedule review.

2.3 Vacancies

The Child and Adolescent training scheme has no vacancies. There are XX new trainees starting in August

2.4 Locum

The NROC is currently being staffed by Trainees and occasionally an external locum.

	Number of shifts	Number Covered	Number Vacant	Clinicians
April	1	1	0	Sprs
May	2	2	0	
June	3	3	0	

2.5 Fines

	Extra hours worked Normal	Enhanced	Total fine	Amount paid to trainees	Fine Remaining
April	10	14	2271.19	814.135	1457.005
May	28	1	2602.72	975.95	1626.77
June	11	3.5	1443.89	541.43	902.46
Totals			6317.8	2331.515	3986.235

In May and June there were 2 exception reports where the exception reported stated that the trainee worked an additional 11 & 13 hours.

Fines accrued 2018-2019

	Total hours	Total fines	Total paid to trainees	Amount accrued
Totals	57.75	£6370.39	£2385.90	£3984.54

Fines accrued 2019 – 2020

Total	Total hours	Total fines	Total paid to trainees	Amount accrued
Annual total	84.25	£10218.41	£3109.88	£6376.61

3. Junior Doctors Forum (JDF)

My final JDF is on 21st July.

Fine Disbursement:

2018-2019	£3,984.54
2019 - 2020	£6,376.61
Total spent to date	- £5948.67
2018 – 2020 remaining	£4412.48
2020 – 2021 Q1	£3986.235

4. Local Negotiating Committee (LNC)

This report will be shared with the Joint LNC on 20th July 2020

5. Conclusions and Recommendations

5.1. Members of the Board are asked to note the report

5.2. Changes implemented during the pandemic have reverted back to a situation closer to "business as usual" from early July. The impact this has on exception report will be monitored.

5.3. I am pleased to have been made aware of a new GOSWH taking up this role in August 2020 and so will be stepping back from the role at the end of the month.

S. Habel

Dr Sheva Habel

Guardian of Safer Working Hours

Report to	Date
Board of Directors	28/07/2020

Designated Body Annual Board Report

Executive Summary

The report provides a summary of the work undertaken by the Responsible Officer for the designated body in the period since the last annual report in July 2019.

Recommendation to the [Board of Directors]

The board of directors is asked to note / discuss this report

Trust strategic objectives supported by this paper

13. Meet the Trust's requirements with its national regulators

Author	Responsible Executive Director
Medical Director/Responsible Officer	Medical Director

Designated Body Annual Board Report

Section 1 – General:

The board of Tavistock and Portman Foundation NHS Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 4th June 2019

Action from last year:

Comments:

There has been a continual investment and improvement in resources for revalidation over the past year. There was a significant review of the appraisal portfolio and overall requirements for revalidation in 2019. All medical staff in the Trust are aware that revalidation requires them to have an annual full appraisal, which has to be recorded on the electronic system of SARD (Strengthened Appraisal and Revalidation Database).

The Trust supports medical staff to complete appraisals and achieve revalidation in order to continue to work with patients. The Responsible Officer (RO) Dr Dinesh Sinha and Appraisal Lead (AL) Dr Caroline McKenna email regular updates on revalidation to all doctors in the Trust. Various appraiser meetings have been used to assess continuing improvements in appraisal processes and revalidation.

The Trust hosted a successful visit by the HLRO (Higher London RO) team to inspect the Trust for its revalidation and appraisal processes. The report outcome and brief action plan underlined the very positive feedback on the various improvements made in the past 2 years and give external assurance to the Board about our revalidation related activity.

Trust Consultants and junior doctors have been highly effective in our response to the changing demands on services during this acute period. We have successfully implemented changes in the out of hours' pathways and Trust doctors have been key in continuing to deliver effective care on various on call rotas. There have been regular supportive welfare calls with Medical colleagues and continuing forums like the MSC. Following the start of lockdown, the GMC moved revalidation dates for those who were due to revalidate between 17 March 2020 and 16 March 2021. This includes introducing flexibility for those doctors who have had their revalidation dates changed, allowing ROs to make revalidation recommendations at any time up to a doctor's new submission date.

Given the move into the next phase of the pandemic, the Trust Medical appraisal process, which was suspended from March 2020 has now been reactivated to provide support for our medical staff. The RO intends to use available portfolio information to make recommendations as possible and advised by the most recent communications with the GMC. We plan to have an appraiser training session for a group of appraisers to continue to develop refresher appraiser sessions within the trust and training for new appraisers. Action for next year: We will continue to improve our processes

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: New RO was appointed in Aug 2018 Comments: Dr Dinesh Sinha, Medical Director is the Trust's Responsible Officer Action for next year: N/A

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: Funding has continued to be available Comments: Yes, we currently have sufficient funds, capacity and other resources for the RO to carry out his role. Action for next year: We will continue to review our processes and resources.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: The Revalidation Manager (RM) keeps an accurate record and reviews prescribed connections, which are also discussed at ROAG Comments: The RM keep an ongoing review of our independent doctors with a prescribed connection. A further review of the prescribed connection to the designated body for our independent doctors was completed and several individuals within our independent list were asked to move their responsible officer and designated body to an independent body. At the same time, we have continued to add individuals who have a basis for prescribed connection to our independents list. Action for next year: We will continue to improve our processes

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Renewal of Appraisal and Revalidation Procedure Comments: Yes, the Trust has an Appraisal and Revalidation Procedure Action for next year: Our Medical Appraisal and Revalidation Procedure is currently being urgently reviewed by the AL.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: n/a Comments: The Trust had a successful review by the HLRO and we have made good progress on the action plan since the visit. Action for next year: We will continue to improve our processes

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: n/a Comments: Yes, we support our locums and short term placement doctors, as appropriate Action for next year: we will continue efforts to support this group of doctors.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: n/a Comments: The expectation of an annual appraisal and its practice are understood and operational. At the same time, we have agreed with the GMC ELA and HLRO to shift appraisal dates closer to revalidation dates, as appropriate. The RO maintains regular contact with the Trust GMC employment liaison advisor and in these we discuss continuing improvements, including the setting up of a Responsible Officer Advisory Group (ROAG) from 2020, which is attended by the appraisal lead Dr Caroline McKenna, Medical HR Umran

Murad and Revalidation Manager Lorna Campbell. A Trust NED has attended the ROAG and will be returning for future meetings.

Action for next year: We will continue to improve our processes and plan to trial a PPI rep and later a service user rep to join the panel on a frequent basis.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: n/a

Comments: Any delays in appraisal or issues with appraisal are discussed with the RO and in Responsible Officer Advisory Group (ROAG)

Action for next year: We will continue to improve our processes

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Renewal of Appraisal and Revalidation Procedure

Comments: Yes, the Trust has a Medical Appraisal and Revalidation Procedure

Action for next year: The Medical Appraisal and Revalidation Procedure is currently being urgently reviewed by the AL.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: N/a

Comments: There has been a session of refresher training for our group of appraisers on the 30 Sept 2019 and a train the trainers event led by an external trainer on 13 June 2019. A further session of appraiser refresher training is planned later this year.

Action for next year: We will continue development of this important workforce for revalidation

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: n/a

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: The Trust has regular appraisers meetings, which enable improvements in training and development.

The RO, RM and AL attend networking and external development events.

Action for next year: We will continue development of this important workforce for revalidation

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: n/a

Comments: RO has set up a Responsible Officer Advisory Group (ROAG), and provides an annual report to the Board regarding systems in place for appraisals and revalidation.

A NED has now joined the ROAG and will attend on regular basis.

Action for next year: We will be doing a pilot for including PPI or/ and service user in the ROAG

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: all recommendations were timely

Comments: The RO has continued to provide recommendation using GMC Connect until the suspension of revalidation.

Action for next year: We will continue to review our processes in light of the changes due to the pandemic

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: n/a

Comments: Yes, the appraiser, appraisal lead and RO attempt to have early discussions about any emerging issues and these issues are noted at

ROAG. All doctors are advised of any deferrals and steps required to reach revalidation.

Action for next year: We have and will continue to improve our processes

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: n/a

Comments: The Trust has had significant improvements in its clinical governance structures and support for learning for all staff, including doctors. This includes well-functioning incident panel, divisional level CG forums, conduct of incident reviews, learning events using an interactive format and the Tavistock Inter Professional Event, which have all remained functional through the period of the pandemic.

Action for next year: We will continue to improve our processes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: n/a

Comments: Doctors are supported in collecting and highlighting relevant information for their appraisals and revalidation. ROAG and our RM have helped further clarify processes to support doctors.

Action for next year: We will continue to improve our processes

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: n/a

Comments: We have a Raising Concerns & Whistleblowing Policy. The RO and HR will always actively seek advice from GMC ELA, NCAS and others regarding possible investigations or interventions for any concerns.

Action for next year: We will continue to improve our processes

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the

Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: n/a Comments: We have not had any significant number of concerns about doctors. The ROAG considers any individual issues through its HR membership. Any significant changes would be reported with analysis to the Board. Action for next year: We will continue to review our processes

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: n/a Comments: RO has ongoing contact with senior colleagues in various other organisations Action for next year: we will work towards substantiating a procedure for transferring information as appropriate

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: n/a Comments: Our Raising Concerns & Whistleblowing Policy contains a detailed description of safeguards for all staff and processes for responding to concerns with links to other policies. The Trust has recently undertaken a raising concerns review and actions from this will add safeguards. Action for next year: We will continue to improve our processes

Section 5 – Employment Checks

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: n/a Comments: Yes. All staff records have been moved to ESR to ensure appropriate governance. Action for next year:

Section 6 – Summary of comments, and overall conclusion

- **This report outlines the systems and processes we have established to facilitate and support the revalidation of doctors in the Trust.**
- **Doctors require revalidation or renewal of their licence to practice once every five years. They need to maintain a prescribed connection with the designated body and revalidation recommendations are made by the Responsible Officer.**
- **The RO for our medical trainees is Dr Sanjiv Ahluwalia who has taken over as Postgraduate Dean for Central and North East London.**
- **None of the doctors for whom the Tavistock and Portman NHS FT is the designated body is currently subject to any GMC fitness to practice procedures or any imposed conditions or undertakings.**

Overall conclusions:

- **The Trust continues to benefit from an exceptionally committed workforce of Medical staff who have contributed exceptionally well during the period of the pandemic.**
- **The RO and colleagues continue to improve processes for appraisal and revalidation. The GMC moved revalidation dates for those who were due to revalidate between 17 March 2020 and 16 March 2021. This includes introducing flexibility for those doctors who have had their revalidation dates changed, allowing ROs to make revalidation recommendations at any time up to a doctor's new submission date. The RO intends to use available portfolio information to make recommendations as possible and as advised by the most recent communications with the GMC.**
- **The appraisal process which was suspended from March 2020 has now been reactivated to provide support for our medical staff.**
- **We intend through the next year to continue to engage stakeholders internally and externally, while continually improving the processes and experience of appraisal and revalidation.**

Section 7 – Statement of Compliance:

The Board of The Tavistock and Portman NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Report to	Date
Trust Board	28/07/2020

Infection & Control Protection (IPC)

Executive Summary

This has been a period of challenges emerging in the assessment of future use of physical spaces at the Trust's main site at the Tavistock Centre, but also the many other London and National sites.

This is especially, as based on the IPC guidance released in May 2020, we like several other providers have felt the impact of the new measures on the use of our estates.

We recognise that this remains a challenging period for all staff and hope that actions taken will help in resolving some of the dilemmas is the current situation.

In this context, we have also agreed that exceptions/ clinically informed agreements to the recent NHSE guidance will be notified to the Board.

Recommendation to the [Board / Council]

Members of Board are asked to discuss and approve the recommendations in this paper.

Trust strategic objectives supported by this paper

6. Continue to deliver high quality clinical and educational services

Author	Responsible Executive Director
Dinesh Sinha	Medical Director and DipC

Infection & Control Protection

1. Introduction

1.1 We are aware of challenges emerging in the assessment of future use of physical spaces for face to face activity, at the Trust's main site at the Tavistock Centre, but also the many other London and National sites.

1.2 This is especially as the Trust like several other providers has felt the impact of the new IPC measures, based on the guidance released in May 2020 and further directive on use of masks.

1.3 Various aspects of work have been completed or are ongoing to take account of the new Infection Prevention and Control needs and maintain safety:

- All clinical rooms at the Tavistock Centre have been assessed for capacity to maintain social distancing and guidance notices put up on the doors
- Signage has been put up around the common areas to help direct flow and maintain social distancing
- Masks are being made available at Reception and there are specific bins dedicated to collecting used masks
- PPE has been made available to teams carrying out face to face activity
- Cleaning schedules amended to adjust to new cleaning requirements

1.4 We have now agreed a plan to implement the following steps for all non Tavi sites:

- All team managers will complete the checklist (Appendix A) and determine the use of clinical spaces to allow social distancing
- Estates (and if needed the health and safety officer) will then visit the site and support assessment of specific issues like use of public areas with the team manager
- Cleaning contracts for all sites are being reviewed
- Cleaning products for in between use by staff and PPE will be provided at all sites to allow the safe use of shared spaces and also to allow safe working offsite, such as in home visits
- Service managers can be contacted for further support and specific queries

1.5 We recognise that this remains a challenging period for all staff and hope that these measures will help in resolving some of the dilemmas is the current situation.

1.6 We have also agreed that there will be exceptions possible, based on clinically informed risk assessed decisions, such as to allow some clients to be seen in clinical settings without masks. We will bring updates on exceptions to Board.

2. Conclusions and Recommendations

2.1 Members of Board are asked to note and approve the actions, as described in this paper.

Appendix A

The Tavistock and Portman NHS
NHS Foundation Trust

NHS
Property Services

Risk assessment and actions

Building name……..

May 2020

☑ We have cleaning, handwashing and hygiene procedures in line with the guidance						
Consider	**Identify** ✓ *(tick those that apply)*		**Current Risk Level**	**Assessment**	**Additional actions**	**Final Risk Status**
Objective: Before reopening, to make sure that any office, therapy space or areas that have been closed or partly operated are clean and ready to start						
Building systems are operating effectively for current conditions		A building safety check has been completed, with a check in ventilation systems (Estates). Windows have been opened to vent the area.			*Check with Estates and Facilities that Water and Fire safety checks have taken place in the last 7 days*	
Objective: To keep the workplace clean and prevent transmission by touching contaminated surfaces						
Keeping the workplace clean		Frequent cleans of workplaces and equipment between use, with standard cleaning products				
		Frequent cleaning of object that are touched regularly – such as door handles and keyboards and have facilities for waste				
		Clean desk / area policy at the end of the shift				
		Limit or restrict the use of printers and whiteboards				
		Ability to commission 'COVID' cleans after a known or suspected case of COVID-19				

Consider	Identify ✓ *(tick those that apply)*		Current Risk Level	Assessment	Additional actions	Final Risk Status
PPE, Hand washing, hygiene and toilets		Ensure PPE stocks are availble		Face masks, Hand sanitiser, wipes. Face visors if needed (when masks are too restrictive to communicate, ensuring 2m distancing) Gloves - single use if there is no handwashing / sanitising available ie home visits.		
		Set clear guidance for the use of toilets and maintaining distance. Ensure they are regularly cleaned.		*Signage; 'Knock before entering' to ensure social distancing*	Set clear guidance for the use of toilets and maintaining distance. Ensure they are regularly cleaned.	
		Display signs of good handwashing technique				
		Ensure there is a good supply of soap in washrooms				
		Provide clear guidance for use of toilets. Maintaining distance and ensure they are kept clean				
		Where possible provide paper towels as an alternative for hand dryers				
		Provide more waste receptacles and more frequent collections				
		Enhance cleaning for busy areas				

		Where hand washing facilities are not available or for those travelling consider providing hand sanitiser				

☑ We have taken all reasonable steps to maintain a 2m distance in the workplace						
Consider	**Identify** ✓ *(tick those that apply)*		**Current Risk Level**	**Assessment**	**Additional actions**	**Final Risk Status**
Objective: To maintain 2m social distancing wherever possible, including while arriving at and departing from work, while in work and driving between sites						
Identify what measures are needed to provide 2m distance to / from work		Need to stagger start / finish time to avoid crowding				
		Additional bike racks to encourage cycling to work if possible				
		Reception to sign in and out for all staff and visitors				
		Masks for all in main reception				
		Entry / exit process , one way system around the building if possible				
		Markings and signage if one way system implemented				
		Handwashing / sanitiser at entry / exit points				
		Provision of face coverings for those who have to use public transport				
Identify what measures are needed for moving						
		Introducing one way flow through buildings/regulating use of corridors				
		Reducing maximum occupancy of lifts, one person , or one family				

around buildings		Restricting access to other areas of the building				
Consider	**Identify** ✓ *(tick those that apply)*		**Current Risk Level**	**Assessment**	**Additional actions**	**Final Risk Status**
Objective: to maintain social distancing between individuals whilst at work.						
Workstations should be assigned to an individual and preferable not to be shared		Maximum capacity for people to work 2m apart				
		Need to redesign workplace and remove desks not to be used if needed				
		Don't place people opposite each other at desk				
		Mark floor space to help people keep 2m distance				
		Where desks have to be shared – clean between occupants				
		Provision for cleaning workstation before and after use				
		Requirement of additional space to accommodate those who need to return to the workplace				
Objective: to maintain social distancing between individuals whilst at work.						
Keeping social distance whilst working in		Need to redesign work areas to provide 2m social distance				
		Provision of signage to help maintain a 2m social distance				
		Reinforce 'catch it, kill it, bin it and good hand hygiene				

occupied areas		Requirement for additional space to deliver services whilst maintaining 2m social distance		*Therapy and administration rooms have signage advising of room capacity*		

Consider		Identify ✓ *(tick those that apply)*	Current Risk Level	Assessment	Additional actions	Final Risk Status
Objective: to reduce transmission due to face-to-face meetings and maintain social distancing in meetings						
Identify how face to face meetings can be accommodated		Use IT tool to facilitate meetings				
		Identify maximum number of participants for room size to maintain 2m separation		*Therapy and administration rooms should have signage advising of room capacity*		
		Mark meeting table with sitting points				
		Remove whiteboard markers / flipcharts and shared pens				
		Use floor signage to help people maintain 2 m distance				
		Provide hand sanitiser, tissues and bins in room				
		Allocate meeting rooms for larger groups / family therapy				
Objective: To maintain social distancing whilst using common areas						
Common areas		Work collaboratively with T&P and Landlords other occupiers to apply consistent approach				
		Use of break rooms / kitchens – stagger allocation of time				
		Use safe outside areas for breaks				
		Reconfigure seating in areas				

Consider	Identify ✓ *(tick those that apply)*		Current Risk Level	Assessment	Additional actions	Final Risk Status
Common areas		Signage requirements to support social distancing				
		Install screens to protect people in receptions				
Objective: To minimise the number of visitors/patients						
Managing contacts		Can the 'visit' be done by remote connection?				
		If site visits are required, when and where		*Requirement to enforce PPE ('grab bag' of essential single use PPE) and social distancing measures in place at the site to visited* *Ensure Lone Working Procedures are followed*		
		Limit numbers of visitors/patients at any one time.				
		Stagger appointments and waiting room capacity, ensure patients know to arrive on time not before if possible				
		Produce schedules for essential services and contractor visits				

		Maintain record of all visitors, sign in and out sheets				
Communications and Training		Provide clear consistent communications				
		Engage with workers representatives				
		Provide induction on ways of working for new employees				

☑ Where people cannot be 2m apart, we have done everything practical to manage transmission risk						
Consider	**Identify** ✓ *(tick those that apply)*		**Current Risk Level**	**Assessment**	**Additional actions**	**Final Risk Status**
Objective: To prioritise safety during incidents						
Measures to take during an accident or fire		Fire safety evacuation		People do not need to stay 2m apart if it would be unsafe		
		Accident / Incident at work		First aiders to be provided with a mask (gloves should be part of the kit already) All involved MUST observe good hand hygiene following the incident	Mask & goggles/visors to be part of first aid kit	
Objective: managing transmission risk where 2m distancing cannot be maintained						
Small reception areas		Assess need for fixed screen and markers of the floor to denote a distance to kept				
Welfare facilities		Take alternative urinals out of use to maintain distancing				
Fixed desk arrangements		Take desks out of use (facing desks) or provide a barrier between desks, Signage on desks/ chairs that are not to be used				
Occupants in all rooms		Ensure the number of occupants in at any one time are adhering to guidelines – specify a maximum number of people				

Consider	Identify ✓ *(tick those that apply)*		Current Risk Level	Assessment	Additional actions	Final Risk Status
Deliveries to site		For large deliveries maintain 2 person pairings, or provide one person with lifting and moving equipment				
		Encourage drivers to stay in their vehicles where possible				

This has been taken from the Government 'working safely' documents dated 11 May 2020 and is subject to revision should any further guidance be provided. www.gov.uk/guidance/working-safely-during-coronavirus-covid-19

Risk Levels

High	Significant Action needed
Medium	Some actions required
Low	All practical measures taken to manage transmission risk

Date Completed		Reviewed by	
Completed by		Organisation	

Report to	Date
Board of Directors	28th July 2020

Annual Complaints Report 2019-20: Patient Services

Executive Summary

Complaints have remained at a similar level over the past year compared to 2018-19. In 2018 an increase in complaints and changes to some administrative structures resulted in a backlog of complaints and an increase in the response times. In early 2019 the back log of complaints had been addressed and during 2019-20 we were able to respond to many complaints within the 25 day target.

An IG incident in September 2019 resulted complaints from 32 patients. This was fully investigated and reported to the Information Commissioners Office.

Complaint numbers within the Directorates have remained at roughly the same level as received in previous years.

Due to COVID-19 a pause was put on the complaints process, this has now ended, but there is a resulting backlog of complaints to investigate.

Recommendation the [Board / Committee]

The Board is asked to approve this report

Trust strategic objectives supported by this paper

Improve the effectiveness and quality of patient experience.
Continue to meet regulatory standards with CQC.

Author	Responsible Executive Director
Amanda Hawke, Complaints Manager	Paul Jenkins, Chief Executive

Annual Complaints Report

1. Introduction

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 majority of our complaints continue to be received within the Gender Identity Clinic. The themes relate to waiting times and communications with a smaller number relating to aspects of clinical decision making, access to therapy, disagreement with clinical reports and information governance incidents. This report summarises the complaints received in the year, and the lessons learned from this important form of patient feedback.

This complaint report covers formal complaints received by clinical and corporate services. All complaints relating to Education and Training are logged and responded to by the Dean.

2. Analysis

A total of 157 complaints were received for the year, 155 of these relate to our clinical services and 2 complaints relate to corporate services.

15 complaints were received in the Adult and Forensic Directorate,
11 were received in the Children, Young Adults and Families Directorate
129 were received in the Gender Services
2 were received in the Corporate Directorate.

Each complaint was investigated under the Trust's complaints procedure and a letter of response was sent by the Chief Executive to each complainant.

During 2019/20 information was requested by the Health Service Ombudsman on four complaints. This has been supplied and we are waiting to hear if any further action is to be taken. No complaints referred to the Health Service Ombudsman have been upheld within the year.

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.

Complaints presentations are given at Induction and INSET days and also at team meetings to ensure that staff are aware of the complaints procedure and how to advise patients who wish to make a complaint. We have also ensured that information on how to raise a complaint is in all patient waiting areas.

The Quality Portal is working well and all complaints are managed through this system. We are now able to record action plans following upheld complaints on the Quality Portal. Patients are able to submit a complaint on-line via our website alternatively they can be submitted by email or letter and these are then uploaded onto the Quality Portal by the Complaints Manager.

3. Formal complaints received

The chart below shows the numbers of formal complaints over the past 6 years.

Year	2015-16	2015-16	2016-17	2017-18	2018/19	2019/20

No of formal complaints	14	27	39	154	156	157

4. Time to respond to complaints

Of the 157 complaints received in 2019 -20, 147 have now been sent a formal response, the remaining 10 are still to receive a response. Patients were kept informed if their complaint response was going to be longer that the target of 25 working days.

Owing to the COVID-19 crisis the complaints process was paused at the end of March. This followed the notice from the Health Service Ombudsman that they would not be accepting any new complaints for a period of 3 months so that NHS staff could focus their efforts on dealing with the Coronavirus crisis. All NHS Trusts imposed a 3 month pause on investigating and responding to complaints. All complainants were informed of this.

Staff have been asked to resume investigation into complaints, but as a result of the pause there is a backlog of complaints to be investigated. Currently there are 30 outstanding complaints.

5. Complaints by Directorate and Service

Of the 157 complaints received 113 of these were relating to the Gender Identity Service so the number of complaints received by the rest of the Trust is 44 (this number includes GIDS) which is a decrease from the previous year.

The table below shows the number of complaints by directorate over the past 5 years. Gender Services were previously counted under CYAF, they are now a separate directorate.

	Number of Complaints		

Directorate	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
CYAF	5	5	19	28	143	134
A&F	7	9	6	8	7	18
Corporate	0	0	2	3	4	4
Total	**12**	**14**	**27**	**39**	**154**	**156**

Data source: Quality Portal

Directorate	Number of Complaints 2019-20
CYAF	11
A&F	15
Corporate	2
Gender	129
Total	**157**

Data source: Quality Portal

6. Complaints Upheld

There is a recognition that patients feel listened to when it is acknowledged that even small errors have occurred, even if the main basis of their complaint has not been upheld. 87 complaints were upheld fully or in part. Following these decisions action plans have been completed for each complaint so that improvements can be made to the services.

Was the complaint upheld?	2015-16	2016 - 17	2017-18	2018-19	2019-20
Upheld in full	7	8	41	45	62
Upheld in part	7	11	21	44	25
Not upheld	9	14	50	67	60

Under investigation at time of report	4	6	42	0	10
Total complaints	27	39	154	156	157

Data source: Complaints database/Quality Portal

7. Lessons learned

Complaints are always considered as opportunities for lessons to be learned, whether or not the complaint is upheld.

All complaints are fully investigated and a detailed report drawn up to address all the issues raised. When a complaint is upheld either in full or in part, an action plan is drawn up to ensure that where appropriate changes are made or further training is offered.

Complaints are discussed at clinical team meetings and the Professional Clinical Advisory Group so that the senior staff are made aware of any themes from the complaints and appropriate action taken.

When corresponding with the complainants we seek to ensure that they feel listened to and that their concerns are being taken seriously. Where appropriate further appointments are offered to complainants with senior staff, to ensure that any issues over our processes and their clinical treatment is clarified.

A number of specific actions have been taken during the year in direct response to complaints and these are shown in the table below:

Topic	What was upheld	Lessons learned
Clinical	Apologised and gave explanation for the errors that had occurred during this patients care. Changes have been made to our protocols when staff leave or are on long	Changes to protocol for existing patient to be made when staff take unexpected leave

Topic	What was upheld	Lessons learned
	term sick leave. Further appointment offered to patient should they want it.	
Trust Administration Issues	Apologised for confusion over appointments and the delay in sending the final report. Adult services have been contacted and they have agreed to backdate referral.	Staff to be reminded of the importance of sending timely reports to adult services. Discussed at the team meeting
Waiting Times	Explanation given about increase in waiting times. Apologised for misleading information and further information given on appointments.	Continue to provide support to families who are on the waiting list. Communicate to staff the importance of uploading all communications to Carenotes and use clear language when corresponding with families.
Discharges	Acknowledged that it was disruptive and distressing for therapy to have ended before the planned date. Further sessions have been offered.	Further treatment to be offered to patient for 6 months of they wish to take this up.
Communication	Letter for an autism referral was produced within an acceptable time (one month). Information on how families should communicate with Bristol outreach service will be clarified.	Voice mail message at Bristol clinic should be clear that phones are not manned all the time and that patients should contact the London clinic.

Data source: Quality Portal

8. Parliamentary Health Service Ombudsman (PHSO) Investigations

If a patient is dissatisfied with a response to a complaint that they have received from an NHS Trust they have the right to refer their complaint to the NHS Health Service Ombudsman who will review the concern and may take one of three options:

- Refer the matter back to the trust for further investigation

- Undertake an investigation itself (if the complaint involves clinical matter the Ombudsman's office is required to seek expert opinion)
- Take no action

During 2019/20 no complaints were upheld by the Health Service Ombudsman. During the year there have been four further preliminary enquiries from the Ombudsman and information has been supplied as requested.

9. Compliments

From time to time we receive compliments from patients. Below are quotes taken from two letters received after successfully resolving their complaints.

'*I want to thank you so much for taking my complaint seriously and with such compassion and for taking steps to improve things. I was very impressed by your apology, your transparency and your empathetic understanding of my situation. It was like a breath of fresh air, it was humane and very welcome.*'

'*I would first like to thank you for the kind and constructive words in your letter, for taking the time to outline the situation and for your apology for the delay in replying, which I accept.'*

10. Next steps

For 2020-21 the Trust is committed to ensuring that all staff are fully aware of the different ways that patients can raise concerns. Further guidance has been issued to staff and new posters have been displayed in all patient areas on who to contact should a patient wish to make a complaint.

Complaints management will continue to be promoted at staff induction, mandatory training events and in clinical team meetings. Administration staff, the PALS Officer, the Complaints Manager and Patient and Public Involvement (PPI) staff will continue to work together as to ensure that patients are appropriately supported when they raise an issue.

Staff who have had a complaint lodged against them will be notified of this by the Complaints Manager and offered support as appropriate.

11. Whistleblowing

There was one whistleblowing case in 2019/20, the matter was investigated independently and an outcome has been communicated to the individual that raised the concerns.

Craig de Sousa
Director of HR and Corporate Governance, July 2020

Report prepared by
Amanda Hawke, Complaints Manager
on behalf of Chief Executive Officer

July 2020

Report to	Date
Board of Directors	28.07.20

Diversity of the Student Body: EDI Data Roadmap

Executive Summary

Following the presentation of a report on EDI Data across the student journey, from recruitment through to completion, to the Education and Training Committee (ETC) earlier this year, a roadmap outlining next steps was requested. This was presented to the July ETC.

The substantive ETC report sets out the findings from the first EDI data reporting and where the significant areas of concern were, largely at application stage where BAME students were 10% less likely to be offered a place on a course and at Award stage where BAME students were 18% less likely to be awarded a Distinction or Merit.

Further work has since been undertaken to draw out the data at course specific level.

The Associate Dean for Learning and Teaching has been working with EDI leads and other professional services staff in setting a Roadmap for the coming year, which is presented for review and discussion in this report.

Recommendation to the Board

Members of the Board are asked to note and discuss the recommendation(s) in this paper.

Trust strategic objectives supported by this paper

Make further progress in increasing equality of opportunity across the organisation with a particular focus on implementing the next stage of the Trust's Race Equality Strategy.

Author	Responsible Executive Director
Paul Dugmore, AD Learning and Teaching	Brian Rock, Dean and Director of Education and Training

1. Diversity of the Student Body: EDI Data Roadmap

1.1 A report for the February ETC set out the ongoing work within the Directorate of Education and Training over the past year to gather and report data on the student experience from recruitment to graduation in order to make comparisons across a number of protected characteristics. These datasets will enable reporting on whether there are differences in the experiences of students from minority backgrounds at Directorate, Portfolio and Course level, feeding into the Directorate and Portfolio Equalities Action Plans. It will enable the Directorate to use routine data reporting to enable an assessment of progress made and the identification of areas for improvement.

1.2 The first data reports across five protected characteristics (Disability, Race, Religion, Sex and Sexuality) resulted in heat maps being produced for each protected characteristic across the five portfolios. These showed particular concern in relation to Race and Disability. It was agreed by the ETC that further work be undertaken to provide a fuller picture at course level.

1.3 A Roadmap was also requested to identify the areas of concern and to address how these would be addressed in the coming months and academic year to follow. It is clear that this is a significant undertaking requiring a large amount of work, both in terms of the ongoing reporting at course level across all protected characteristics and what actions will be taken to address the areas of concern.

1.4 This Roadmap has been developed to identify the areas requiring immediate action and a process of addressing these. There is now a fortnightly working group, led by the Associate Dean of Learning and Teaching, including the Operations Director, the EDI leads, the Head of Academic Governance and Quality Assurance, Head of Student Recruitment and the Student Data Analyst.

1.5 The actions required to address the respective areas in the roadmap are the responsibility of course teams and professional services. Each

portfolio manager has been given the reports for all of the courses in their respective portfolio so that they can be discussed within course teams. Each portfolio is required to complete an Equalities Action Plan for the new academic year outlining how they plan to address the specific concerns of the courses within the portfolio. These will be reviewed by the EDI leads and Associate Dean to ensure that they are specific, realistic, and have measureable targets within the academic year. They will be reviewed annually along with the data reports for the subsequent academic year so that there is effective benchmarking and to ensure that progress is being made. Updates will be provided to the Education and Training Executive and to this committee.

1.6 **Prioritisation**

To address the significant work required in delivering on this roadmap we will be increasing the resources of the EDI leads to enable closer liaison and review of the data and the plans developed for it. Once portfolio action plans have been completed these will be shared across portfolio to promote pan- portfolio sharing to ensure consistency and best practice. The agreed plans will be signed off by the Training Executive with the ETC providing a more strategic oversight on a bi-annual basis. It will be important that the EDI group shapes and influences where we put our efforts to ensure the work is targeted and achievable, focusing on where we can make a tangible difference. The data reports will be considered alongside other data points including the annual student survey and complaints and also feedback from the BAME, LGBTQ+ and Disabled students support groups.

DET Equalities Data Road Map

Theme	Objective	Action required	Target	Timescale	Lead	Comments
Student demographics	To capture data across student experience from application to award	To report the data for disability, sexuality, sex and religion at course level	To have a full data set for AY 18-19	8 July 2020	Ade Imoru	
Recruitment	To extend Trust reach to a wider pool of applicants from BAME backgrounds	Review entry level courses to establish if more courses needed		2021 AY	Paul Dugmore Elisa Reyes-Simpson PMs	
Recruitment	Promote the Trust as a place to learn for prospective applicants from BAME backgrounds	Focus groups with existing students to capture their experience of recruitment Surveying unsuccessful applicants Targeted open events Summer school taster sessions Support with applications Bursary Mentoring		2021 AY	Roz Wood	

Recruitment	Reduce variance in rejections between BAME/white students in all portfolios	Review interview records and shortlisting decisions to establish reasons for rejections by course		Summer term	Roz Wood	Applications more difficult to analyse than interviews
Recruitment	Reduce variance in rejections between Disabled and non-disabled students in PC portfolio	Review interview records and shortlisting to establish reasons for rejections by course Encourage a higher level of disclosure at application stage		Summer term	Roz Wood	Applications more difficult to analyse than interviews
Teaching and Learning	Ensure more inclusive curricula	Review curricula to ensure issues of EDI are adequately represented in teaching and learning activity e.g. reading lists, case studies, resources		Summer term	Portfolio Managers	
Assessment	Reduce variance between BAME/white students in average grade across all portfolios except systemic	Identify average grade at course level and identify where concerns lie. Identify areas of good practice (Systemic portfolio)		Summer term	Ade Imoru PMs/CLs	

		Develop course action plans to review assessment strategy and develop more inclusive assessment practices				
Assessment	Reduce variance between Disabled and non-disabled students in average grade in PA portfolio	Identify average grade at course level and identify where concerns lie and areas of good practice (in PC portfolio) Develop course action plans to review assessment strategy and develop more inclusive assessment practices		Summer term Beginning of AY 20/21	Ade Imoru Course Leads/PMs	
Awards	Reduce variance between proportion of BAME students awarded Distinctions and Merits compared to white students	Identify numbers/percentages at course level and highlight areas of concern Develop course action plan to review assessment strategy and develop more inclusive assessment practices		Summer term Beginning of AY 20/21	Ade Imoru Course Leads/PMs	

Awards	Reduce variance between proportion of Disabled students awarded Distinctions and Merits compared to non-disabled students	Identify numbers/percentages at course level and highlight areas of concern Develop course action plan to review assessment strategy and develop more inclusive assessment practices		Summer term Beginning of AY 20/21	Ade Imoru Course Leads/PMs	
Complaints	Reduce variance between proportion of complaints from BAME vs white students	An annual data report to be produced and reported to the Training Exec in December and following ETC.	Identify trends beyond a particular issue or a particular course.	November of each year	Simon Carrington and Isabelle Bratt	
Appeals	Reduce variance between proportion of appeals from BAME vs white students	An annual data report to be produced and reported to the Training Exec in December and following ETC.	Identify trends beyond a particular issue or a particular course.	November of each year	Simon Carrington	
Academic misconduct	Reduce variance between proportion of academic misconduct cases from BAME vs white students	An annual data report to be produced and reported to the Training Exec in December and following ETC.	Identify trends beyond a particular issue or a particular course.	November of each year	Simon Carrington	

Bullying and harassment	Reduce variance between proportion of academic misconduct cases from BAME vs white students	Further analysis to understand overrepresentation of Muslim students and non-white students. To explore this over-representation alongside data from equalities section of the student survey		Autumn term	Rebecca Bouckley	

Report to	Date
Education and Training Committee	06 February 2020

6 Diversity of the Student Body

Executive Summary

This report sets out the work that has been ongoing within the Directorate of Education and Training over the past year to gather data on the student experience from recruitment to graduation in order to make comparisons across a number of protected characteristics.

It also discusses the resource required to produce such datasets and the limitations of our current informatics capacity to run required reports. Sitting under the remit of the Learning and Teaching Committee, chaired by the Associate Dean for Learning and Teaching, an Equalities work stream was established to take forward this work.

The production of these datasets will enable us to report on whether there are differences in the experiences of students from minority backgrounds at Directorate, Portfolio and Course level, feeding into the Directorate and Portfolio Equalities Action Plans. It will enable the Directorate to use routine data reporting to enable an assessment of progress made and the identification of areas for improvement.

Recommendation to the Committee

The Committee is asked to discuss the data and approve this reporting format. It is also asked, In light of the challenges in producing the data, to consider how the DET reporting environment can be developed, to ensure timelier reporting in future.

Trust strategic objectives supported by this paper

1. Make further progress in increasing equality of opportunity across the organisation with a particular focus on implementing the next stage of the Trust's Race Equality Strategy.

Author	Responsible Executive Director

Paul Dugmore Associate Dean, Learning & Teaching	Brian Rock Director of Education & Training/ Dean of Postgraduate Studies

1 Background

1.1 In 2017/18 the Directorate set out an Action plan to support the Trust in its aim for wider participation by ensuring education provision is inclusive and the diverse needs of students are recognised. This included a number of objectives including increasing the diversity of teaching staff, making our existing student support services and information more visible and developing the knowledge and skills of staff in working with diversity across all forms of delivery.

1.2 To support this agenda, a one session post of an Equalities, Diversity and Inclusion lead within DET was recruited to in 2019. In recognition of the volume of work, an additional session was made available by redirecting the work of another member of faculty to support EDI initiatives.

1.3 As the work developed it was agreed a data driven approach to inform the ongoing work was required. A working group was established to identify what data were needed in order that progress and areas for improvement could be identified. Over the past term data have been collected for the academic year 2018-19, some of which are presented in this report. Data in relation to recruitment does not include courses which are delivered jointly with university partners who have responsibility for recruitment (M23, M35) or where recruitment is managed via a consortium (M4).

1.4 The production of this dataset represents a huge achievement for the Trust as we have never before been able to gather accurate data about the demographics of our student population across the student journey. For the first tranche of this work, data have been gathered against the following protected characteristics: disability, race, religion, sex and sexuality regarding the experience of students in relation to recruitment and enrolment,

assessment and progression, and student complaints, appeals and academic misconduct. An additional piece of work was undertaken to report on the responses to questions on equality, diversity and inclusion in the 2018-19 student survey.

2. Findings

2.1 Substantial work has gone into producing these datasets and to date, only initial analysis has been possible. This has focused on DET as a whole and further work will be conducted and reported in due course at portfolio level. Benchmarking against these datasets in subsequent years will be a helpful measure of progress. The data are reported against each of the five protected characteristics with data on race broken down to portfolio level to align with the Trust's Race Equality Strategy and data on disability also at portfolio level.

2.2 Disability

2.2.1 87% of enrolled students have indicated that they have no known disability. 5.5% of all currently enrolled students identifying as having a disability, the largest percentage of those (5%) had a specific learning difficulty such as dyslexia. These data do not show immediate areas of concern regarding the experience of disabled students at the recruitment, enrolment or progression stage of the academic cycle, however, we know that there may be significant issues regarding the extent to which students are declaring disabilities and our response, understanding and capacity to act upon reasonable adjustments. The first disabled students support group took place this month with a second scheduled for February as an opportunity for us to hear from our disabled students about their experience and how we can best support them.

2.2.2 Portfolio level data heat map

Portfolio	Application	Enrolment	Progression	Achievement	Award
Psychoanalytic Applied	4% of disabled students rejected vs 12% non-disabled students	No disabled students withdrew	No disabled students failed at second attempt compared with 2 non-disabled students	Lower average mark for disab led students	27% of disabled students awarded Distinction or Merit vs 72% of non-disabled students
Psychoanalytic Clinical	37.5% of Disabled students rejected vs 33% of non-disabled students	No disabled students withdrew	No disabled students failed at second attempt compared with 2 non-disabled students	Higher average grade for students with LD; lower average for those with 'other disability'	None of the 2 disabled students awarded or M compared to 36% of non-disabled students
Psychological Therapies	10% of Disabled students rejected Vs 20% of non-disabled students	No disabled students withdrew	No students failed at second attempt	2 categories of disabled students with higher average grades and 2 lower	60% of disabled students awarded or M or D compared to 47% of non-disabled students
SCLM	0 disabled students rejected vs 3% of non-disabled students	No identified disabled students withdrew but 43% did not provide info	No disabled students failed at second attempt compared with 3 non-disabled students	Disabled students had significantly higher average grades	No disabled students in data set

Systemic	8% of Disabled students rejected vs 18% non-disabled	0 Disabled students withdrew vs 8% of non-disabled students	No students failed at second attempt	Higher average grades for most categories of disabled students	100% of disabled students awarded D or M vs 74%

2.3 Race

2.3.1 25% of students who applied in 2018/19 were from a BAME background. Of those 56% were offered places and 49% were Rejected or Withdrew, compared to 31% being Rejected or Withdrawing from a White background. Of enrolled students, 21% were from a BAME background and 71% were White; 9% of BAME students withdrew compared to 7% of white students. In all portfolios other than the Systemic portfolio, students from at least one BAME category received lower than average marks. 13% of students who achieved a Distinction were from a BAME background, compared to 88% from a White background and 17% of students achieving a Merit were from a BAME background.

2.3.2 Portfolio data heat map

Portfolio	Application	Enrolment	Progression	Achievement	Award
Psychoanalytic Applied	15% of BAME students rejected vs 10% white students	10% of BAME and 10% of white students withdrew	3% of BAME students failed at second attempt vs no white students	Lower average grade for all BAME categories of students than white	48% of BAME students awarded Distinctions and Merits vs 72.5% of white students
Psychoanalytic Clinical	42% of BAME students rejected vs 32% of white students	0 BAME students withdrew Vs 6% of white students	2% of BAME students failed at second attempt vs .75% of white students	Lower average grade for all categories of BAME students	33% of BAME students awarded Distinctions and Merits vs 36% of white students

Psychological Therapies	31% of BAME students rejected Vs 16% of white students	6% of BAME students withdrew (1 student) vs 1.5% white	0 students failed at second attempt	Lower grade average for all categories of BAME students	33% of BAME students awarded Distinctions and Merits vs 68% of white students
SCLM	12% BAME students rejected vs no rejections of white students**	28% of BAME students withdrew vs 5% of white students *	8% of BAME students failed at second attempt vs 0 white students	Lower average grade for 3 out of 4 categories of BAME students	40% of BAME students awarded Distinctions and Merits vs 46% of white students
Systemic	30% of BAME students rejected vs 12% white	5.5% of BAME students withdrew vs 8% of white students	0 students failed at second attempt	Equal or higher average marks for BAME students	64% of BAME students awarded Distinctions and Merits vs 80% of white students

*46% of students did not provide ethnicity and recruited undertaken by UEL

*16% of white students have no outcome of their application so uncertain as to whether they were rejected or withdrew.

2.4 Religion

2.4.1 Of all applicants, 47% identified as having no religion, 27% Christian, 5% Jewish and 4% Muslim. Of enrolled students 45% identified as having no religion, 23% as Christian, 5% Jewish and 2% Muslim. The figure of almost half of applications from Muslim applicants rejected warrants further exploration to identify the reasons for rejection. Of all cohorts enrolled (including Y1), 5 of the groups identifying as having a religion showed an average mark below the overall average, two groups (Buddhists and Muslims) had average marks below the overall average across all

portfolios and one group (Sikh) with a significantly lower average mark.

2.5 **Sex**

2.5.1 85% of Enrolled students are Female and 13% Male, with the remainder either not provided or refused. There is only a binary choice on application forms of Male and Female so this requires some attention. The performance of Year 1 students, based on assessment was equal to the overall average for both Male and Female, with Female slightly below average in two portfolios, and Males slightly below average in one. However all average marks for both Male and Female remained within 5 marks of the overall average. 82% of Distinctions were Female students received and 83% of Merits.

2.6 **Sexuality**

2.6.1 81% of applicants identified themselves as Heterosexual. Benchmarking data within an education setting is yet to be identified but the last National Survey undertaken in 2017, indicated that the proportion of the UK population identifying as Heterosexual or Straight was 93.2% and 2% Lesbian, Gay or Bisexual. 9% of all currently enrolled students identified as LGBT+ and 72% as Heterosexual. 18% of students either refused or did not provide the information. There are no immediate areas of concern regarding the data of LGB students at the recruitment, enrolment or progression stage of the academic cycle. The data in relation to assessment shows some instances where LGB student's average grade is lower than the portfolio average. Further analysis of this at course level is required to identify if there are any issues of concern to be addressed.

2.7 **Complaints, Appeals, Academic Misconduct**

2.7.1 These data are reported separately from application, enrolment and progression data due to the relatively small number of students represented across these three categories where students' identities could be visible. Such numbers also mean that care needs to be taken in extrapolating any conclusions.

2.7.2 The results for sex and sexuality show that there is no evidence of any one group being overrepresented compared to their proportion of the student population as a whole. The data for sexuality has a disproportionate number of students 'not disclosed'. This is mainly due to Trust data collection from students who started their programmes a number of years ago. The quality of this dataset will be improved with the current enrolment and registration data collection procedures.

2.7.3 There is a similar situation with disability. The data show no disparities, however this measure will improve with better data recording for students joining more recently.

2.7.4 The results for religion show that there is a notable over-representation of Muslim students in this dataset. There is also an over-representation of non-white students and specifically those with a non-mixed black or Asian heritage. Fifteen students appear where there would be expected to be no more than five.

2.7.5 These latter results require further consideration and monitoring. It is not immediately clear whether students having these characteristics are more likely to have difficulties in navigating the Trust's organisational structure and therefore better support needs to be in place or whether there is another common factor at play which is not apparent. Comparison needs to be made with the academic performance of these groups of students to look for recurring themes.

2.8 Student Survey data

2.8.1 The overall satisfaction rate for 2018/19 is 92%. In terms of protected characteristics, the most notable findings are:

2.8.2 That those who did not wish to disclose their gender were significantly less satisfied (77%) than the Trust average of 92%. Only a binary response option of male/female was provided on the survey.

2.8.3 It is difficult to draw conclusions about overall satisfaction by ethnicity due to the very small numbers some ethnicities are represented by. High-level data shows that BAME (93%) and white (92%) students have an equivalent level of overall satisfaction, in line with the Trust benchmark.

2.8.4 Sexual orientation was the only protected characteristic where there were notable differences in satisfaction – where only 80% of those identifying as bisexual were satisfied with their overall student experience, compared to the Trust average of 92%. This represents 25 students out of 752 respondents. Without considering a trend over at least three years it is difficult to draw conclusions due to the low number of respondents in this bracket.

2.8.5 No issues were noted in relation to the other protected characteristics.

2.8.6 Harassment and Bullying

2.8.7 6% of students who completed the survey reported witnessing or experiencing harassment and bullying (41 out of 752 students). However, of those students, 31 did not feel able to raise this with a member of staff. This raises the question of how safe students feel to discuss or report these issues, and whether the disclosure rate on this survey is a fair reflection of students' experiences.

2.8.8 In terms of the protected characteristics, these are the most notable findings amongst those who have witnessed or experienced harassment and bullying when compared with the total student population:

2.8.9 There is a disproportionate number of students of Asian descent experiencing bullying or harassment. Whilst they represent only 7% of student numbers, the 17% involved in appeals, complaints or academic misconduct is much higher.

2.8.10 There is a disproportionate number of students who are Christian (28% vs 42%).

2.8.11 There is a disproportionate number of students who identify as disabled (10% vs 18%).

2.8.12 There is a disproportionate number of students who would rather not disclose their sexual orientation (9% vs 14%), religion/belief (7% vs 15%), gender (3% vs 10%) and age (3% vs 10%).

3. Discussion and future direction of travel

3.1 The provision of these datasets provides an opportunity for portfolios and courses to be able to explore more deeply the experience of students from recruitment through to progression against specific protected characteristics. Examples of good practice will be able to be identified as well as areas of concern which will inform subsequent action plans.

3.2 Whilst these datasets have only recently been produced leaving insufficient time for a full analysis, there are some clear areas which need additional focus, primarily, disproportionate numbers of students from BAME and Muslim backgrounds being rejected and represented in relation to appeals, complaints and academic misconduct. With regards to accessing further data about why minority groups are rejected at application stage, such data are available in the interview feedback but it is qualitative and will require additional resources to analyse in order to identify themes.

3.3 The disproportionate 'awarding gap' between students from BAME backgrounds compared to white students which is prevalent in all but one portfolio requires urgent exploration and greater understanding so that appropriate action can be identified and taken. The disproportionate 'awarding gap' between some categories of disabled students and those students without a

disability in some portfolios also raises issues of concern that warrant further exploration.

3.4 Further analysis of these data will be able to inform future action plans, recruitment campaigns and identification of specific support needs for BAME and disabled students on their student journey. These data will drive emerging thinking around a bursary programme which is currently under design. It is anticipated that a bursary will be put in place with two overarching aims. Firstly, more targeted support of the development of Trust staff to contribute to a more representative faculty. Secondly, to assist preparedness to train for external applicants by accessing Trust CPD provision. As the current available resource is relatively small, decisions on how best to spend and sustain this fund need to be made with a view to charity fundraising.

3.5 Further monitoring is required in relation to complaints, appeals and academic misconduct so that if a notable over-representation of Muslim and non-white students continues in subsequent years that this can be attended to.

3.6 Attention is required regarding how data relating to sex is collated with the current binary option needing to be addressed.

4. Data collection

4.1 Once the data required for the Equalities reporting was specified, a request was submitted to the Trust's Information Management & Technology team, for a report that would meet the specification. Because of other priorities for systems and reports developments, the report was not written, meaning a more manual reporting process was necessary.

4.2 Additionally, it was not possible to include data for some of our students at application stage, as some our courses do not route

applications through the student database, SITS. This applies to M23 (a joint course with UEL), M35 and M4.

4.3 Unfortunately there were some delays to the extraction and dissemination of the data, owing to the manual nature of the task. The Equalities working group has discussed the need to schedule the production of future reports in advance, to ensure the work is not delayed by other projects. Work is also being planned, with IM&T, on the potential development of a reporting environment which would mean that these reports could be produced on demand, once built and added to the environment. This initiative is seen as a high priority for DET as we expect to have many more requirements for reporting on our student data.

5. Conclusion

5.1 Discussions are currently underway within the Education and Training Executive to implement a system of running data reports at specific points in the academic cycle, cognisant of the other reporting demands upon staff. This will also require significant informatics changes so that such reports do not continue to expend the significant resource required in the provision of these first datasets. This will enable routine reporting which will feed into the executive and at portfolio level and will inform recruitment strategy as well as course and portfolio equalities action plans. The Committee's view on whether these data are sufficient, or whether there are any other areas requiring attention, what reporting timescales in the future might be and the mechanism for reporting is sought. There is currently a limited resource in place for this work and the committee is asked for its view on whether this is sufficient or needs recalibrating.

Paul Dugmore
Associate Dean, Learning and Teaching
January 2020

Report to	Board of Directors
Report from	Education and Training Committee – 2nd July 2020

Key items to note

The Education and Training Committee met in July conducting its normal business obtaining assurance and updates in relation to various work streams. The committee particularly noted the following;

Registration with the Office for Students

The committee noted that the Office for Students is prioritising current registrants, particularly in relation to financial sustainability, student well-being, and the new academic year. It is expected the Trust will be engaging with them at the end of July in relation to the Trust's application.

Financial Forecast

The committee noted the redrafted budget which reflects a reduction of 50% across all key areas – long courses, CPD and short courses, and Tavistock Consulting. Long course recruitment is currently forecast at the level of 90% (student numbers).

Student Recruitment

The committee received an update on the first fully virtual Trust open day which was well-attended and very engaging. The committee noted that applications submitted are up 5% as against this time last year, and offers accepted are up 9%. Conversion remains important, in light of the current context and prevailing uncertainties

Online Developments

The committee noted the significant online developments with FutureLearn, and with our Chinese partner WWYY.

Response to Covid-19

The committee noted the ongoing work and engagement of DET staff across teaching and professional services in response to Covid-19. Of note, the Committee discussed the Association of Family Therapists (AFT) stipulations around 50% of activity (both clinical and teaching) being delivered face-to-face and the need to continue the dialogue to reach a collective, sustainable solution. [Post meeting update: Paul Jenkins & Brian Rock are meeting with the AFT Chair and CEO to discuss.]

The committee also noted the emerging dynamic in relation to new students, and the need to think about how to engage new students and where possible to bring them into the building to meet fellow students and tutors, within the prevailing parameters.

EDI Roadmap

The committee discussed the EDI Roadmap which has been developed by Paul Dugmore, Associate Dean, Learning and Teaching, and is a working document to allow portfolios to develop their own targets. This is included on the agenda of the Board of Directors for a wider discussion.

Planning for Academic Year 2020-21

The committee commended the engagement of students, professional services, and teaching staff in developing plans for Academic Year 2020-21, including through a pulse survey of students and through the engagement of Portfolio Managers and Course Leads in a series of portfolio meetings. The committee noted the parameters set down in relation to the reduction of teaching session length from 75 to 60 minutes, and from 90 to 75 minutes, and the considerations that led to this.

The committee supported the recommendation taking account of the following factors:

- Key student feedback in relation to session length
- Financial considerations, including the need to make savings following the loss of the National Training Contract
- Manageability and sustainability of teaching for staff and students
- Resourcing
- Face-to-face sessions are only one aspect of the student-tutor interaction
- A high quality student experience and learning and teaching will be maintained
- Where there is a clear rationale for activity remaining the same, this will be considered, alongside the requirements to meet learning outcomes.

The committee recognised that there were some strong views on this issue but felt proper account had been taken of the impact on the quality of student experience.

TEL Planning and Preparations for AY20-21

The committee discussed three options presented by Simon Kear, Head of TEL, which set out a manageable ambition for AY2020-21, whilst also looking to the future, in relation to technology enhanced learning. The committee approved option 2, which is a Moodle upgrade, bringing forward the Trust's Moodle development plans by one year, and allowing the Trust to reconsider user experience and address concerns raised by users over the years. Further, the committee approved option 3, to pilot another learning platform, Aula, to allow the Trust to explore the potential of learning technologies in the future.

Student Complaints Procedure

The committee agreed to recommend the revised Student Complaints Procedure for adoption.

Digital Academy

The committee noted the ongoing progress in relation to branding development for the Digital Academy. We are planning for a soft launch of the DA website in July with a full launch of the DA and the first wave of programmes in Sept 2020.

DET Board Reporting

The committee noted the proposed framework for reporting on DET data to the board and the progress made in student reporting. The committee also noted the developments in operational and external reporting, and the need for a level pf reporting which reflects requirements in the delivery of education and training. The committee deferred this item for further discussion in September. A new format of reports based on the previous reporting format has been included in the quality dashboard for this Board meeting.

Actions required of the Board of Directors
The Board of Directors is asked to note this paper.

Report from	Paul Burstow
Report author	Brian Rock, Director of Education & Training / Dean of Postgraduate Studies
Date of next meeting	03 September 2020

The Tavistock and Portman
NHS Foundation Trust

Report to	Date
Board of Directors	28th July 2020

Annual Report for the Integrated Governance Committee (IGC) 2019-20

Executive Summary

This annual report of the Integrated Governance Committee (IGC) provides an overview of assurance from this committee for 2019-20. The annual review of the IGC's Terms of Reference took place in January 2020 which included:

- restructuring of work streams into sub committees
- amended reporting focus for sub committees
- disbanding of the Corporate Governance and Risk work stream
- Introduction of Organisational, Development & People sub committee
- Additional members and attendees joining the committee

The new formation of sub committees is set out below:

- **Data Security & Protection Sub Committee** – Terry Noys/Jon Rex
- **Risk & Safety Sub Committee** – Caroline McKenna
- **Patient Experience & Quality Care Sub Committee** – Chris Caldwell
- **Estates & Facilities Compliance Sub Committee** – Terry Noys/Ian Garlington
- **Research and Development Sub Committee** – Eilis Kennedy
- **Organisational, Development & People Sub Committee** – Craig de Souza

Although the Corporate Governance and Risk work stream was disbanded, all relevant reporting topics have been subsumed into alternate new sub committees or via other routes outside the IGC. The committee's membership now also includes the Divisional Directors covering CYAF, AFS & and Gender services (GIDS & GIC). Oversight of the CQC inspection preparation is no longer part of the IGC remit and is reviewed regularly via the Executive Management Team.

This year's committee's work has provided assurance of good governance in all areas as reported in the Q4 report. There were no specific governance issues

raised during the year, but work has been impacted across the Trust during Q4 in relation to the Covid-19 pandemic and this remains ongoing.

This committee has received assurance that the Trust has continued to provide appropriate and safe care to as many of our patients as possible during this particularly difficult time and that our staff team in general has switched to remote working quite seamlessly in most areas.

It is of note that our IMT staff team performed extremely well during the pandemic, not only in providing the correct equipment to staff able to work from home, but also in providing remote support for systems to enable as much seamless working as possible. Another out performing staff team is our estates and support services teams who are managing to keep sites open and as Covid-safe as possible for all staff, students and patients, and this work continues on a daily basis.

Recommendation the [Board / Committee]
The Board is asked to note this annual report.

Trust strategic objectives supported by this paper
Regulatory compliance and delivering high quality services.

Author	Responsible Executive Director
Irene Henderson & Work Stream Leads	Dr Dinesh Sinha